



Public Health
HEALTH AND HUMAN SERVICES

RICHARD O. BRAJER
Secretary

DANIEL STALEY
Director, Division of Public Health

June, 2016 Finance 101 FAQ's Answers from LTAT Administrative Consultants

THE CONSOLIDATED AGREEMENT

1. Will the departments receive local appropriations that are to be budgeted for FY 16-17?
Answer: Each county decides if they will provide local appropriations in support of Health Department budgets. Local appropriations that are budgeted should not be supplanted, per the Consolidated Agreement. If there are surplus funds, due to higher than anticipated revenues, the surplus should be carried forward for use in subsequent years (per the Consolidated Agreement).
2. Has any county actually been held accountable for supplanting cost settlement funds?
Answer: The Administrative Consultants are not aware of any county which was challenged and held accountable for supplanting cost settlement funds.

AGREEMENT ADDENDA

1. Is it possible to receive clearer copies of the allocation pages attached to the agreement addenda?
Answer: This request has been submitted to Phyllis Rocco, Branch Head for Local Technical Assistance and Training Branch (LTAT).

BUDGET PREPARATION

1. What is the rationale that the counties operate on a different fiscal year than what the state does (July 1-June 30 versus June 1-May 31)?
Answer: Counties operate on a fiscal year that runs July 1 – June 30. The first WIRM payments for the new fiscal year are paid by the state in July, which is actually for June expenditures. It is our understanding that this is why the activity period for our state funding runs from June 1 – May 31.
2. Is prior approval for Capital Outlay only required for STATE funds? Please clarify that this stipulation does not apply to local funds?
Answer: Please refer to the Consolidated Agreement section “B. Funding Stipulations” number “10” letter “b”. This section refers to prior approval for equipment purchased





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using program funds. If equipment is purchased using local funds, then you should refer to your county guidelines and requirements concerning prior approval.

MAINTENANCE OF EFFORT

1. Can you go over the MOE slide again? We had a question about a change regarding this slide.

Answer: Please refer to the Consolidated Agreement section "A. Responsibilities of the Department" number 18. Counties must maintain the Maintenance of Effort for WCH programs from fiscal year 84-85. There was an attachment in the Consolidated Agreement that showed the adjusted amount of each county's required MOE. General Statute 130A-34.4 (the Consolidated Agency law) which required local appropriations to equal SFY 10-11 levels has been repealed and is not required for SFY 16-17.

2. If MOE was not filled out (or if a year was missed filling it out), do I need to go back and fill it out or just be sure that it is filled out every year moving forward?

Answer: We would suggest that you go back at least three years and complete the Maintenance of Effort form. It is not necessary to send the form to the state; but, you should keep the form on file at your agency.

TIME EQUIVALENCIES

1. Can you send out the timesheet template Steven created? We'd like to compare it to what we use.

Answer: Sample time equivalency forms presented in Finance 101 will be available on the DPH website under the Finance 101 link. Inquiries about Steven Garner's time sheet or time equivalency forms should be directed to Steven Garner at sgarner@ncapha.org

2. If the employee is absent, can the supervisor sign on behalf of the employee? **Answer:** Because the signature is a certification that the time is correct, then the employee should sign the timesheet.

3. What happens when salaries do not match Time Study?

Answer: General Ledger for salaries and fringe **MUST MATCH** time equivalencies for salary and fringe.

4. Where should time be placed on daily/program time study if on FMLA?

Answer: When completing time studies for WIRM, the county will need to follow their written policies and procedures. The time can be recorded based on the last completed time study, or the time can be coded as general administrative time and treated the





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same as other administrative time. The Consolidated Agreement and the program agreements do not have restrictions outlined in them for staff on FMLA.

5. Steven Garner said that only time worked could go on time equivalency?

Answer: Please refer to question #4 above. Steven may have been referring to rules that apply to the Medicaid Cost Study. All questions about the Medicaid Cost Study should be directed to Steven Garner at sgarner@ncapha.org

6. If we have an employee on FMLA, what can we do to make sure the employee signs their time sheets?

Answer: Please refer to question #2 above.

WIRM EXPENDITURE REPORT PREPARATION

1. What happens if there are internet issues that prevent filing WIRM?

Answer: WIRM is due by 5:00 on the published due date. We recommend that you key your report before the due day to allow time for any issues which may arise.

2. Why is there a 3:00 p.m. deadline for resetting WIRM passwords?

Answer: This directive was issued to us by the DIRM section at the state. They have told us that they will no longer reset password after 3:00 p.m.

3. Has there been any talk about granting HDs another WIRM account access beyond the current 3?

Answer: Yes, we ask this question often; however, at this time the Controllers Office only allows three user roles per county and two user roles for Districts or Public Health Authorities.

4. Can WCH Long Acting Reversible Contraceptives be used for Medicaid Clients? **Answer:** WHSF (Women's Health Service Funds) have to be used for non-Medicaid patients. The funds can be used to purchase long acting reversible contraceptives or to reimburse time to insert or remove these devices. If the funds are used for time, there should be a separate column on the time study for WHSF.

5. Is there ever a chance that WIRM due dates will ever be pushed back? By the time our county closes, it is usually right around the due date. WIRM is due today, and our county still hasn't closed.

Answer: These dates are set by the State Controller's office. We are not aware of any plans to change their due dates.

6. If I am out and have a staff to do my WIRM, can I get her a log in or does she have to use my log in and password?





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Answer: The state Controllers Office only allows three passwords per county: one for the certifier, one for the approver, and one for the user. They do not have a provision for adding additional temporary users.

7. If our county purchased things in May, but the companies did not send the invoice until June, so it was not paid until June, when I report the WIRM in July it will come off of the state's next year's budget. Correct?

Answer: Yes, that is correct. The first WIRM report of the state fiscal year (which is paid in July) is for June expenditures.

8. If the county finance has not closed out by the WIRM due date (i.e. June 15) and we go with our figures, then next week we find a discrepancy, can we do an amendment in July for May? With May being in the previous state year?

Answer: No. We cannot make amendments in WIRM for the prior state fiscal year.

POLICY AND PROCEDURE DEVELOPMENT

1. Do employee confidentiality statements need to be signed annually or will upon employment suffice?

Answer: You should have the original Confidentiality Statements signed by staff who were employed at the time HIPAA was implemented. They do not need to be resigned/replaced. New employees need to sign the statement as part of their initial orientation process.

DPH ADMINISTRATIVE MONITORING

1. How often is the monitoring visit?

Answer: The Administrative Monitoring schedule is typically once every two years.

2. What is the higher audit? How is it determined who must undergo the higher audit?

Answer: The "higher audit" that was referred to during the presentation was in reference to FP Title X or other federal agency audits. The federal agencies determine which counties will be audited and then advise the state which counties have been selected for audit.

3. May we get a copy of that financial checklist?





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Answer: A copy of the Financial Checklist is available on the DPH website. Click on “For Local Health Departments” and then click on “Finance 101 Workshops”. The checklist is under “Handouts”.

340b PRICING

1. New guidance came out in December from Steve Garner and Betty Cox that we can set charges for Medicaid (based on acquisition cost) that may be different from what we set the charge for private insurance and self-pay?

Answer:

- LHDs should follow the guidance below in billing Medicaid for methods/devices.
- LHDs that operate and dispense through an outpatient pharmacy (either a contract pharmacy or a LHD operated pharmacy that fills contraceptive prescriptions written by any community provider, not just LHD providers) can either bill using the Medicaid Outpatient Pharmacy Rules or can use the Physician Drug Program (PDP) process. If the Pharmacy is a Medicaid Pharmacy Provider (outpatient pharmacy), then standard dispensing fees (as established by Medicaid) can be billed to Medicaid along with the cost of the method/device.
- LHDs that bill for IUDs, Nexplanons, and Depo through the Family Planning Clinic/PDP process must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.
- LHDs that dispense and bill for other Family Planning contraceptives through the Family Planning Clinic/PDP process (LHDs that fill contraceptive prescriptions only for clients seen in the health department Family Planning Clinic) must bill Medicaid the actual (or acquisition) cost which they paid for the method/device and no dispensing fee is allowed.
- **N.C. Medicaid requires the UD modifier to be billed with the applicable HCPCS code and NDC to properly identify 340B drugs. All non-340-B drugs are billed using the associated HCPC and NDC pair without the UD modifier.**
- Since 340b prices change regularly, WCH suggests that you determine your average cost for a year for each 340b method or device. This amount can then be





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used for billing using the UD-modifier and FP-modifier. As this methodology is updated annually, this should provide the least amount of risk as it will be the closest to your actual cost. Your purchase cost for each device should be reviewed and updated at least annually.

2. Regarding 340B when you send out FAQs please clarify whether Medicaid Health Choice (a private insurance) is billed at acquisition or actual charge.

Answer: 340B drugs can only be used for FP patients. If a Health Choice patient is seen in the FP clinic, then we can use 340B drugs (which are billed to Medicaid at the acquisition cost). If a Health Choice patient is seen in the Child Health clinic and the patient is not a FP patient, then we cannot use 340B drugs. If the agency enrolls the patient in the FP clinic and provides a FP clinic visit, then they can offer the patient FP 340B drugs. All 340B drugs billed to Medicaid must have the FP and UD modifiers and must be billed at the acquisition cost.

3. In regard to 340b drugs, do we have to bill the amount we paid for these drugs?

Answer: You have to bill Medicaid the amount you paid (acquisition cost); but, you can bill patient pay or private insurance a different amount (your established and approved fee).

4. How do we do that when the CPT code is the same for all payors?

Answer: In HIS, you can set the charge at the acquisition cost for the CPT code with the "UD" modifier appended. You can then set a separate charge for the CPT code without the "UD" modifier. If your agency does not use HIS, then you will need to consult with your private vendor for billing instructions.

PROGRAM GUIDANCE

1. What is the threshold for willingness to pay and inability to pay?

Answer:

Family Planning: The Title X guidelines do not distinguish between "inability" and "unwillingness" to pay. For FP patients who do not pay, the agency can use NC Debt Setoff. Even if a patient establishes a payment plan but then refuses to honor the plan, services cannot be denied or restricted.

Maternal Health: Denying or restricting services would constitute patient abandonment. Therefore, services for Maternal Health may not be denied because a patient is unwilling or unable to pay.





Child Health: CH services may not be restricted due to an outstanding bill. Title V funds are used to prevent barriers to care for clients who are non-Medicaid or not insured.

2. Are there any restrictions on patient donations in any program?

Answer: We are not aware of any restrictions, as long as there is no coercion or schedule of donations. You just need to have a policy on accepting donations in all programs.

3. Will there be better guidance provided for Maternal health and Family Planning budget documents required requested for 16-17 and beyond? We needed to provide documentation on how we specifically were going to spend State funding. The guidance provided this year wasn't sufficient and we have had multiple follow up questions.

Answer: Guidance should be requested from the Women's Health Regional Nursing Consultants. They can provide assistance in completing the Program Agreement Addendum.

4. In the revenue earned being used in program earned, isn't CH included in with FP and MH?

Answer: Per the Consolidated Agreement Section C. FISCAL CONTROL 4. b. it says "All earned revenue (officially classified as local funds) must be budgeted and spent in the program that earned it except: (1) Revenue generated by Women's and Children's Health (WCH) Section Programs, except WIC, may be budgeted and expended (consequently reported) in any WCH Section Program activity." State funds for Child Health (Activity 351 in WIRM) specified in Section III. Scope of Work and Deliverables may not support services and activities that have not been approved by the Children and Youth branch. Funds used to support services in Attachment A worksheets may not be used to support services or activities supported by other Agreement Addenda. Funds may not be used to supplement Medicaid services. Receipt of Medicaid reimbursement for services rendered is considered "payment in full". Activity 351 Child Health funds may be used to support attendance at C&Y Branch-supported CH regional meetings for programmatic updates.

5. On the slide for earned revenues, you stated that FP and MH were the only areas where there was an exception. The area mentioned was WCH - does that not include CH?

Answer: Please refer to #4 above.

6. Can flat fee services (immunizations/TB skin testing) be refused if a patient is unable to pay?





Answer: Yes, if it is documented in your Fee and Eligibility policy. This would include only those non-essential “private pay” immunizations and TB for work or school.

7. So, as long as we have a clause in our policy, we can reschedule an ADULT Medicaid immunization patient due to them not having their \$3 co-pay?

Answer: Please refer to Medicaid billing guidelines or contact Medicaid directly for specific guidance. Per the April, 2012 Basic Medicaid Billing Guide “Providers may bill the patient for the applicable copayment amount, but may not refuse services for inability to pay copayment.”

8. Should the administration fee be the same throughout all programs? **Answer:** Yes. Please refer to the October 30, 2009 memorandum from the Immunization Branch which stated that LHDs are now allowed to charge an administration fee for state-supplied vaccines when certain conditions are met. The maximum charge is based on the state Medicaid administration fee on the date of service. Your agency may choose to set the standard Immunization Administration rate at the Medicaid rate for all programs; or, your agency may choose not to charge the administration fee for state-supplied vaccine and set the standard rate higher than the Medicaid rate. Your agency is not required to charge the administration fee for statesupplied vaccine.

9. Please confirm your statements for copays.

Answer: Please refer to the “Collecting Co-Pays and Applying Sliding Fee Scales” document distributed several years ago by the Family Planning program consultants. “No matter what, the client should be charged the lesser of the two: the co-pay or the discounted fee based on the sliding fee scale.” “. . . clients whose family income is at or below 250% of the Federal Poverty Level (FPL) should not pay more (in co-pays or additional fees) than what they would otherwise pay when the sliding fee scale is applied.” One example given in their document includes a fee of \$60 with an 80% discount which results in a \$12 charge. The insurance co-pay is \$20. In this scenario, the patient would be charged \$12 (since it is the lesser of the two amounts).

10. Does dental fall under WCH umbrella?

Answer: No, Dental does not fall under WCH. Some dental services (fluoride and assessment) may be performed in Child Health and would also be billed through CH, not Dental. As a public health agency, your agency is a cost-based provider and is costsettled through Medicaid Cost Settlement (including Dental services). As a result, you are required to serve those at or below 100% of federal poverty level. You should apply a sliding fee scale to Dental services; but, it does not have to slide to zero. However, you cannot refuse to provide services to anyone below 100% of federal





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poverty level who is unable to pay that minimum fee. Please refer to the July 10, 2003 memo "Policies for Local Public Health Dental Clinics" from Joy Reed. The memo is posted on the DPH website in the Finance 101 section.

11. Please define the services that fall under "Adult Health" for the sliding scale of minimum of 40%?

Answer: It is up to the agency to determine what services they will provide under Adult Health. The reference to the 40% SFS was intended to say that a health department may wish to limit their SFS to 40% instead of sliding to zero so that Adult Health clients would never pay less than 40% based on their income determination. Even if they are at 0% they would be required to pay the 40% amount.

12. BCCCP is restricted to Medicare rates for all procedures. The amount for an office visit is almost certainly less than what it actually costs the county. How can they set a fee for BCCCP if they use a sliding scale?

Answer: You are correct that this poses a problem, since we can only charge the Medicare reimbursement rate to our BCCCP patients. Most counties (following the "your charge is your charge" rule) have elected not to charge BCCCP patients. Questions related to BCCCP should be directed to your regional BCCCP Consultant. The regional map can be found at

<http://ncpublichealthnursing.org/directories/bcccpwisewoman-12-1-15.pdf>

FUNDING SOURCES

1. In years past we could tell state vs federal funds. Is there a tool that would tell us what the funds are that we receive in the beginning of the year?

Answer: You can use The Federal Schedule of Assistance Division Key Page. The website address is <https://www2.ncdhhs.gov/control/auditconfirms.htm>. Click on "Audit Confirmation Reports" and then click on the drop down box beside "Division Key Pages". Click on "DPH Key Pages" and then click on "Download".

2. Is CAQH not just for providers? The Health Department itself can't get a CAQH can it?

Answer: CAQH may be used to register providers and practices (LHDs). The site may be accessed via the internet at <http://www.caqh.org/solutions/caqh-preview>. The login options include Provider, Practice Manager, and Participating Organization (LHD).

3. How does roster billing work?

Answer: Rostered billing is the mechanism where you can bill Medicare for Flu & Pneumonia vaccines administered during mass clinics (typically during flu season). You may access the Rostered Billing forms and instructions at:





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<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Part-B~8ERPCC3328>

NOTE: Use of Rostered Billing requires the "Red, White & Blue" Medicare identification number. Other Medicare plans must be billed directly.

MEDICAID COST SETTLEMENT

1. Will the departments receive the Medicaid earnings?
Answer: If this is in reference to the Medicaid Cost Settlement, then this question should be directed to Steven Garner.
2. When was our most recent cost report completed?
Answer: Since the Administrative Consultants are not involved with the Cost Settlement process, we do not know when the most recent report was completed. Questions about the Medicaid Cost Settlement should be directed to Steven Garner.
3. Who does the cost report?
Answer: Steven Garner and Vicky Smith do the Medicaid Cost Report.
4. Are you saying that any cost settlement monies we receive MUST be used in the program that it was earned in? Our health director is under the impression that the county commissioners could use that money to use throughout the county if needed. Although they have never touched this money.
Answer: Please refer to the Consolidated Agreement, section "C. FISCAL CONTROL" number "4" letter "b". "All earned revenue (officially classified as local funds) must be budgeted and spent in the program that earned it . . ." There are two exceptions noted, neither of which would allow for moving the funds away from the Health Department.
5. Any idea how long the Medicaid cost settlement will continue?
Answer: It is our understanding that the cost settlement is expected to continue. Questions about the Medicaid Cost Settlement should be directed to Steven Garner.

GENERAL QUESTIONS

1. What Does AC stand for?
Answer: Administrative Consultant
2. How can I get this Power Point presentation?
Answer: This information is available on the DPH website. Click on "For Local Health Departments" and then click on "Finance 101 Workshops". The Power Point presentation is called "Finance 101 for June 2016".





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3. What is LTAT?

Answer: Local Technical Assistance and Training

4. Will this webinar be archived or offered on another date? We have a new Health Director starting on June 30th and it would be good for him to see this training. **Answer:** The webinars were not recorded. Your regional Administrative Consultant can do a one-on-one training onsite, if requested.

5. Who do you contact for the training?

Answer: Your regional Administrative Consultant. The Regional Administrative Consultant map can be found on the DPH website. Click on "For Local Health Departments" then click on "Contacts".

6. We have covered a lot of material where we have heard a lot of information is available on various websites. Can we get a listing of all pertinent websites that would help us LHDs?

Answer: Following is a list of websites which were referred to during the Finance 101 presentation

- CAQH Insurance Application <http://www.caqh.org/solutions/caqh-proview>
- Consolidated Agreement FY 2016
<http://publichealth.nc.gov/employees/forms/contracts/agreementAddenda/FY16ConsolidatedAgmt.pdf>
- DPH website
<http://publichealth.nc.gov/>
- Family Planning Title X Program <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>
- Federal Schedule of Assistance
<https://www2.ncdhhs.gov/control/auditconfirms.htm>
- Local Government Budget and Fiscal Control Act
http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_159/Article_3.html
- NC Debt Setoff <http://www.ncsetoff.org/>





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- NCGS 130A-34 Local Health Departments
http://www.ncga.state.nc.us/enactedlegislation/statutes/pdf/byarticle/chapter_130A/article_2.pdf
- Practice Management <http://publichealth.nc.gov/lhd/> under “Practice Management”
- Records Retention Schedule
http://archives.ncdcr.gov/Portals/3/PDF/schedules/Local%20Schedules/Local_Health_Departments_20070907t.pdf?ver=2016-03-11-084038-573
- Regional Administrative Consultants Map
<http://publichealth.nc.gov/lhd/docs/AdminConsMapSept2016-051216.pdf>
- Regional BCCCP Consultants Map
<http://ncpublichealthnursing.org/directories/bcccp-wisewoman-12-1-15.pdf>
- Regional Nurse Consultants Map <http://publichealth.nc.gov/lhd/docs/NurseCons-050516.pdf>
- Roster Billing forms and instructions
<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-PartB~8ERPCC3328>
- WIRM Portal
<https://wirm.dhhs.state.nc.us/login.aspx?reason=0&redirect=https%3a%2f%2fwirm.dhhs.state.nc.us%2fDefault.aspx>



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