HENNEPIN COUNTY
MINNESOTA

Contract Management Services
Contracting guide

Contract Management Services
300 South Sixth Street, MC: 165
Minneapolis, Minnesota 55487

Contents

I. Purpose

This contracting guide is for vendors that have contracted with or are interested in contracting with the Hennepin County Human Services and Public Health Department (HSPHD). The guide can help vendors understand the processes and procedures that HHS uses when writing contracts and overseeing contracted relationships. Should anything in this guide conflict with the specific terms and conditions in a vendor's contract, the contract supersedes this guide.

Vendors are strongly encouraged to review this guide to keep current with any revisions. Vendors are asked to inform HHS Contract Management Services (CMS) about any changes to their executive director's email address. A copy of this guide, when revised, will be sent via email to the executive directors of those organizations that have an email address on file with CMS. Vendors can also find a copy of the current guide on the Hennepin County Web site by visiting the partners in health and human services page.

II. Contract types

Contract types used by the Human Services and Public Health Department

HHS uses several types of contracts. The type of contract used depends on the service being purchased. HHS has sole discretion to determine the appropriate form of contract to be used in each situation. Types of contracts are briefly categorized as follows:

Human service contracts

These contracts are used for the purchase of client-based human services. Human service contracts reimburse a vendor's eligible expenses via unit rates, cost reimbursement, or on a pay-for-performance basis.

Personal/professional service agreements

Personal/professional service agreements (PSA) are used with individuals, firms, partnerships, corporations, or other organizations to purchase a product, deliverable, or other non-client service such as consultant or training services.

Subrecipient contracts

In some instances, federal funds awarded to HHS are passed directly to an agency via a subrecipient agreement. A "subrecipient" is defined as an entity that receives federal assistance that is passed from a prime recipient or another subrecipient to carry out or administer a program. In instances such as this, the subrecipient that spends the funds has the responsibility for programmatic decision making. HHS is responsible for ensuring that federal funds provided to other organizations via subrecipient agreements are used for authorized purposes and in accordance with applicable laws and regulations. HHS must also ensure that performance goals are achieved. HHS is further responsible to ensure that subrecipients meet the audit requirements of the Office of Management & Budget (OMB) Omni Circular, as further described in the financial standards section of this guide. The subrecipient agreements that HHS executes contain these requirements.

Special contracts

Some contracts do not fall into the more common categories that have already been described. These contracts contain funding that comes from sources outside Hennepin County. In many such instances, contracts are developed to meet state or federal requirements. These contracts serve as vehicles to regulate contracted services, as mechanisms that allow for the payment for services, or both. Some contracts that are developed are necessary for an agency to bill the State of Minnesota for Medical-Assistance-related services such as targeted case management or other services that have the same billing mechanism.

Contract Type - Payment Methods

HHS uses four primary payment methods in its contracts:

Unit rate (fixed price)

When using this method of payment, a rate is established for a pre-determined and defined service unit. The agency receives payment for each service unit provided, based on a negotiated or pre-determined rate. Per contract specifications, the agency is responsible for invoicing HHS after the service has been delivered and expenses have been paid.

HHS typically uses these contracts when a service is pre-authorized to a client and/or when a service is delivered in a distinct, controllable unit.

Cost reimbursement – invoice

This payment method is when the agency is paid only for actual expenses incurred. The agency is reimbursed for all actual allowable expenditures, as agreed upon in the contract, based on the submitted and approved budget. The agency is responsible for submitting an itemized invoice (typically monthly) to HHS. The submitted invoice specifies the actual expenses incurred and revenues obtained during the billing period. All expenditures and revenues are governed by the contracted budget. All payments for contracted services are subject to financial review by HHS. This financial review is the final determination of reimbursable expenses under the agency's contract.

HHS uses this payment method when a meaningful unit of service cannot be accurately determined for the purchased service, when HHS needs to assure available capacity, or when there is no client authorization system in place to control utilization or total expenses.

Cost reimbursement – settle up

With cost reimbursement—settle up, pre-determined, fixed-amount payments are issued to the agency based on anticipated and agreed upon costs, per a submitted and approved budget. All expenditures are governed by the approved budget, as described in the contract. While HHS pays an agreed upon amount, only allowable expenses may be reimbursed. Therefore, at the end of the contract-budget period, reconciliation or "settle up" may be needed. During this settle up, HHS will review the agency's expenses in order to ensure that the contracted agency's actual eligible expenses match that total of the payments made by HHS. This settle up might require the agency to refund money to HHS in those instances when payments have exceeded the agency's actual eligible expenses. This version of a cost reimbursement contract is used only in rare instances, when the county deems it acceptable or necessary to issue payments to the agency before expenses are actually incurred.

Deliverable

With this method of payment, the agency is paid upon the completion or delivery of a clearly defined product or service. Payment for the specific deliverable can be made at an agreed upon price or for costs incurred. Deliverables are used for some personal/professional service agreements but are not appropriate for client service contracts.

Hennepin County Board resolution 09-0381 requires HHS to implement pay-for-performance (PFP) in its human service contracts. Under PFP requirements, HHS enters into a unit-rate or cost-

reimbursement contract with an agency. However, a portion of the payment will be made only when specific client results have been achieved.

III. Getting a contract with HHS

Vendor selection

It is the practice of HHS to select contracted agencies by using an open and competitive selection process on a regular basis or as required by the specific funding source.

The department has developed processes which support that practice. A variety of methods are used to solicit proposals for new or existing services:

Request for proposal (RFP)

An RFP is used to collect information on services available and make recommendations to a service area regarding the service providers that seem most likely to be able to deliver a desired service. In many instances, the service providers that submit proposals during an RFP are competing for a specific amount of resources that will be used to develop contracts. Depending on the needs of the service area, one or more service providers may be invited to enter into contract negotiations after an RFP has concluded. However, HHS reserves the right to reject any and all submissions received during an RFP process.

Request for qualifications (RFQ)

An RFQ establishes a qualified agency list or panel from which the County may purchase services. Contracts awarded to qualified agencies are often contracts that enable the County to purchase services but do not commit the County to a specific funding level.

Request for information (RFI)

An RFI is a vendor selection method used when HHS is not certain about the exact nature of the service that is needed. An RFI typically originates with a specific target population that has some identified need. The proposals that are recommended to the service area following an RFI are those that appear to be best able to meet the needs of the identified population. An RFI is seldom the final step and sometimes will result in a subsequent RFP.

If HHS is going to solicit services through an RFP, RFQ or RFI, the vendor selection information is posted on the supplier portal webpage. Contracted agencies and potential providers are strongly encouraged to establish an account with the supplier portal to receive announcement of posted vendor selection processes.

As necessary, the department may use vendor selection methods such as sole-source contracting in instances when the service provider that is the sole source possesses a unique performance capability, is the single source of services proposed, in instances when immediate action is required, when federal or state regulations require the County to have a contract for a specific service, when a disruption of service would be overly difficult for persons receiving a service, or in other circumstances when the department determines that a sole source agreement is in its best interest.

Required materials for HHS contracts

Prior to any contract being completed, an agency must submit all requested documentation and/or information to their contract manager in CMS. Failure to submit documentation will prevent CMS from being able to finalize a contract.

Some information that is requested, such as verification of insurance, is standard for all contracted services. Other requested items, such as a copy of a state license, relate specifically to a purchased service. Agencies should be prepared to submit all documentation that is required for their specific contract.

Programmatic requirements

A clear and concise written description of the service being purchased through the contract will be required from the agency or will be provided by HHS. This information is used as the foundation for developing the contract and may be attached to the contract document as an exhibit. The contracted service description for client-service contracts may include any or all of the following:

- Description of the specific services to be provided
- Target population
- Admission and discharge criteria and process
- Details regarding client progression through the program
- Coordination, consultation, and other community involvement
- Quality assurance efforts for the agency
- List of planned activities for the program
- Staffing pattern for the program and job descriptions for each position

Performance measurements

All client-service contracts developed within CMS must contain performance measures. The performance measurement form, which is the standard form for identifying and reporting contracted outcomes, is given in Appendix A.

All contracted agencies are required to maintain records and submit reports showing actual results. Such records may include, but are not limited to, individual eligible recipient case files and program plans; demographic information; enrollment, attendance, and/or utilization information; and information about the type and amount of service provided, such as output and outcome information. An agency's ability to deliver contracted outcomes is a factor that can be considered when HHS is making contracting decisions.

As an additional method to ensure contract performance, HHS has implemented a process to periodically survey clients to collect feedback about their program experiences. Contracted agencies are expected to participate in the County's client satisfaction survey program, when their participation is requested by HHS.

Financial requirements

Most new contracts require the agency to submit some financial data to CMS. Exceptions may be permitted for personal/professional service agreements and special contracts. Items typically required from the agency are:

- Independent audit reports and AU-265 management letters from the last two years
- Revenue and expense statements from two prior years
- Agency-wide and program specific budgets with administrative cost allocation and salary schedules for the anticipated funding period for the contract

CMS has forms available which show the suggested format for submitting the agency's financial information.

Administrative requirements

Unless these documents have been supplied within the prior year for another contract with HHS, agencies are required to provide certain types of administrative documentation on an annual basis with their contract documentation packet. The required document includes the following:

- Completed "Provider Fact Sheet" (Appendix B) showing general information about the organization and contact persons
- Current list of the board of directors *
- Board directive showing who has been given authorization to sign contracts
- Affirmative action information
- Verification that insurance coverage is in place at the required levels
- Copies of current city, state, or federal licenses if required for the contracted service

* Indicates that an item may not be applicable to personal/professional service agreements or special contracts.

Contract term

HHS contracts generally run for a term that lasts from one to four years. Although CMS establishes multi-year contracts, funding is sometimes added to a contract one year at a time, as the County budget is determined and approved annually. A multi-year contract with HHS that has been approved by the Hennepin County Board of Commissioners does not imply a continued funding commitment by the County during the entire term of the contract.

Fully executed contract

All new contract documents must be signed by the HHS assistant county administrator and approved by the Hennepin County Board of Commissioners or their delegated authority. Once the contract document has been signed by all responsible parties, it is considered to be a fully executed document, allowing the agency to begin providing services as indicated in the contract.

The County's purchasing rules require the contract to be approved and fully executed prior to service being authorized or paid. The purchasing rules also require that the agency sign the contract prior to it being authorized by the Hennepin County Board of Commissioners. Any contract offered for signature to a potential agency is not a commitment by the County to enter into the agreement.

Once the process has been completed, the electronic contract-management system will send a copy of the fully executed agreement via email to the agency's authorized signer.

IV. Renewing contracts

Contracts can run for a term that lasts from one to four years. Prior to the expiration of a contract, HHS evaluates the continued need for the contracted service. If the department decides to continue to contract for a service, decisions are made about whether to renew any or all existing contracts or begin a new vendor selection process. The process for renewing a contract is similar to establishing a new contract. Please review the "Getting a contract with HHS" section of this guide for additional details.

If the department determines that it is necessary to renew a contract, the contracted agency will be contacted by CMS several months prior to the expiration of the existing contract. The notification indicates that the agency's contract is up for renewal, and a list of required documents accompanies the notice. An agency must submit those documents if they wish to continue the contract.

During the renewal of a contract, vendors may be asked to submit any of the following items:

- Updated service description narrative
- Revised or updated outcome and performance measurement criteria
- Agency wide and program specific budget for the proposed funding period with detailed substantiation of each expense
- Current list of the board of directors
- Board directive showing who has been given authorization to sign contracts
- Affirmative action information
- Verification that insurance coverage is in place at the required levels
- Copies of current city, state or federal licenses if required for the contracted service

Any changes or updates to the contract that are requested by the agency will be negotiated during the contract renewal period. If the requested change is a significant modification to the contract to be renewed, such as a change to the target population, service delivery, outcomes, or financial rates or payments, the agency is required to submit a letter, along with the contract documentation packet, describing the change and the rationale for the change that is being requested.

Once all of the required documents have been submitted and are deemed acceptable by CMS, a new contract document will be developed. Renewed contracts are reviewed and signed by the HHS assistant county administrator and approved by the Hennepin County Board of Commissioners or their delegated authority. As with a new contract, once the renewed contract document is signed by all responsible parties, it is considered to be a fully executed agreement.

V. Reporting

Agencies are required to routinely submit reports to CMS as part of the contract monitoring process. Failure to submit reports as required can result in termination of a contract.

Annual financial reporting

The County requires agencies to submit financial reports at least annually. The type of financial report submitted will depend upon each agency's financial standing.

Independent external audit

The County requires nonprofit agencies to hire certified public accountants to conduct annual independent external audits of financial statements, if an agency's total annual revenues for the prior year meet or exceed $750,000.

Agencies that meet the criteria for an audit shall provide a copy of it their audit report to CMS with a full set of audited financial statements containing all disclosures required by generally accepted accounting principles (GAAP) and a copy of the AU-265 management letter (report on internal controls) from the independent auditors. The management letter is a document that is issued by the external auditors that is addressed to the agency and states the findings (if any) that were noted during the audit. The AU-265 management letter will have definitions for material weakness or significant deficiency.

Financial statement review or compilation requirement

If an agency does not have an independent audit performed, but has total receipts arising out of all HHS contracts for the preceding calendar year of $200,000 or more, the County requires the agency to hire an external accountant to perform a compilation or review of their financial statements. Compilations or reviews must include a review of the agency's statement of financial position, revenue and expense statement, statements of cash flows, and all other disclosures required by GAAP. A copy of the compilation or review must be submitted within thirty (30) days of completion, but not later than 180 days after the end of agency's accounting year.

Minimal financial reporting

If agencies do not meet the criteria for an audit, review, or compilation, the County requires an unaudited financial report containing an agency wide balance sheet and revenue and expense statement prepared by the agency's internal accountant. These statements must be submitted within ninety (90) days of the end of the agency's accounting year.

In no instance will a balance sheet and revenue and expense statement prepared as part of a agency's income tax return or IRS Form 990 meet the County's financial reporting requirements.

Additional reporting requirements

Financial reports

Agencies are required to submit annual agency-wide and program-specific line item revenue and expense statements and administrative allocation schedules, including methodology used, within thirty (30) days after the end of the reporting period, unless otherwise indicated in writing by the County.

Performance measurement

All contracts require the agency to submit regular performance reports to the county. The frequency of submission of the reports is governed by the terms of the contract.

The standard format for identifying and reporting contracted outcomes is given in Appendix A. This form must be completed and submitted by each agency. The submission requirement (quarterly, semi-annually, or annually) will be established in the contract.

Insurance

The County requires agencies to carry insurance coverage in accordance with the tort liability limits under Minnesota Statutes, Chapter 466 during the entire term of their contract. In addition, agencies are required to submit verification of insurance coverage at least annually or whenever there is any change in insurance coverage.

Licensing

For city, state, or federally licensed services, each time a new or renewed license is received by the agency, a copy of the document must be submitted to their contract manager.

Other

Significant organizational changes within an agency or a contracted program must be reported in writing to the County. Information about such changes should be submitted as the changes occur or as indicated in the contract. Examples of change that should be communicated are changes of key staff, membership changes on the board of directors, or the sale of at least 50 percent of the agency's assets to another entity. If an organization is acquired by another entity during the term of the contract, written notice must be sent to CMS within 10 days of the acquisition, along with the name and business address of the acquiring person/entity. Prior written approval from the County is required to assign an HHS contract to another entity. The assignment of a contract cannot occur without the written authorization of the county administrator, or designee, via the County's consent to assignment of contract form.

VI. Financial standards

Fiscal capacity standards

Agencies that hold human service contracts with HHS must have fiscal capability and financial stability commensurate with the level of service indicated in their contracts. A fiscally capable agency must remain in compliance with the following requirements:

- Have an accounting system that is appropriate to the size and nature of the organization and is in compliance with generally accepted accounting principles (GAAP) and governmental regulations
- Issue regular financial statements that conform to GAAP standards
- Comply with applicable federal requirements and County financial procedures as identified in this manual and its contract(s)
- Maintain and routinely review an annual organizational budget that is clear, arithmetically accurate, and appropriately detailed; this detail includes cost centers (service elements) and revenue and expense line items appropriate for the size and nature of the organization
- Have documented financial policies and procedures that are appropriate to the size, nature and needs of the organization and comply with GAAP and contract requirements.; these policies and procedures are to be reviewed regularly by the agency's governing body
- Provide its governing body with timely and appropriate fiscal information which must be reviewed at least annually at a meeting of the governing body
- Be on stable financial footing, as indicated by a lack of excessive recurring losses, significant liabilities, and/or insufficient working capital as determined by the County

OMB Uniform Guidance requirements

Federal single audit requirement

Agencies must comply with all applicable single audit requirements, as outlined in the OMB Compliance Supplement. Compliance Supplement means Appendix XI to Title 2, US Code of Regulations, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit requirements for Federal Awards (Uniform Guidance). Under the requirements of this circular, any non-profit organization receiving federal funds must determine what level, if any, of federal compliance audit to perform. Subrecipients of federal funds will be notified by the County of their status. A subrecipient is subject to the requirements of OMB Uniform Guidance; a vendor is not.

Determination of federal funds

If federal funds are a part of the funding for a human services contract, the County will give the agency information concerning the amount of federal funds and Catalog of Federal Domestic

Assistance (CFDA) number for each service element as soon as this information is available. It is the agency's responsibility to forward this information to their auditors for determination of federal audit requirements.

Responsibility for determining federal audit requirements

It is the agency's sole responsibility for determining compliance with federal audit requirements. The County can only provide information about federal dollars contained in an agency's contracts and the related CFDA number(s). However, because organizations may receive federal dollars from sources other than the County, they should not depend solely upon receiving information from the County in determining their own compliance with federal requirements.

Independent external audits

Depending on an organization's total budget and on the total amount of service that organization has contracted to deliver for the County, agencies may be required to have an external certified public accountant perform a full-scale, organization-wide financial audit. All agencies receiving federal funds must comply with OMB Omni Circular, as applicable.

Audits must be conducted by certified public accountants who satisfy the independence requirements outlined in the rules of the American Institute of Certified Public Accountants (AICPA) and (Rule 101 of the AICPA Code of Professional conduct, and related interpretation and rulings), the Minnesota State Board of Accountancy, the independence requirements contained within Government Auditing Standards (1994 Revision), and rules promulgated by other federal, state, and local government agencies with jurisdiction over the organization. Those rules require that the certified public accountant be independent in thought and action with respect to organizations that engage them to express an opinion on financial statements or to perform other services that require independence.

If required per contract specifications, financial statement audits are due 180 days after the end of a agency's fiscal year. Single audits are due 30 days after receipt of the auditor's report or nine months after the end of the audit period, whichever occurs first. Agencies must also submit a copy of the AU-265 management letter provided to the organization, if one exists, or a letter from the audit firm stating that no AU-265 management letter was issued.

Important Note: Federal and/or state requirements do not relieve agencies of specific HHS contract requirements.

Organizations requesting an extension of a report submission deadline must submit a written request, at least two weeks before the deadline, clearly stating the reason for the request to the following address:

HHS Contract Management Services
Contract Manager
Hennepin County Government Center, A-1006
300 South 6th Street
Minneapolis, MN 55487-0106

The agency must establish and maintain systematic written methods to assure timely and appropriate resolution of audit/review findings and recommendations.

Non-conforming or sub-standard independent audits or reviews

If the County determines that an agency's independent audit is non-conforming, written notice will be provided to the agency's executive director. Corrections to the audit report must be made and submitted to the CMS contract manager within six months of the date of notification. Failure to comply with this requirement may result in corrective actions (no further client referrals, payment holds, etc.) up to and including contract termination.

Agencies may appeal the determination of non-conformity by sending a written request to:

HHS Chief Financial Officer
Hennepin County Government Center, A-1340
300 South 6th Street
Minneapolis, MN 55487-0134

If the appeal is not upheld, corrections must still be made within six months of the date of original notification.

Allocation of administrative and overhead costs

The agency is required to file an administrative cost allocation schedule (Appendix D) with their anticipated budget for the contracted service period. The administrative cost allocation schedule will be reviewed by HHS as part of the contract budget approval process. The intent of all service contracts is to maximize the level of service given to clients; therefore, to the greatest extent possible, administrative and overhead costs charged to contracts with HHS must be minimal. HHS's policy is that the allocation of the agency's administrative and allocated direct costs must meet the following standards:

- Be made in a reasonable and consistent manner across all of the agency's program services
- Be verifiable
- Ensure that the County's share be proportionate to the total program cost
- Not include any unallowable costs

The following items show costs that are not allowed to be charged to the County:

- Advertising, except for personnel recruitment
- Alcohol
- Bad debts
- Contingency reserve
- Depreciation, if County funds were used to acquire the asset
- Donations made by the agency to others, including cash and goods
- Entertainment costs for employees, donors or other related parties (e.g., tickets to shows, sporting events, meals)

- Federal, state or local (including Hennepin County) lobbying
- Goods and services, including housing, provided to the agency's employees, donors, or other related parties
- Legal and associated expenses related to any administrative, civil or criminal proceeding
- Penalties and interest from the Internal Revenue Service, Minnesota Department of Revenue, or other state or federal agency
- Personal use of automobiles provided by, or paid for by, the agency (e.g., a car allowance)

The following definitions guide the implementation of the administrative costs policy:

- Administrative costs: The costs incurred for the provision of management and general administration and indirect costs.
- Direct costs: The costs incurred in the provision of program services that can be identified as being solely related to one program or functional activity.
- Fundraising: An organization's activities, including conducting special fundraising campaigns, preparing fundraising manuals, instructions or materials, and conducting other activities involved with soliciting contributions from individuals, foundations, government agencies, and others.
- Indirect costs: Those costs that were incurred for more than one direct service or supporting function (fundraising or administrative) and that cannot be attributed solely to a single direct service such as utilities, insurance, and rent costs. Since all programs and functions benefit from a shared space and utilities, all programs and functions must carry their proportionate share of these costs.
- Management and general administration: The activities related to organizational oversight, business management, general recordkeeping, budgeting, financing, and related administrative activities, and all management and administration except for direct provision of program services or fundraising activities.
- Program services: The activities that result in goods and/or services being distributed to beneficiaries, customers, or members that fulfill the purposes or mission for which the organization exists.

In the event the County is using federal, state, or other outside funder to pay for the services in a specific contract, and that funder's policy on the allocation of overhead and administrative costs is different than the County's, that policy will supersede the County's policy.

VII. Contract monitoring

Agencies are required to be in compliance with all elements of their contract during the entire term of the agreement. In order to ensure that high quality and effective services are being delivered to our clients, all contracts are monitored on a routine basis to ensure compliance with the terms and conditions stated therein. Effective monitoring ensures the delivery of high quality and cost-effective services and the achievement of process and performance objectives, as outlined in the contract. The level and degree of monitoring is based upon the complexity of the contract.

Agencies can expect to be visited on-site by contract managers and to have their contracts monitored annually in the following categories:

- Administrative
- Financial
- Programmatic/quality assurance

Administrative monitoring consists of reviewing contract documents such as licenses, certificates of insurance, and affirmative action plans to determine whether or not they are current and meet contract specifications. Contract managers also determine whether or not required financial, utilization, and performance measurement reports have been submitted by agencies as part of administrative monitoring.

Financial monitoring consists of reviews of budgets, financial reports, and audits to assess the financial status of programs and agencies. Contract managers also review supporting documentation including client files and agency expenses to ensure whether or not services were appropriately billed.

Programmatic/quality assurance monitoring reviews examine the effectiveness of services and whether or not the service delivery is consistent with contract requirements. Programmatic/quality assurance monitoring activities may include facility and service observation, program and client file review, staffing review, licensing/accreditation review, performance management data verification, and overall discussion of an agency's performance.

VIII. Financial compliance reviews

All agencies will be subject to fiscal compliance reviews performed by the Hennepin County Internal Audit Division, even if the agencies are also required to submit annual and/or federal OMB Omni Circular audits. The review done by internal audit is not intended to replace or duplicate an audit by a qualified external auditor, nor should it replace financial reviews by contract managers or be relied upon by the agency or its governing body as a statement on the financial condition of the agency. The internal audit division performs a systems review of current business and accounting practices only, targeted toward specific compliance requirements contained in the County's standard contract language.

Financial compliance reviews will take place in the agency's primary business office, unless otherwise arranged in advance with the County. Agencies are responsible for ensuring that all records specified or referred to in the financial compliance review notice are available for examination by County staff on the date of the site visit. Agencies must furnish County staff with adequate space in which to work as well as access to appropriate staff. Agencies will be given the financial review notice at least two weeks in advance.

Notification of financial review findings and need for agency response

A financial review findings report will be sent to the agency generally within 30 days after the review. This report will cite findings and recommendations resulting from the review and may also restate findings from the most recent external financial or federal compliance audit. Agencies must respond in writing to any adverse finding(s), as required by the County. The agency may submit additional documentation or dispute the findings of a review by submitting a response to the County within 30 days of their receipt of the report.

Definitions of commonly used terms in the site visit reports include:

- Corrective action plan (CAP) is a document, that when required, enables the agency to formally respond to the identified findings. Generally, the CAP is due to the internal auditor 30 days after the release of the site visit report.
- Findings address specific contract compliance issues and require corrective action, which will be delineated in the site visit report.

The agency's CAP should include steps to address the findings and implementation dates. The internal auditor will review and approve the agency's CAP. All findings will be reviewed by the HHS contract manager or internal auditor after the implementation date to ensure the steps taken by the agency address the findings sufficiently. Additional documentation will be requested as part of this finding close out procedure.

Determination of need for financial compliance reviews

The County determines the need for financial compliance reviews by an internal analysis of risk to the County. The factors the County considers include, but are not limited to:

- Total amount of funding under contract with the County
- Sources of funds used to pay the agency and any requirements of other funders
- Type of contract(s) and payment method(s)
- Results of independent audit
- Timeliness of filing of reports to the County
- Last financial compliance review
- Reports of unusual situations such as possible fraud or embezzlement

IX. Invoicing and payment

Billing frequency

Invoices should be submitted for payment according to the schedule established within the contract. Invoices submitted for services that were delivered more than one year prior to invoice submission will not be paid without special prior approval from the HHS Chief Financial Officer.

Required billing information

An invoice must contain the following billing information to be used for payment of eligible expenses:

- Agency (Vendor) name
- Remittance address
- Vendor number

- Contract number
- Purchase order (PO) number
- Description of the service for which the County is being billed
- Date(s) of service
- Specific client identifiers, if required in the contract
- Dollar amount requested to be paid, consistent with the terms of the contract
- Invoice must be signed and dated by the agency's staff member that has verified the accuracy of the invoiced amount.

Billing address

All invoices without client information must have a purchase order number on them and must be submitted to the correct address shown below to generate a payment.

Invoices that have client data will not have a purchase order number but must have correct service arrangement information on them. There are two separate addresses for submitting invoices. Be certain to determine whether or not your invoice contains client data before you choose the submission method.

Invoices that have a purchase order number but do not contain client data may be submitted by email to OBF.Internet@hennepin.us or via the postal address below:

Hennepin County Accounts Payable
PO Box 1388
Minneapolis, MN 55440-1388

Invoices that contain client data must be sent to the following address:

Hennepin County HHS Accounts Payable
Attn: Admin Payables/MC 134
300 South 6th Street
Minneapolis, MN 55487-0134

Substitute Form W-9 and Direct Deposit request forms can also be submitted by email to the following address:

OBF.Internet@hennepin.us

For billing or other payment questions call 612-348-3445.

Payment processing

- It is the County's policy to make payments within 35 days of receipt.
- The County will not pay interest on any invoice less than 35 days old or for any invoice that was originally sent to an address other than the ones listed above.

- In instances when an invoice or bill is sent back to a vendor for revision or correction, the 35-day timeline will be reset. After the vendor has made its revisions or corrections or any billing disputes have been resolved, a new 35-day timeline will start upon receipt of the corrected or undisputed invoice.
- To check on the status of payments, call 612-348-3445.

Overpayment collection

As a condition of contracting with the County, agencies agree to repay all amounts that meet any of the following criteria:

- Paid to the agency in error
- Paid in excess of the contracted not-to-exceed amount
- Determined to have been incorrectly billed by the agency
- Due to the County if the agency has a cost reimbursement-settle-up contract and the year-end reconciliation (described below) determines that the agency did not incur costs commensurate with payments made

Regardless of the type of contract, the County may withhold from any payment due to the agency any amount which has been determined, in accordance with the terms of the contract, to be due and owing the County. This withholding shall include, at least, amounts owed the County due to overpayment or, as the result of an audit, from any contract between the agency and the County.

Repayment appeal

If it is determined that the agency must repay the County for a cost reimbursement-settle-up contract, the agency will be notified in writing explaining the finding. If the agency wishes to dispute the reconciliation, they may appeal in writing within 30 days of receipt of the notice to the following address:

HHS Contract Management Services Manager
Hennepin County Government Center, A-1006
300 South 6th Street
Minneapolis, MN 55487-0106

Repayment timeframe

When a repayment is required, the agency will be notified of the need for repayment by mail. Thirty days after a written notification is mailed, the agency will be invoiced for the total amount due. Payment will be due 45 days from the invoice date.

If the agency wishes to enter into a repayment arrangement, they must contact the accounts receivable manager:

HHS Accounts Receivable Manager
Hennepin County Government Center, A-1356
300 South 6th Street

Minneapolis, MN 55487-0134

(Please note that any repayment arrangement longer than 12 months requires additional approval by the HHS Chief Financial Officer.)

For contract types other than cost reimbursement – settle-up, if the agency is paid more than the not-to-exceed amount or an overpayment is determined as a result of an audit, the agency is required to reimburse the County for the excess payments within 45 days of the invoice date.

Cost reimbursement – settle-up reconciliation process

For cost reimbursement-settle-up contracts, payments will be adjusted annually based on the agency's year-end financial information. The County determines the payback amount.

The reconciliation process for reviewing cost reimbursement-settle-up contracts includes the following steps:

- The agency submits the necessary financial information, which is required under the contract agreement.
- HHS reviews the financial information and determines if any payback is owed.

At the end of the contract budget period, the HHS Financial Analysis and Accounting Administration will complete a cost reimbursement-settle-up contract calculation based on the agency 's audited or unaudited financial statements for all agreements.

A payback is required only when an agency had a contracted program surplus. A "contracted program surplus" is defined as an excess amount of total program revenue over the total allowable program expenses. Any expenses that were not approved in the contract budget will be considered as "unallowable program expenses" and will be subtracted from the reported total program cost.

If the review of financial statements shows a contracted program surplus, the payback amount to the County is the County's proportionate share of the total contracted surplus. The County's proportionate share of the contracted surplus is determined by the ratio of actual incurred County revenue to total actual revenue received/incurred for the contracted program. On the following page are examples of this calculation:

Example with Payback

Vendor	XYZ
Program	DDD
Period	1/1/12-12/31/12
Annual NTE	$100,000

	Program Budget	**Program Actuals**	
Total Expenses	$100,000	$95,000	
Adjustments (1)	$0	($2,000)	
Total Allowable Expenses	$100,000	$93,000	
Non-county Revenue	$30,000	$30,000	
Henn. Co. Revenue	$70,000	$70,000	
Total Revenue	$100,000	$100,000	
Surplus/ (Deficit)	$0	$7,000	
HC Share of Expenses (2)	70%	70%	
Amount Due to HC (3)	N/A	$ 4900	($7,000 X 70%)

(1)--Any expenses that were not approved in the contract budget, or allocated expenses that were not distributed/charged in an equitable manner to the contracted program. In this example, $2,000 was reported as a Bad Debt cost in the program's financial statement.

(2)--HC share of expenses determined by the ratio of actual incurred HC revenue for the contracted program to total actual revenue received/incurred for the program.

(3)--Amount due to the County is determined as (HC Share of Expenses %)
If the program's operations resulted in a deficit (excluding unallowable expenses) for the contracted period, no repayment is due to the County.

Unallowable Expenses include, but are not limited to:

> Bad debt
> IRS Penalties and Interest
> Capital Expenditures (unless approved by the County as a one time expense)
> Expenses not approved in the contract budget. Providers are able to make adjustments to their budgets, but all adjustments need to be approved by the Contract Manager, and the adjustments must be included in the contract.

Example with No Payback

Vendor	XYZ
Program	DDD
Period	1/1/12-12/31/12
Annual NTE	$100,000

	Program Budget	Program Actuals
Total Expenses	$100,000	$100,000
Adjustments (1)	$0	$0
Total Allowable Expenses	$100,000	$100,000
Non-County Revenue	$30,000	$30,000
Henn. Co. Revenue	$70,000	$70,000
Total Revenue	$100,000	$100,000
Surplus/(Deficit)	$0	$0
HC Share of Expenses (2)	70%	70%
Amount Due to HC (3)	N/A	$0

Notes:

(1)--Any expenses that are not approved in the contract budget, or any allocated expenses that were not distributed/charged in an equitable manner to the contracted program.

(2)--HC share of the expenses determined by the ratio of actual incurred HC revenue to the contracted program to total actual received/incurred for the program.

(3)--The amount due to the County is determined as (The HC Share of Expenses percentage) TIMES Surplus. If the program's operations resulted in a deficit (excluding all unallowable expenses) or $0 net income for the contracted period; no repayment is due to the County.

Unallowable Expenses include, but are not limited to:

> Bad debt
> IRS Penalties and Interest
> Capital Expenditures (unless approved by the County as a one-time expense)
> Expenses not approved in the contract budget. Agencies are able to make adjustments to their budgets, but all adjustments need to be approved by the contract manager, and the adjustments must be included in the contract.