WHAT'S

IN 2010-11

- These guidelines apply to both Ryan White Part B (Part B) and General Revenue Patient Care Network (PCN) contracts. We strongly advise contract managers to become familiar with the contents of these guidelines and to review their contents with contracted providers at the time of the contract negotiations. A copy of these guidelines should be given to the lead agency during negotiations. (Section 1, page1)

- County health departments serving as the lead fiscal agencies are subject to the same programmatic and monitoring requirements as other lead agencies. (Section 1, page 3)

- Bureau of HIV/AIDS Program Notices can now be found on the Bureau's web site at: http://www.doh.state.fl.us/Disease_ctrl/aids/care/Program_notices.html. (Section 1, page 4)

- All requests for advances must be approved by the deputy secretary of the department. When submitting an invoice that contains a request for an advance, allow time for the processing of this additional approval. (Section 2, page 2)

- Lead fiscal agencies must ensure that subcontracts are in compliance with the primary contract and must complete the following forms as part of the subcontract process:
  - Certificate Regarding Lobbying
  - Civil Rights Checklist

- Certificate Regarding Debarment and Suspension
- Federal Sub Recipient and Vendor Determination Checklist
- Documentation of Non-Competitive Procurement (if applicable)
- IRS form W-9 (http://www.irs.gov/pub/irs-pdf/fw9.pdf) (Section 2, page 2)

- For Patient Care Part B and PCN contracts and subcontracts, the allocation of indirect costs to services category line items is not allowable. It is allowable to allocate up to 10 percent of the total contract amount to administrative costs, which include such items as supplies, rent, utilities and other costs necessary to the administer the contracted program. There are situations where some or all of an administrative cost may be allocated to a direct service line if that cost is part of the provision of direct client services. An example would be supplies or facilities costs that are directly related to the provision of client services. When the cost is properly placed in the direct care line item, it would then be considered part of the direct cost for that service category. It must be noted that all costs assigned to a service line item will be calculated as part of the unit cost for reporting purposes and, as such, only those costs that can be clearly identified as necessary to the provision of direct services should be placed in the service line item. If a contractor or subcontractor uses a formula to calculate the portion of administrative costs associated with direct service categories, they must provide, in writing, the formula used to calculate these costs. Contract managers will be responsible for reviewing contractors' and subcontractors' calculations and documentation related to these costs. The Office and Management and Budget (OMB) Circular No. A-122 provides guidance on determining how these costs are documented. (http://www.whitehouse.gov/omb/assets/omb/circulars/a122/a122_2004.pdf). (Section 2, page 3)

- Appendix C is an Administrative Assessment tool. Lead fiscal agencies are responsible for ensuring that subcontractors, especially new subcontractors, have sufficient infrastructure to support their contracts and meet their deliverables. Options for assessing the viability of subcontractors include reviewing the organization's most recent audit or performing an administrative assessment. Contract managers may also use the assessment tool to evaluate the lead agency, especially if there are questions regarding the lead agency's financial viability. (Section 2, page 3)

- Contract managers must monitor all lead agency contracts and lead agency memoranda of agreement twice a year. Patient Care is piloting a new contract monitoring schedule to afford contract managers the opportunity to review the lead agency's first Quarterly Financial Report prior to the first monitoring and still allow

time to identified and correct problems. Therefore, the first contract monitoring should be completed after the receipt of the provider's first Quarterly Financial Report (due 30 days after the end of the first quarter) but no later than 135 days after the start of the contract and once between the last 90 to 60 days of the contract. Lead agency memoranda of agreement are monitored by the Bureau of HIV/AIDS Community Programs Coordinators acting as the contract manager for these agreements. (Section 2, page 3)

- For department contract managers, a monitoring template is provided on the shared drive. The template should be modified to reflect any additional contract provisions and providers specific to an area. In the column "Ratings Based Upon," all provisions must be verified either by direct observation by the contract manager or by supporting documentation. Interviews will no longer be accepted. (Section 2, page 3)

- For the 2010-11 contract year, each area is required to develop a minimum of one outcome/output measure for each core service funded by the contract. If a contract does not fund a core service, outcome/output measures should be written for the support service categories receiving the largest portion of the funding. A minimum of two measures per contract is required. HRSA's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents should be used for pertinent services (ambulatory/outpatient care, oral health care, mental health services, treatment adherence, substance abuse services and health education/risk reduction). (Section 2, pages 5-7)

- Additional information will be required on the budget narrative for all services funded, such as agency information on providers subcontracted to deliver services. (Section 3, page 5)