**The 15% IDC Minimum Policy IN CONTEXT**

**Answers to the Most Frequently-Asked Questions**

H. Orf, 21 September 2016

*1. Why did Partners Research Management decide to impose this 15% minimum IDC rate on research grants?*

Actually, the impetus for this policy change emanated from the hospitals’ trustees financial committees and senior leadership. At MGH, they have observed over the past decade the continued and strong growth of the total sundry fund balance (which surpassed $1B in 2015) while simultaneously watching the annual loss resulting from unrecovered research overhead grow from $30M to over $90M annually. The role of Partners Research Management was to: 1) find a way to slow or reverse the large research overhead loss and/or find means to cover it with a source other than hospital operating funds, and 2) implement a consistent policy across all Partners institutions.

*2. Are indirect costs real? How do we know they are not made up or padded by the hospital?*

They are very real and are set by the government, not the hospital. Every year, the hospital tabulates all indirect costs (for research space, utilities, maintenance, purchasing, grant administration, etc.) and submits them to the Department of Cost Allocation at DHHS. There, rate negotiators conduct a thorough audit of the submitted costs and then conduct a site visit to review their findings and get any questions they have about methodology or allowable costs answered. The negotiators then make a final determination of which indirect costs are allowable, which then determines the official indirect rate for the hospital for that year.

*3. How can my accepting a foundation grant at low or zero overhead possibly cost the hospital anything?*

It won’t immediately, but it will have a very negative impact next year! Here’s why.

The overhead rate is a quotient with all direct research dollars in the denominator:

Total of all indirect expenses incurred ($)

Total of all direct research fund spending ($)

Let’s use a simple example\* to illustrate why the foundation grant will have a negative impact. Say that in one year a hospital incurs $150M of indirect expenses and spends $200M of research grant funds. The overhead rate would then be $150M/$200M = 75%. If all of the $200M of research funds spent were from NIH or other grants paying full overhead, the hospital would receive 75% overhead from all grant spending and would recover all of the $150M of indirect costs it spent. There would be no overhead loss. Now imagine that in addition to the $200M of fully-overheaded grant spending, there was another $200M of foundation grant spending in that same year that paid zero overhead. The overhead rate would now be $150M/$400M = 37.5%. The NIH and other fully-overheaded grants would continue to pay their full overhead rate share, but that would only bring in $75M (37.5% x $200M) of indirect revenue to the hospital, leaving the hospital overhead recovery $75M short in that year. Since our overhead rate is set annually based on the previous year numbers, every grant we accept at less than full overhead lows our rate the following year and results in real dollars lost that the hospital is required to cover.

Here are the actual numbers for MGH. In FY15, direct dollar (MTDC – modified total direct cost) research spending on government grants was $176.7M and this spending brought in with it an additional $104.9M of indirect dollars (59% average indirect recovery rate). In that same year, direct dollar research spending on all other grants (industry, foundation, sundry) was $233.5M, yet it brought in only $66.4M in indirect dollars (28% average indirect recovery rate).

*4. How many fewer dollars in indirect costs does MGH recover than it spends?*

In FY15 (the most recent year that we have complete data), indirect costs at MGH totaled $275.3M and the hospital recovered $184.5M, leaving an investment (loss) of $90.8M.

*5. Isn’t this indirect cost investment (loss) more than offset by license/royalty income?*

No, but it helps. In FY15, MGH received $15.8M in net royalty/licensing revenue. If credited against the FY15 $90.8M investment (loss), then the net investment (loss) in FY15 would be $75.0M.

*6. It seems like this new policy will disproportionately impact/hurt junior investigators, since they are likely to have less discretionary (sundry) funding to make up the overhead shortfall.*

Research leadership is aware that foundation awards are important to junior faculty and it set the policy specifics to minimize the impact on them. Research fellowships, an important funding vehicle for young PI’s and their postdocs and graduate students, are excluded from the 15% minimum requirement. Also, in FY15, a total of 55 junior PI’s were impacted, with a median cost of only $2,200 per PI. Hopefully, this amount will be manageable for most junior faculty but, if not, then the policy affords that junior faculty member an opportunity to discuss the foundation grant opportunity with their departmental mentor and/or chief. These discussions will increase the visibility of the faculty member’s research program within the department and provide a basis for the department to consider funding the IDC shortfall.

*7. Does Partners expect that foundations paying less than 15% overhead will simply increase their allowable IDC rate because we are now requiring the PI to come up with the difference?*

We do not expect that most foundations paying less than 15% IDC will simply increase to our minimum. But the new policy should create opportunity for dialogue with these foundations to help them realize that indirect costs are real and, even at 15% (the minimum the hospital assesses on all gifts it receives), the hospital is contributing over 55% IDC toward the project they are funding in order to cover its true cost. Also, whenever requested by a PI, Research Management will happily speak with any foundation about the nature and importance of indirect costs in sustaining the research enterprise.