CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH)

INDIRECT COST RATE (ICR) POLICY

FREQUENTLY ASKED QUESTIONS

Revised September 10, 2014

Contracts Impacted by the ICR Policy

1. **Does *Contract Management Unit (CMU) Bulletin 13-07: Indirect Cost Rates for Contracts with Local Health Departments* (ICR Bulletin) apply to all CDPH contracts?**

   No. The ICR Bulletin applies only to Subvention/Local Assistance contracts, Allocation Agreements, and Grants with local health departments.

2. **Are any CDPH programs exempt from the ICR Bulletin?**

   No. The ICR policy applies to all CDPH programs; however, federal grant restrictions and/or statutory requirements can supersede the CDPH published ICR for local health departments. For example, if a federally funded program has ICR requirements or restrictions that are different than the CDPH published ICR, CDPH programs shall use the federal fund ICR requirements.

3. **Does this ICR process apply to city health departments?**

   Yes. The ICR Bulletin applies to Long Beach, Berkeley, and Pasadena city health departments. However, the ICR must be certified by the City's equivalent of the County Auditor-Controller and the city must use methodologies to calculate the ICR that are consistent with the Federal Office of Management and Budget (OMB) 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles and Audit Requires for Federal Awards (commonly referred to as the OMB Super Circular and formerly known as OMB Circular A-87). The OMB Super Circular requirements are available at the Electronic Code of Federal Regulations (*e-CFR*) website.

4. **Does the ICR Bulletin apply to "federal pass through grants to the State?**

   Yes. It applies to all contracts, grants and allocation agreements between the local health department and CDPH.

5. **Historically, there have been CDPH programs that did not allow indirect costs or only permitted a very low ICR, has this practice changed?**

   Yes. The ICR Bulletin standardizes ICR practices across all CDPH programs; however, a local health department may elect to use an ICR that is lower than the CDPH-posted ICR for that local health department.

6. **If a Tobacco Control Program is organizationally situated in the Alcohol & Drug Department rather than Public Health Department should the Public Health Department's ICR be used or is the Alcohol & Drug Department to submit a separate ICR certification to CDPH?**

   The maximum allowable ICR for the local health department is the basis for any CDPH-funded program's allowable ICR. If a CDPH-funded program operates out of a department other than the local health department, that department may charge an ICR no more than the actual ICR within that department or no more than the local health department's maximum allowable ICR, whichever is less. For example, a Tobacco Control Program located within an Alcohol & Drug Department may charge the actual ICR for the Alcohol & Drug Department, provided the ICR does not exceed the maximum allowable local health department ICR for that county.

7. **When is the CDPH-Posted ICR effective?**

   CDPH posts each local health department's approved ICR in January for use in the following fiscal year.

Updating the ICR Used in Contracts

8. **What if I am in the middle of a multi-year contract? Do I need to amend the contract to update the ICR? If so, when?**

   A contract's ICR may only be changed when an amendment for other Business/Programmatic reasons is initiated. When an amendment for other Business/Programmatic reasons is initiated, the ICR percentage may be adjusted to the current FY ICR at the time of the amendment. However, the ICR's application, (i.e.,

Total Personnel Costs or Total Allowable Direct Costs) may not change for the life of the contract.

For example, if an existing contract was executed with a 14% ICR applied to the Total Allowable Direct Costs and at the time of amendment, the local health department's published ICR is 14.5%, the contract's ICR may be amended to 14.5%. However, the new ICR would apply to expenses incurred after the amendment's final execution date and not retroactively. Conversely, if the ICR decreased, the lower ICR will be applied at the time of the amendment's final execution and not retroactively.

9. Can the local health department amend a contract at any time to reflect a new ICR?

No. An amendment solely for the purpose of changing the ICR is not allowed. However, the ICR can be changed at the same time an amendment is made for other Business / Programmatic reasons.

10. What if the local health department's ICR goes down? Do I need to amend the contract?

See answers to questions 8 & 9.

11. If the ICR increases, will my contract budget be adjusted to accommodate the increase?

No. Changes to the ICR do not impact the total contract award. Any increase in the ICR is to be funded by shifts from other budgeted line items. Conversely, any ICR decrease is to be redistributed to other budgeted line items.

12. Can the local health department charge less than the ICR for its indirect costs?

Yes, a local health department may elect to charge less than its CDPH posted ICR. However, the ICR basis (i.e., Total Personnel Costs or the Total Allowable Direct Costs) may not differ from the CDPH-posted ICR for that local health department.

For example, if the local health department's CDPH posted ICR is 20% of Total Personnel Costs, the local health department may elect to charge less than 20% of Total Personnel Costs, but it cannot change its ICR application to a percent of the Total Allowable Direct Costs.

13. May a local health department program opt to use an ICR calculation over the other (i.e. 25% of Total Personnel s Costs vs. 15% of Total Allowable Direct Costs)?

No. At the time of submittal, each local health department provides CDPH with its ICR percentage and application (i.e., Total Personnel Costs or the Total Allowable Direct Costs), it intends to use. This selection will apply to all CDPH contracts with that local health department. However, a program within the local health department may opt to charge a lower ICR than the CDPH-posted ICR. See question 6.

14. May a local health department revise its CDPH-Posted ICR or how it is applied (e.g., switch from Total Personnel Costs to Total Allowable Direct Costs? If so, when?

Yes. A local health department may change its ICR or how it is to be applied during the annual submittal.

15. What if different programs within a local health department submit different ICRs?

A local health department may only submit one ICR to CDPH which will be applied to all local health department programs and contracts with CDPH.

However, a local health department program may elect to charge less than its CDPH-posted ICR as long as the ICR application (i.e., Total Personnel Costs or Total Allowable Direct Costs) remains consistent with the CDPH-posted ICR.

16. Is the indirect cost amount invoiced based on the total indirect cost calculated in the contract budget exhibit or based on actual expenditures?

The ICR's total dollar amount in the contract's budget is the maximum allowable to be invoiced. The invoice is to be calculated on the local health department's *actual* expenses consistent with the fully executed contact budget.

Information about ICRs

17. How do I know if the cost is built into the ICR or should be a direct cost?

Indirect costs are incurred for the benefit of multiple programs, functions, or other cost objectives and therefore cannot be specifically identified with a particular program or other cost objective. The indirect cost expenditures are billed through an allocation process. Indirect costs are necessary for the general operations of the local health department. Typically, indirect costs include such items as: executive personnel costs, administration, legal services, audits, accounting, data processing, and janitorial services.

For more information, please refer to the OMB Super Circular available at the *e-CFR* website.

18. Do Total Personnel Costs include salaries and benefits or just salaries?

Total Personnel Costs includes salaries, wages and benefits.

19. How is Total Direct Cost different from Total Allowable Direct Cost?

The term Total Allowable Direct Cost refers to the fact that when calculating the ICR off of total costs, that only the first $25,000 of each subcontract may be used in the calculation.

20. Are retiree costs included in the salary and benefits (Total Personnel Cost)?

Pension plan costs are allowable as fringe benefits, provided the local health department, under its established written policies, grants such benefits. Post-retirement health benefits (PRHB) may be allowed if they were not included in the pension plan. These post-retirement health insurance costs may be computed using a pay-as-you-go or an acceptable actuarial cost method. If they were calculated using an actuarial cost method then they are allowable up to six months after the end of a given funded fiscal year. However, this provision is not automatically allowed. In order for such benefits to extend beyond the six months, this approval must be explicitly included in CDPH contract language. Issues revolving around pension costs can become involved, and it is suggested that if a local health department offers these benefits they review OMB-A87 sections d and e.

ICR Package Completion, Submission, and Processing

21. What is a local health department to do if its cost categories do not match those on the Indirect Cost Rate Schedule?

The categories listed on the Cost Rate Schedule are standard cost categories typically used by government agencies and are defined in the OMB Super Circular. You are required to use the pre-identified cost categories. Additionally, there is an "Other" category which you may use to describe cost categories unique to your local health department. If the total of the "Other" category exceeds 5% of the total operating expenses, an explanatory comment is required.

22. I have Interagency Agreements (IAA) with other County organizations to provide internal services. Where do I record the cost those agreements?

Reporting of your IAA's cost should be consistent with your County's audited OMB Super Circular financial reports. Any difference or changes to the reporting should be identified in the Comment Section where these costs are reported.

23. Who in the local health department has authority to submit the local health department's ICR package to CDPH?

The ICR package is to be submitted by the local health department's Health Administrator or designee.

24. Who is to sign the ICR Certification?

The Auditor Controller (or designee) and the Agency/Department Official are required to sign and certify that the documents submitted are accurate, consistent with generally accepted accounting principles, prepared in conformance with OMB Super Circular, and that the costs used in calculating the ICR are the most recently independently audited actual financials available to the local health department

25. Does the County Controller get involved in the certification?

Yes. The Auditor Controller or his/her designee is to sign the Internal Certification of Indirect Cost Rate Proposal.

26. Who within CDPH verifies that the local health department's proposed ICR is accurate?

Each year the local health department's proposed ICR will be reviewed and verified for compliance by the CDPH Financial Management Branch.

27. Who within CDPH will post the local health department ICRs? Where?

The CDPH Contract Management Unit (CMU) will post the ICR on the CMU Internet and Intranet sites by January 1st to be used in the upcoming State Fiscal year.

28. What is the timeline for all of this to happen?

CDPH will post ICRs in January 2015 for Fiscal Year 2015/16 contracts.

29. What if I must submit a FY 2015/16 budget prior to CDPH posting revised ICRs for use in FY 2015/16?

Use the FY 2014/15 CDPH-posted ICR for the initial budget submission and then prior to finalizing the contract budget, request to use the FY 2015/16 ICR.

30. What happens if the local health fails to submit its ICR certification and documentation or submits it late?

The ICR package is due November 14, 2014. If the required documents are not received by CDPH by the due date, CDPH will cap the local health department's ICR at 15% of Total Personnel Costs (Salaries, Wages, and Fringe Benefits) for FY 2015/16. Additionally, if the ICR package is not submitted by the annual due date in 2015 (and subsequent years), the local health department ICR will be capped at 10% of Total Personnel Costs.

31. What happens if a local health department submits an incomplete ICR package or a package without appropriate signatures?

The ICR package will be returned to the local health department with a hard deadline for correcting the problems. If the corrections are not received timely, then CDPH will cap the local health department's ICR at 15% of Total Personnel Costs (Salaries, Wages, and Fringe Benefits) for FY 2015/16.

32. What if I have a problem with this process or have additional questions? Who do I go to?

Please consult your CDPH Program's Contract Analyst. If they are unable to assist, then the CDPH Program contract analyst can contact the Program's assigned CMU analyst.

33. Which fiscal year do I need to use for the local health department's ICR? The most recent?

The local health department is to base the ICR calculation on the most recently independently audited actual financials that are available. Based on local government processes and procedures, the financials are generally two or three years in arrears. For example, the ICR calculated for FY 2015/16 may either be based on FY 2012/13 or 2013/14 actual financials depending on the timing of the independent audit.

34. Will the documentation be different for city health departments since they don't file a Countywide Cost Allocation Plan with the State Controller's Office?

Each city must determine what equivalent documentation means for them; CDPH will review cities' submitted documentation.

35. What changes were made in the ICR certification process from last year?

- The former *Internal Certification of Indirect Cost Rate Proposal* was revised to consist of two separate one-page forms: 1) *Auditor Certification* and 2) *Local Health Department (LHD) Cost Rate Submission*
    - The purpose of the *Auditor Certification* is for the Auditor Controller (or designee) to certify the accuracy of the financials used to develop the ICR.
    - The purpose of the *Local Health Department (LHD) Cost Rate Submission* is to communicate which ICR methodology the local health department is selecting (i.e., Total Personnel Costs or Total Allowable Direct Costs) and to identify the fiscal year of the financial data used in calculating the ICR.
- A four-tab spreadsheet was created which includes the following: 1) ICR Schedule, 2) ICR Crosswalk, 3) ICR Crosswalk Example, 4) ICR Checklist and Assessment.
    - <u>ICR Checklist and Assessment:</u> This spreadsheet is used to indicate whether an OMB Super Circular cost category is associated with indirect costs, direct costs or both indirect and direct costs. It also identifies whether or not the cost category is also included in the Countywide Cost Allocation Plan as an indirect cost. The cost categories were revised to include definitions for Professional Services Contracts and Rental Costs of Buildings and Equipment.
    - <u>ICR Schedule</u>: This spreadsheet provides a template for the local health department to key-in prior FY expenses. The template defines terminology and calculates the ICR based on the expenses keyed into it,

which reduces math errors and provides standardization across local health departments.

- ICR Crosswalk Example: This spreadsheet provides a sample reconciliation "crosswalk." It was provided by a local health department and illustrates how a local health department's cost categories relate to OMB Super Circular cost categories.
- ICR Crosswalk: This spreadsheet provides a "crosswalk" template for the local health department to identify how the LHD's actual cost categories align with the OMB Super Circular cost categories used in the ICR calculation template.

36. What will CDPH programs do if they see utilities allocated as an indirect cost in the information submitted by the local health department, but the program level budget also includes utilities as a direct cost? Is CDPH program staff permitted to request clarification from the local health department?

Yes. CDPH program staff may request clarification regarding the ICR and possible conflicts with program budgets. There may be instances where a contract budget includes expenses that are directly budgeted and that are also included in the ICR. Typically, these costs include: rent, utilities, telecomm or information technology. For example, if the local health department leases a building specifically to provide the contracted Subvention/Local Assistance services that are identified within the Contract Scope of Work, then the rent or lease cost associated with the specific services may be allowable as a direct cost even though the local health department's ICR includes rent.