Local Health Department Finance & Billing Principles

Presented by

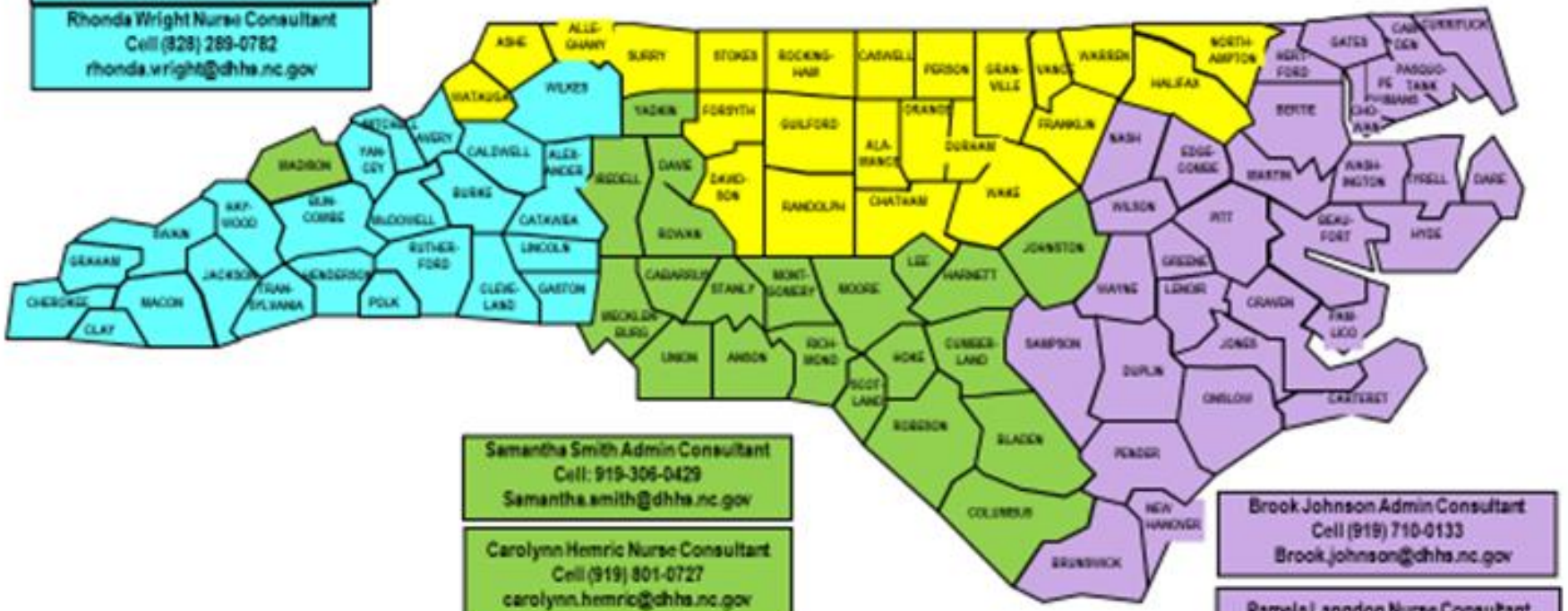
Public Health Administrative Consultants

DHHS/DPH/LTAT

Local Technical Assistance and Training Branch

Administrative and Nursing Consultants Map

12/1/2019 (interim)



Consolidated Agreement & Agreement Addenda

Consolidated Agreement

- Contract between Local Health Department & DPH
- Outlines requirements for Local Health Departments and NC Division of Public Health
- It applies to all activities related to DHHS funding reimbursed through the ATC
- Revised and Renewed Annually
- Consolidated Agreement FY 20

Responsibilities of the LHD

Comply with all program rules in North Carolina Administrative Code, as well as all other federal/state regulations

Perform the activities specified in the Program Agreement Addenda

Report client, service, encounter, and other data as specified by applicable program rules into the HSA system

Enforce all rules adopted by the Commission for Public Health (GS 130A-29)

Provide formal training for Governing Boards

http://www.ncga.state.nc.us/enactedlegislation/statutes/html/bychapter/chapter_130a.html

Funding Stipulations

- Funding is always based on availability of state and federal dollars
- Supplanting is not allowed
- Time records/sheets must be based on actual time worked in the activity
- Complete a provider participation agreement with Medicaid
- Establish one *charge/fee* for all payors (including Medicaid) based on related costs

Reimbursement for Public Health Training

- Principles & Practices of Public Health Nursing
- Management & Supervision for Public Health Professionals
- Environmental Health Centralized Intern Training
- See Attachment C in the consolidated agreement for details

Fiscal Control

Health Departments shall retain copies of the following budget & expenditure reports:

- All Funding Authorizations
- Monthly certified electronic printed screen of the Expenditure Reports with any amendments via ATC
- Consolidated Agreement
- Agreement Addenda

Records Disposition Schedule

- https://archives.ncdcr.gov/documents/local-health-departments-schedule

Audit Requirements

The Department shall have an annual audit performed in accordance with "The Single Audit Act of 1984 and OMB Circular A-133

All District Health Departments and Public Health Authorities must complete quarterly a Fiscal Monitoring Report

Confidentiality

All information regarding provision of services or other activity under this agreement shall be privileged and be held confidential

Information cannot be released without proper consent

All employees must sign confidentiality statements

Responsibilities of the State

- Provide training and technical assistance:
  - Assist with Management Teams/Staffing
  - Policy Development
  - Program Planning and Implementation
  - Quality/Performance Improvement
  - General Administrative Consultation
  - Board Relations

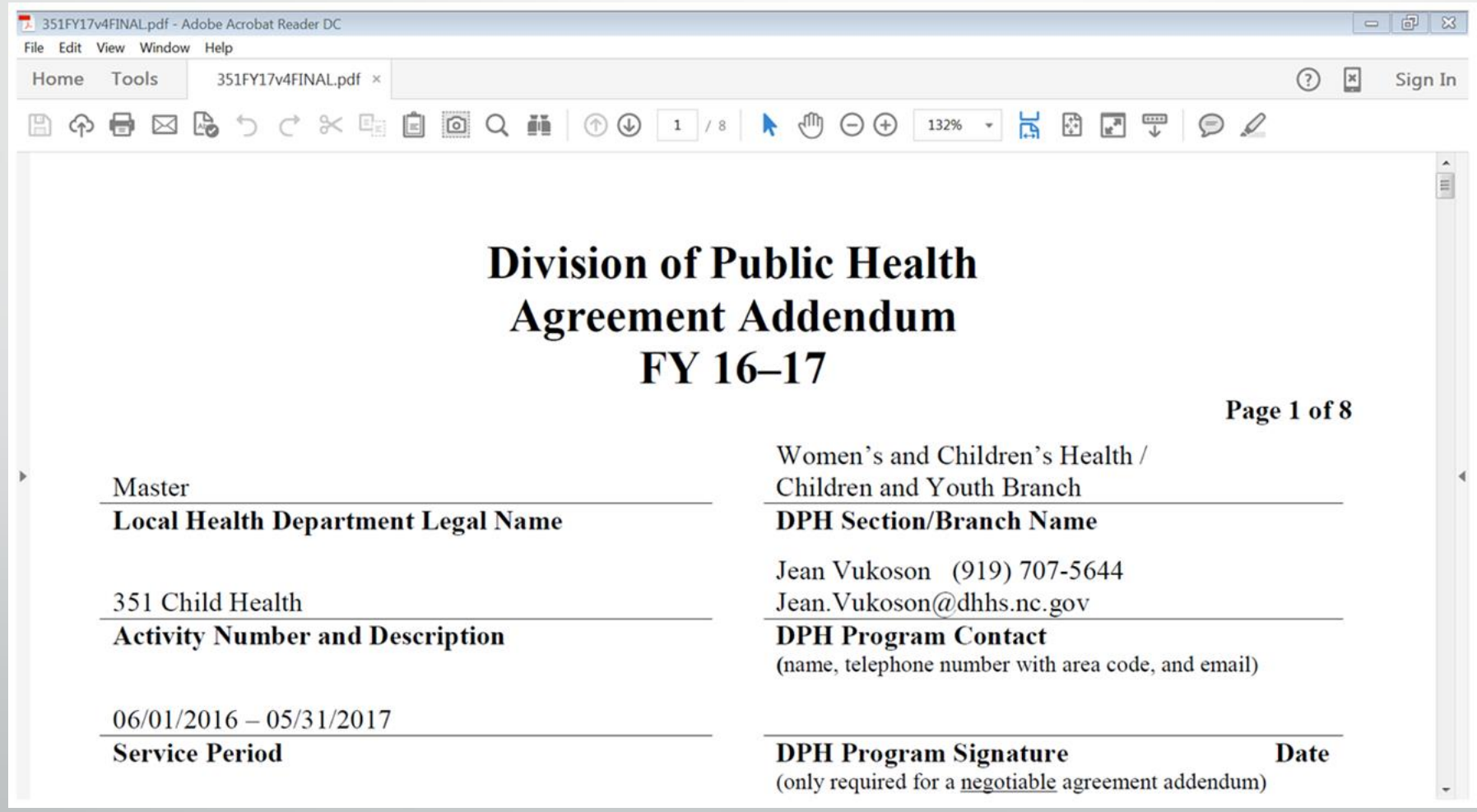
Responsibilities
of the State

Provide "Estimates of Funding Allocations" no later than Feb 15th

Provide a "Funding Authorization" to the Department and provide a final Budget Form after the receipt of the Certified State Budget

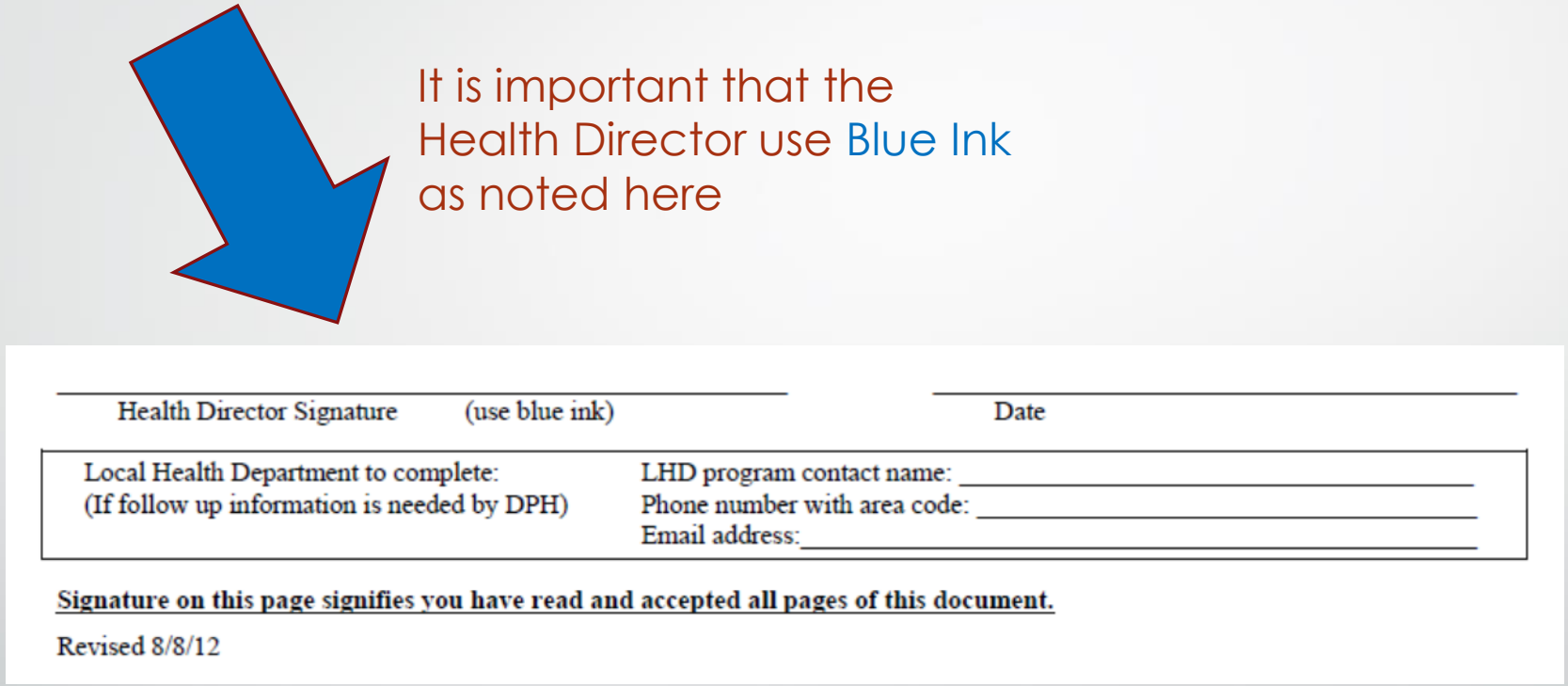
Agreement Addenda

Agreement Addenda



Agreement Addenda

It is important that the Health Director use Blue Ink as noted here



Health Director Signature (use blue ink) _____ Date _____

Local Health Department to complete: (If follow up information is needed by DPH)	LHD program contact name: _____ Phone number with area code: _____ Email address: _____

Signature on this page signifies you have read and accepted all pages of this document.

Revised 8/8/12

Scope of Work and Deliverables

Scope of Work and Deliverables:
The Family Planning program has a negotiable Agreement Addendum. Please complete Sections A and B along with the appropriate worksheets (attached). Attachment A and Attachment B worksheets, if needed **must** be returned with the signature page (page 1). Women's Health Branch (WHB) staff will review and approve.

Section A: Non-Medicaid Services (Attachment A) **Amount $_____**
The Health Department will provide Non-Medicaid Service Deliverables in FY14 that meet or exceed the total dollar value of all services budgeted. Health Information System (HIS) service data as of August 31, 2014 will provide the documentation.

Instructions: Using Attachment A worksheet, local agencies must use the reimbursement rates for each service type in estimating the total cost of Section A deliverables.

Section B: Other Program Services (Attachment B) **Amount $_____**
If the total estimated cost of Section A is less than the total amount of Department of Health and Human Services (DHHS) funds budgeted in the budgetary estimates in the DPH Aid to County Database (WIRM), additional information must be provided on how the local agency will use the remaining DHHS funds to further the program's goals and objectives. In Attachment B, list only activities that are not Medicaid reimbursable and not part of the cost of the service deliverables in Section A. No physician time can be billed except for clinical visits that are not reimbursed by Medicaid. **The total estimated cost of all Section A and Section B deliverables must equal or exceed the total DHHS funds budgeted.**

Instructions: See Attachment B; Section B, Other Program Deliverables for suggestions of allowable areas of expenditures for this Section. Please return this worksheet with your signed Agreement Addendum, only if Section B/Other Program Deliverables are being used.

Total Family Planning Budget (Attachment A amount + Attachment B amount)

Total Amount $_____

Please return to DPH:

- **Signature page (page 1)**
- **Page 2**
- **Attachment B, if necessary (page 14)**
- **Attachment C (page 16)**

In Summary

Be certain to send your completed Consolidated Agreement & Agreement Addenda in on time- typically noted in the cover letter that comes with the packet

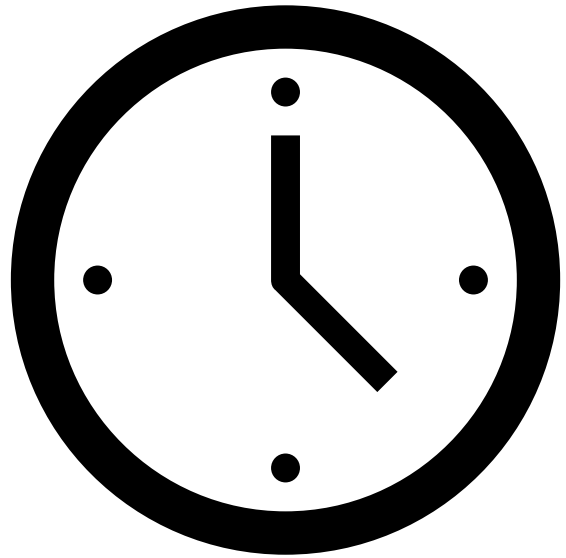
Review and retain copies of each of these documents. This is your fiscal guide for the year and contains requirements for drawing down funds

Ensure that appropriate clinical staff have this information (program coordinators/ DON/etc).

QUESTIONS

ACTIVITY

Time Sheets, Time Equivalencies & ATC Expenditure Report

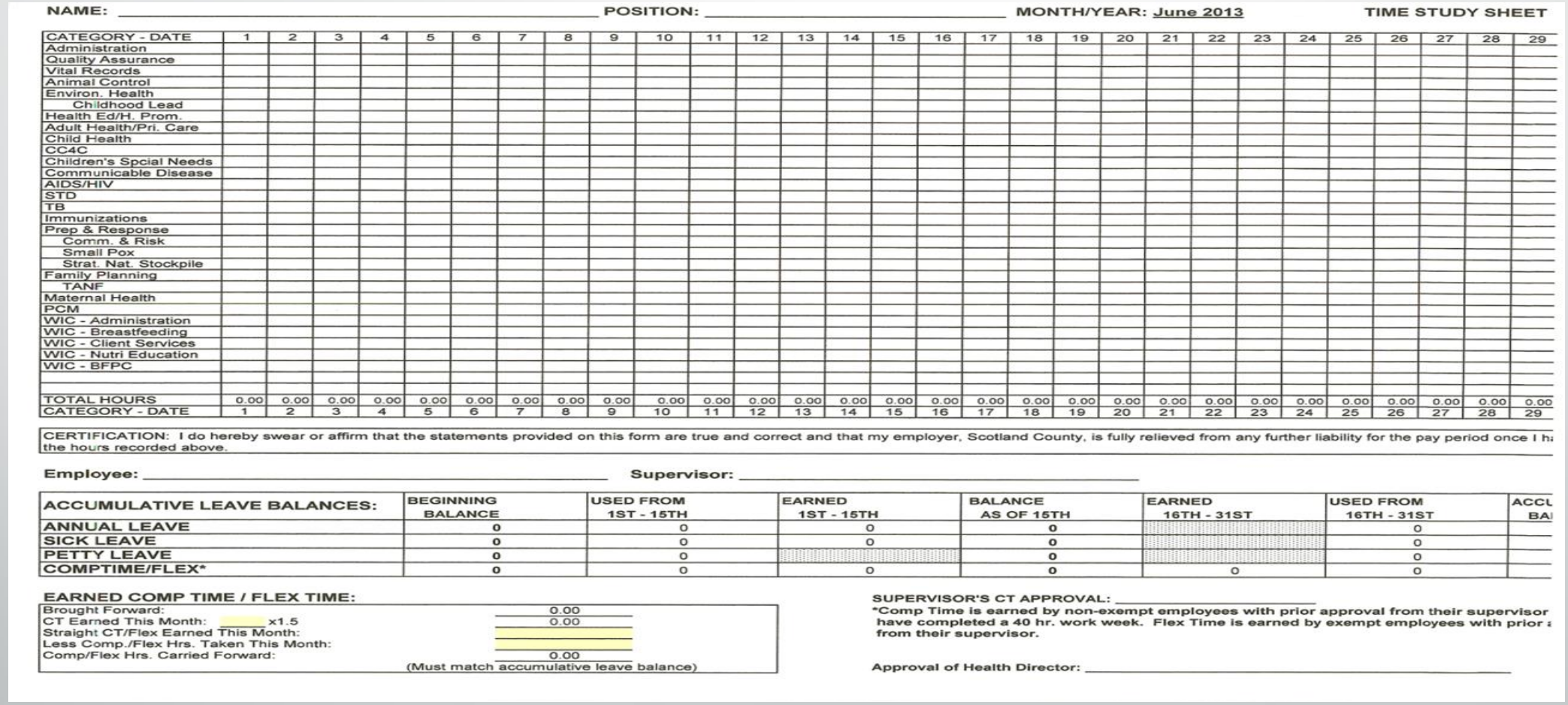


Consolidated Agreement B.6

- Signed employee time records
- Actual work activity
- Completed Daily
- Computed at least monthly
- Charged to Federal and State grants

Ensure that there are enough categories to capture all time

Example of a Time Study



NAME: _____ POSITION: _____ MONTH/YEAR: June 2013 TIME STUDY SHEET

CATEGORY - DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Administration																													
Quality Assurance																													
Vital Records																													
Animal Control																													
Environ. Health																													
Childhood Lead																													
Health Ed/H. Prom.																													
Adult Health/Pri. Care																													
Child Health																													
CC4C																													
Children's Spcial Needs																													
Communicable Disease																													
AIDS/HIV																													
STD																													
TB																													
Immunizations																													
Prep & Response																													
Comm. & Risk																													
Small Pox																													
Strat. Nat. Stockpile																													
Family Planning																													
TANF																													
Maternal Health																													
PCM																													
WIC - Administration																													
WIC - Breastfeeding																													
WIC - Client Services																													
WIC - Nutri Education																													
WIC - BFPC																													
TOTAL HOURS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CATEGORY - DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29

CERTIFICATION: I do hereby swear or affirm that the statements provided on this form are true and correct and that my employer, Scotland County, is fully relieved from any further liability for the pay period once I h
the hours recorded above.

Employee: _____ Supervisor: _____

ACCUMULATIVE LEAVE BALANCES:	BEGINNING BALANCE	USED FROM 1ST - 15TH	EARNED 1ST - 15TH	BALANCE AS OF 15TH	EARNED 16TH - 31ST	USED FROM 16TH - 31ST	ACCU BA
ANNUAL LEAVE	0	0	0	0		0	
SICK LEAVE	0	0	0	0		0	
PETTY LEAVE	0	0		0		0	
COMPTIME/FLEX*	0	0	0	0	0	0	

EARNED COMP TIME / FLEX TIME:

Brought Forward:	0.00
CT Earned This Month: _____ x1.5	0.00
Straight CT/Flex Earned This Month:	
Less Comp./Flex Hrs. Taken This Month:	
Comp/Flex Hrs. Carried Forward:	0.00

(Must match accumulative leave balance)

SUPERVISOR'S CT APPROVAL: _____

*Comp Time is earned by non-exempt employees with prior approval from their supervisor have completed a 40 hr. work week. Flex Time is earned by exempt employees with prior from their supervisor.

Approval of Health Director: _____

Time Equivalency

Employee's salary and fringe comes from county payroll register

Hours worked in each program is converted to percentages

Salary/Fringe expense is re-calculated for each program based on time sheets

Total Salary/Fringe from County Expenditure Report should equal Total Salary/Fringe on Time Equivalency

Sample Time Equivalency

TIME STUDY - SALARIES

COUNTY OF:

EMPLOYEE		hrs paid	actual hrs wkd	PRI CARE	OTHER SER	GEN - 5110	CD - 5120	STD	TB	FP - 5153	CH - 5160	IMMUN	MH - 5164	ADULT HLT	ADM - 5202
PHNI	HOURS:	160.00	160.00	0.00	20.00			10.00		40.00	10.00	0.00	40.00	40.00	
	PERCENTAGE:		1.00	0.00	0.13	0.00	0.00	0.06	0.00	0.25	0.06	0.00	0.25	0.25	0.00
	SALARY:		48,000.00	0.00	6,000.00	0.00	0.00	3,000.00	0.00	12,000.00	3,000.00	0.00	12,000.00	12,000.00	0.00
PHN Supervisor	HOURS:	160.00	160.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	50.00
	PERCENTAGE:		1.00	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.31
	SALARY:		58,000.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	3,625.00	18,125.00
Management Support Supervisor	HOURS:	160.00	160.00	20.00	15.00	15.00	10.00	10.00	10.00	20.00	20.00	10.00	20.00		10.00
	PERCENTAGE:		1.00	0.00	0.09	0.09	0.06	0.06	0.06	0.13	0.13	0.06	0.13		0.06
	SALARY:		37,500.00	0.00	3,515.63	3,515.63	2,343.75	2,343.75	2,343.75	4,687.50	4,687.50	2,343.75	4,687.50	0.00	2,343.75
TOTAL DIRECT SALARIES			**143,500.00**	**3,625.00**	**13,140.63**	**7,140.63**	**5,968.75**	**8,968.75**	**5,968.75**	**20,312.50**	**11,312.50**	**5,968.75**	**20,312.50**	**15,625.00**	**20,468.75**
Percentage by Program				**0.06**	**0.28**	**0.16**	**0.13**	**0.19**	**0.13**	**0.44**	**0.25**	**0.13**	**0.44**	**0.31**	**0.38**
Administrative Salaries															
Finance Officer		3,319.56	3,319.56												
Health Director		5,272.16	5,272.16												
Total Adm. Salaries		8,591.72	8,591.72	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GRAND TOTAL SALARIES		87,941.63	87,941.63	3,625.00	13,140.63	7,140.63	5,968.75	8,968.75	5,968.75	20,312.50	11,312.50	5,968.75	20,312.50	15,625.00	20,468.75
Total Fringes (if applicable)		*26,521.05*	*26,521.05*	*1,388.47*	*5,791.98*	*3,194.80*	*2,592.69*	*3,891.28*	*2,592.69*	*8,991.27*	*5,095.50*	*2,592.69*	*8,991.27*	*6,582.83*	*8,146.55*
TOTAL SALARIES & FRINGES		**114,462.68**	**114,462.68**	**5,013.47**	**18,932.60**	**10,335.42**	**8,561.44**	**12,860.03**	**8,561.44**	**29,303.77**	**16,408.00**	**8,561.44**	**29,303.77**	**22,207.83**	**28,615.30**
			TOTAL	PRI CARE	OTHER SER	GEN - 5110	CD - 5120	STD	TB	FP - 5153	CH - 5160	IMMUN	MH - 5164	ADULT HLT	ADM - 5202
FRINGES BY PROGRAM	% OF TOTAL FRINGE														
FICA/Medicaire	0.25		6,727.53	277.31	1,005.26	546.26	456.61	686.11	456.61	1,553.91	865.41	456.61	1,553.91	1,195.31	1,565.86
INSURANCE	0.52		13,875.04	867.19	3,902.36	2,167.98	1,734.38	2,601.57	1,734.38	6,070.33	3,468.76	1,734.38	6,070.33	4,335.95	5,203.14
RETIREMENT	0.22		5,918.47	243.96	884.36	480.56	401.70	603.60	401.70	1,367.03	761.33	401.70	1,367.03	1,051.56	1,377.55
TOTAL FRINGES	***1.00***		***26,521.05***	***1,388.47***	***5,791.98***	***3,194.80***	***2,592.69***	***3,891.28***	***2,592.69***	***8,991.27***	***5,095.50***	***2,592.69***	***8,991.27***	***6,582.83***	***8,146.55***

Aid to County Expenditure Report

- Completed Monthly
- Draw Down State Funding
- Report Local Appropriations, Grants & Revenue by Program
- Deadlines set by State Controllers Office

ATC Expenditure Control Schedule

Aid-To-County Payment Schedule For
Calendar Year 2020

Month	Counties/Expenditures start date	Last day LHD Expenditure Reports Due for pymnt in month	Payment Date	Budgetary estimate start date	Budgetary estimate end date
January	January 9th	January 15th	January 21st	January 23rd	February 7th
February	February 10th	February 17th	February 20th	February 24th	March 6th
March	March 9th	March 16th	March 19th	March 23rd	April 7th
April	April 8th	April 15th	April 20th	April 22nd	May 7th
May	May 8th	May 15th	May 20th	May 22nd	June 5th
June	June 8th	June 15th	June 18th	June 22nd	July 8th
July	July 9th	July 15th	July 20th	July 22nd	August 7th
August	August 10th	August 17th	August 20th	August 24th	September 8th
September	September 9th	September 15th	September 18th	September 22nd	October 7th
October	October 8th	October 15th	October 20th	October 22nd	November 6th
November	November 9th	November 16th	November 19th	November 23rd	December 7th
December	December 8th	December 15th	December 18th	December 22nd	January 7th

Please note that LHD expenditure report due date is not a consistent date. This schedule takes
into account weekends and holidays.

* NCAS Changes for DPH include, but are not limited to, budget revisions via 606's, reclassifications of expenditures, and budget amendments to LHD contracts. These changes will not be reflected in the monthly payments to the counties until they have been submitted to the Aid-to-County web site and "State Admin. Certified".

Preparing for
Aid to County Expenditure Report

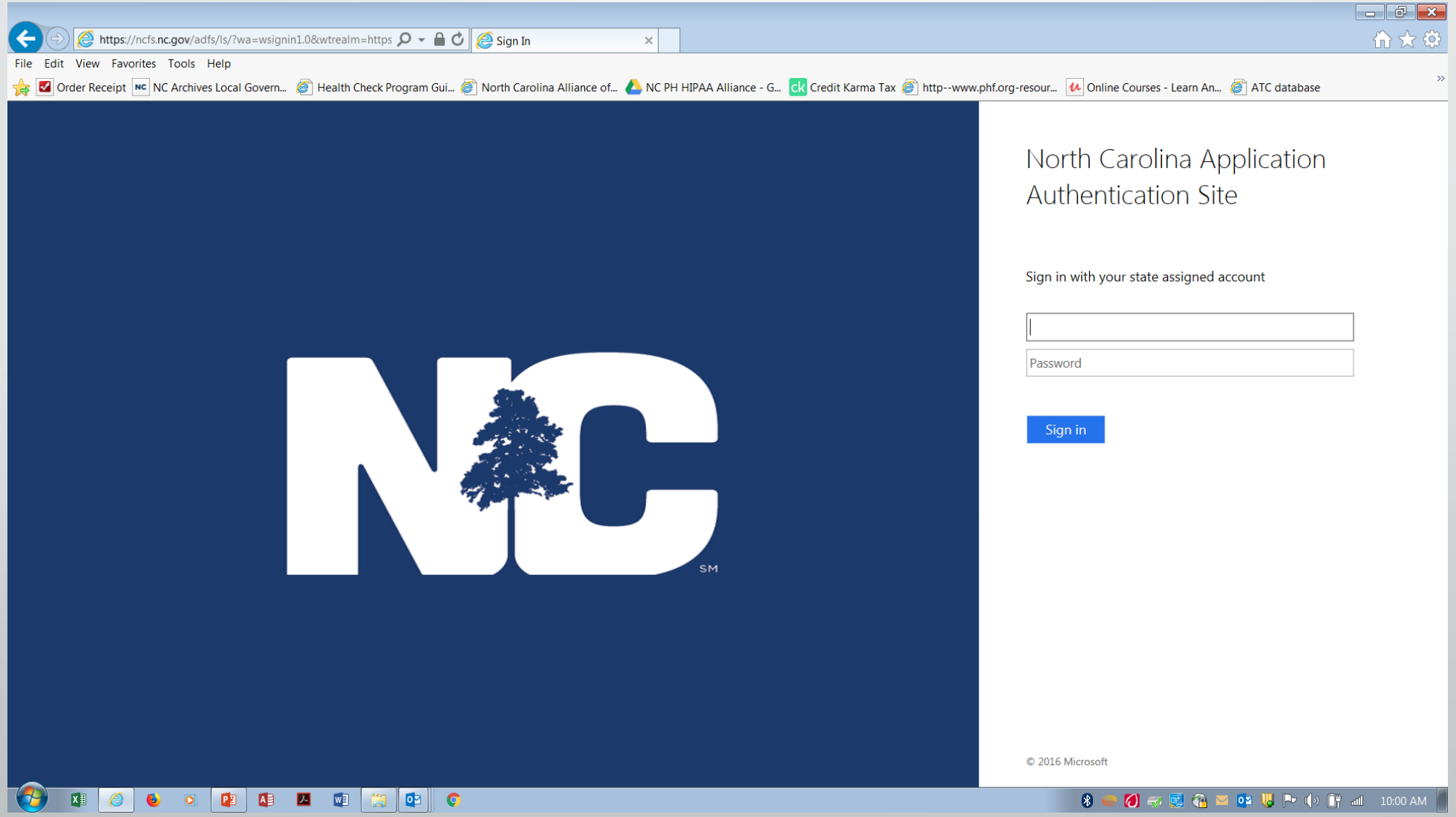
County Finance General Ledger Expenditure Report

Time Equivalency Report

Monthly Revenue Sources

- Medicaid earnings by program
- Patient Fees collected by program
- Insurance earnings by program
- Grant or Other funding

ATC Login Screenshot



Drawing down State Program Funds

- Refer to the Agreement Addendum for each program:
  - Required Work Activity
  - Funding Stipulations
  - Prior Approval for Purchases
  - Draw down by method other than expenditures

Reporting Revenue

- County Appropriations (101)
- Medicaid Revenue by program- local (102)
- Other Local Revenue (103)
    - Patient Fees collected by program
    - Insurance earnings by program
    - Grant or Other funding

Search

Medicaid Revenues(local):	$0.00
Other Local Revenues(fees and grants)	$0.00
Teen Pregnancy:	$0.00
Bioterrorism:	$0.00
Temporary Food Establishment Fees:	$0.00
Grand Total:	$0.00

Page 1 of 7

<< Previous 1 2 3 4 5 6 7 Next >>

Activity	Fund	RCC	FRC	Description	Begin Date	End Date	Fiscal Year	Remaining Allocations	Amount Requested	County Appropriations 101	Medicaid Revenues(local) 102	Other Local Revenues (fees and grants) 103	Teen Pregnancy Match	Bioterrorism	Temporary Food Establishment Fees	Line Items
101	13A1	5740	00	Maternal Health	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
101	ZZZZ	ZZZZ	ZZ	Local use only- Maternal Health	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
107	ZZZZ	ZZZZ	ZZ	Local use only-PCM for women Ineligible for Medica	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
110	1161	4110	00	General Aid-To-County	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
110	ZZZZ	ZZZZ	ZZ	Local use only- General Aid-to-County	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
113	ZZZZ	ZZZZ	ZZ	Local Use Only- Electronic Health Record	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
114	1161	4110	00	CHA/CHIP PEer Review	1/1/2019	5/31/2019	18/19	$1,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
114	ZZZZ	ZZZZ	ZZ	Local Use Only- CHA / CHIP Peer Review	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
116	13A1	5116	00	Healthy Beginnings	6/1/2018	5/31/2019	18/19	$18,470.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
116	ZZZZ	ZZZZ	ZZ	Local use only-Healthy Beginnings	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
129	ZZZZ	ZZZZ	ZZ	Local use only -NC Baby Love Plus	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	5151	T2	TANF	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	5735	00	Family Planning - State	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	5735	AP	HMHC - FP - February start	2/1/2019	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	5735	AP	HMHC - FP - June start	6/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	5735	AP	HMHC - FP - October start	10/1/2018	5/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	592A	FP	Family Planning - 11/12 Months	9/1/2018	3/31/2019	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	592C	FP	Family Planning - Title X 1/12 Month	6/1/2018	6/30/2018	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0
151	13A1	592D	FP	Family Planning - 2 Month No-Cost Extension	7/1/2018	8/31/2018	18/19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0

NC DHHS DPH Aid To Counties V4.0 Last Modified 8/01/2016

Aid to County Line Screenshot

Checks and Balances

- Total County General Ledger Report for month should balance to the ATC report for the month
- Program audits to ensure proper draw down of state funds
- Administrative Monitoring to ensure proper method for calculating ATC

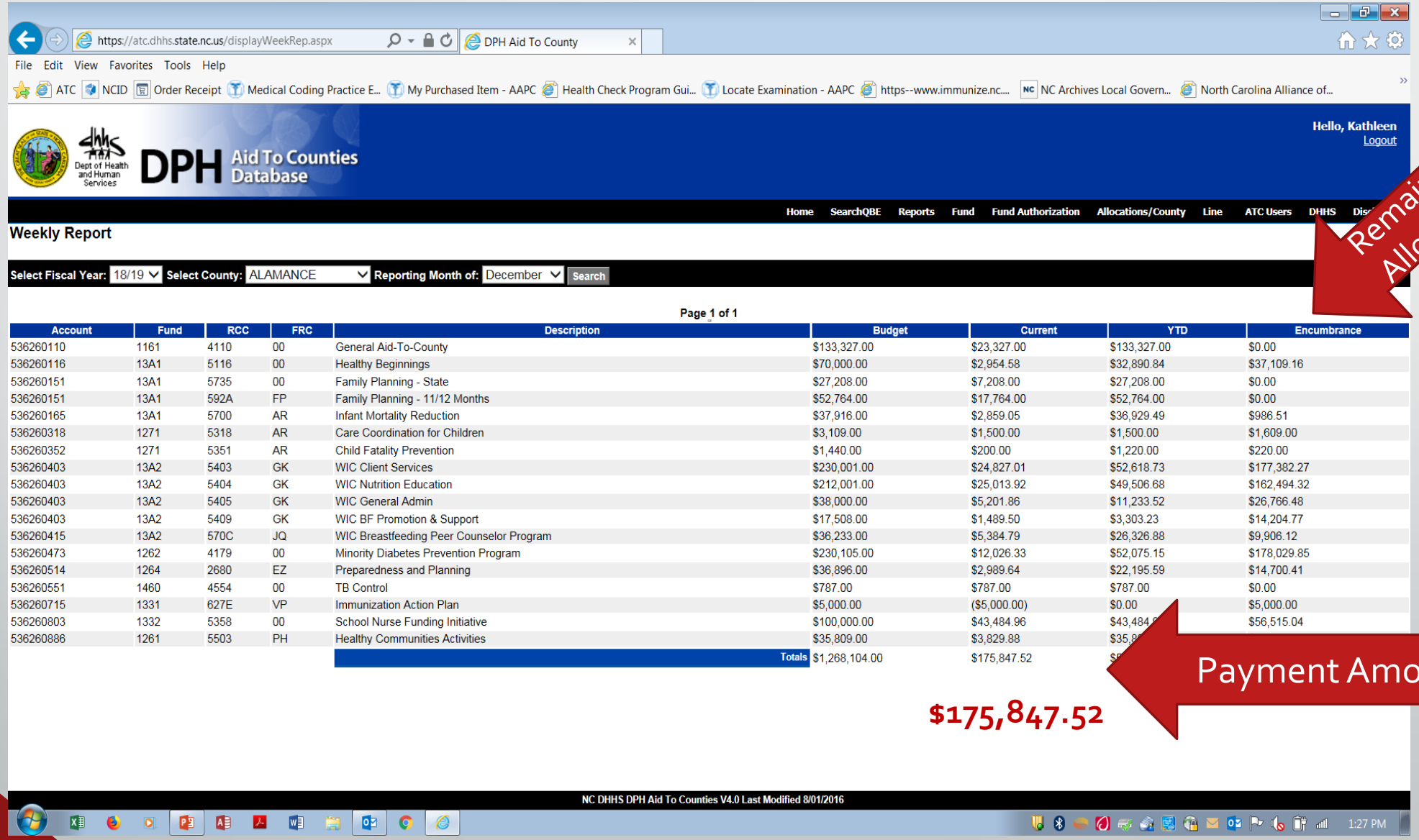
ATC Totals for the Month

Requested (state)	$175,847.52
County Appropriations	$358,158.63
Medicaid Revenue	$79,361.22
Other Revenue (fees, grants, ins, pt pay)	$39,288.00
Teen Pregnancy match	$0.00
Bioterrorism match	$0.00
Temporary Food Establishment Fees	$150.00
Grand Total	$652,805.37

Matches State payment

Matches GL totals

Payment Report (state program funds)

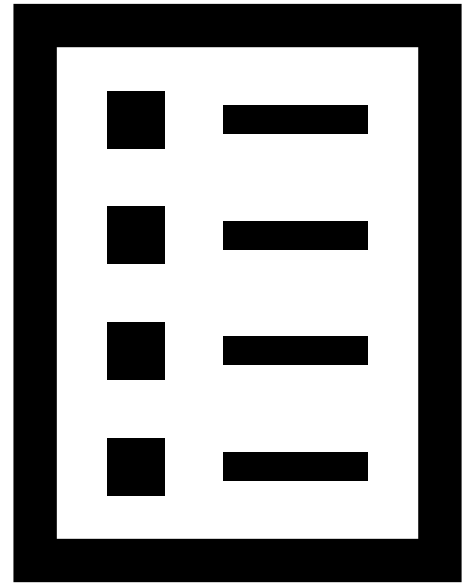


Remaining Allocation

Payment Amount

QUESTIONS

Administrative Monitoring



Administrative Monitoring

Administrative Monitoring was developed to assure that Local Health departments are in compliance with the Consolidated Agreement, State Program Rules, Title X Requirements, and Local Policies.

Programs Reviewed

The following programs are reviewed as a part of Administrative Monitoring

- **Maternal Health**
- **Child Health**
- **Family Planning**
- STD
- TB
- Immunizations

Areas Reviewed During Administrative Monitoring

- Staff Time Documentation
- Expenditure Reporting
- Budgeting
- Revenue Management
- Patient Fee & Eligibility Policies
- Patient Financial Eligibility Screening
- Medicaid Eligibility
- Residency Requirements
- Accounts Receivable

DPH Financial Checklist

- Additional review tool which is now a part of Administrative Monitoring
- County Finance Office maintains many of the policies required for review
- District Health Departments are responsible since they are a separate entity
- Findings related to the Financial Checklist are considered funding conditions and may require a corrective action plan

DPH Financial Checklist Requirements

- Contracts (Consolidated Agreement)
- Budgets
- Accounting Procedures
- Purchasing Policies and Procedures
- Internal Control Policies
- Cost Allocation
- Inventory System
- Staff Time Records & Allocation of Personnel Expense
- Expenditure Reporting and Support Documentation

Billing Policies and Procedures

Written policy should be in place addressing how denied claims are handled; who is responsible, time frame for processing, steps for processing claims that can be re-billed

Fee Schedule should reflect 340B pricing, and policy should indicate how charges are applied for any drug/device purchased through a 340B contract

Monitoring Process

- Completed every 2 years
- Health Director is contacted by the Administrative Consultant 45 days
- Findings are discussed with staff and a formal review letter is sent to the agency within 30 days of the visit
- The health department has 45 days to complete CAP requirements if needed
- Billing Review is also completed during the monitoring visit

Monitoring Results

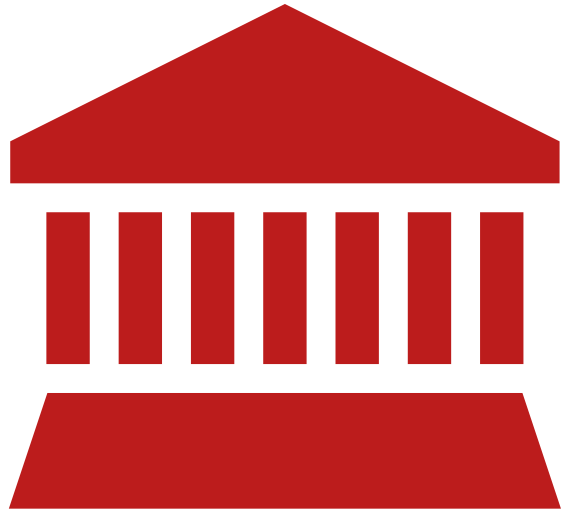
Findings are in one of two categories:

Recommendations: Usually are issues identified that are considered to Best Practice.

Funding Conditions: Are any non- compliance issues identified r/t State or Federal program rules. A written CAP is required to address all Funding Conditions

QUESTIONS

Fee Setting in the Local Health Department



Why do we charge fees?

- increase resources and use them to meet residents' needs
- in a fair and balanced way
- cover the full cost of providing recommended and needed health services
- set fee amounts based on the real cost of providing that service (calculated as direct costs plus indirect costs).

Direct and Indirect Cost

- **Direct Costs may include:**
  - Salary and fringe -typically 75-80% of budget (or more)
  - Supplies- band aids, table paper, forms, syringes, alcohol wipes, etc.
  - Pharmaceuticals
  - Travel
  - Computer hardware & software
- **Indirect Costs may include:**
  - Facility costs (utilities, rent, insurance, cleaning contracts, etc)

North Carolina law[1] allows a local health department to charge fees for services as long as:

1) Service fees are based on a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners.

2) The health department does not provide the service as an agent of the State (i.e. VFC immunizations)

3) And the fees are not against the law in any way.

[1] North Carolina General Statute 130A-39(g)

How do we set fees?

- Health Department fees should be set based on the cost to provide the service. There is updated language in the Consolidated Agreement that states you may use "cost related" methods. This includes the Medicaid Cost Report.

- Methodology for setting fees is a required piece of evidence for reaccreditation. This should include any minutes from meetings held during the process.

Non-Sliding Scale Fees

- Also determined based on the cost to provide the service
- No Sliding Fee Scale required
- Typically collected prior to service
- Reminder: WCH program services are required to slide on a scale to 0% of poverty.

Do's

Do- Set fees based on the cost to provide each service. You may use tools such as the Medicaid Cost Report, vendor rates (increased or decreased cost of supplies and services), and personnel costs. It is acceptable to inquire from surrounding county health departments as to their fee schedule to see if you are in the "ballpark".

Another tool you may use is the **"Workbook for Setting Fees"** located under the Policy & Procedure heading on the DPH/LTAT/LHD website.

https://publichealth.nc.gov/lhd/

Do- Document your methodology for setting your fees in a policy or procedure. In addition, be sure to retain any notes or minutes from your fee setting team meetings. These are required as documentation for Re-Accreditation.

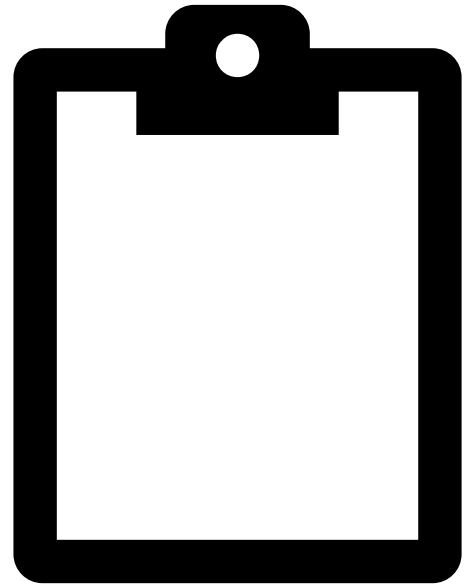
Do- charge Medicaid only your ***acquisition*** cost for all 340b drugs and devices

Don’ts

- **Do not-** take your current fees and add a percentage, such as 5%. This is not an acceptable method for fee setting
- **Do not-** use the Medicaid rate as your reimbursement rate. Remember, your rate should be based on the cost to provide the service.
- **Do not-**

Eligibility

How do we collect the information we need?



Follow Your Policies

- Residency Requirements
- Method of Collecting Income Information
- Proof or Declaration of Income
- Formula for Calculating Income
- Sliding Fee Scale
- Applying Fees Based on % of pay

Fee & Eligibility Policy: Key Elements

- Must follow your agency Policy on Policies format
- Identification
- Proof of Residency
- Documentation of Income
- Determining Gross Income & Family Size
- Program Specific Eligibility Guidelines
- Billing & Revenue
  - Direct Patient Charges
  - Billing Medicaid and Insurance
  - Follow-up on Denied Claims
- Fee Collection

Sample Fee & Eligibility Policy

- Located on the DPH/LHD website http://publichealth.nc.gov/lhd/
  - Template for your convenience
  - Includes all components to meet Administrative Monitoring requirements
  - If you use this be sure to change anything in RED font to reflect your own agency information.

Elements of Registration

- Name
- Alias (if applicable)
- Address (PO & Street)
- Phone
- Race & ethnicity
- Employer
- Social Security # or ITIN
- Medicaid/insurance, income documentation
- Household contacts & income
- Identification
- Signatures (Clerk & Client)

Residency Requirements

- Must serve anyone requesting services regardless of what county they live in for:
  - ✓ Family Planning
  - ✓ Communicable Disease
  - ✓ Immunizations

Local Policy For Residency

- It is a local policy decision as to whether or not you serve non county residents for
  - ✓ Adult Health
  - ✓ Maternal Health
  - ✓ Child Health

Proof of Identification

- A copy of the proof of identification may be placed in the medical record dated with the date obtained and initials of clerk.

- If no proof of identity is available due to theft, loss, or disaster, an individual is homeless, or a migrant, document the reason for no proof of identification on the Patient Registration .

Proof of Identification

- If the client refuses to provide picture ID for immunization, pregnancy prevention, sexually transmitted disease and communicable disease services then you may not require that they do so. Effective July 1, 2011 as per Consolidated Agreement.
- Document any “alias” names that the client may present with

Proof of Identification

- Name changes should not be made unless proper ID with corrected name is presented, i.e. social security card, driver's license, official ID with photo, birth certificate (children only).

Race & Ethnicity

- **Race Standards**(*Census.gov)*

  Based on Self-identification:

  - White, Black or African American, American Indian or Alaska Native, Asian, or other Pacific Islander

- **Ethnicity**: Ethnicity is a variable commonly used in studies on health disparities. Ethnicity is broken into two categories: Hispanic/Latino or Not Hispanic/Latino.

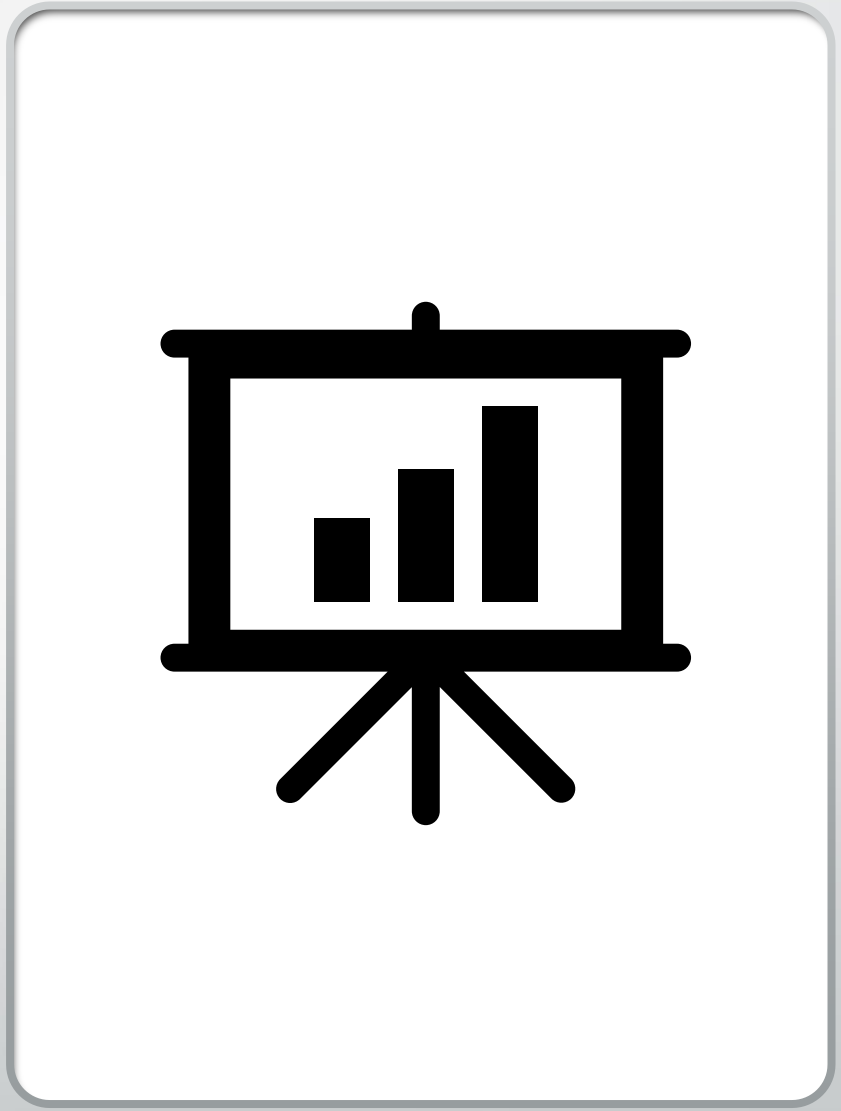
  NOTE: Patients who do not complete the Race/Ethnicity section on the registration form will be asked by registration staff to complete the Race/Ethnicity section or to decline to self-identify. This will be marked in the patient's demographic screen.

Collection of Revenue

Make every reasonable effort to collect your cost in providing services, for which Medicaid reimbursement is sought, through public or private third- party payors except where prohibited by Federal regulations or State law; however, no one shall be refused services solely because of an inability to pay.

Sliding Fee Scales

- Provided by DHHS and updated annually
- Based on Federal Poverty Register
- FP requires 101%-250% scale be used
- CH and MH is local decision
- BCCCP requires 101%-250% scale be used



Computing Income

- Use **Gross** Income or for **self-employed income after business expenses**.
- **Weekly** = pay x 52
- **Biweekly** = pay x 26
- **Twice a month** = pay x 24
- **Monthly** = pay x 12

For a list of acceptable income sources/documents and those that are not acceptable, please see the list at the link below

https://publichealth.nc.gov/lhd/docs/ApprovedIncomeDocuments-SourcesOfIncome.pdf

Computing Income

If the client is **not employed or has changed jobs in the last 12 months**, use the **Irregular Income Formula** or **Six Month Formula**.

Unemployed today= last six months income + projected unemployment (if applicable) or zero if client won't receive unemployment. If no unemployment compensation, ask how the client is going to support themselves.

Computing Income

If a client states they have **no income or a very low income**:

Ask the client if they have worked in the last year. If yes, when was their last day? Refer to Six Month Formula

Ask what the client pays for: shelter, rent, food, etc. Compare HH income to the SFS to see if income is at or below federal poverty level. Is there more money going out then coming in? Use the Expense Worksheet and scan into EMR (if appropriate)

Computing Income

*If someone **outside** the home is providing food, clothing or **if pays utilities directly to utility company** etc., make a note **but don't count as income**. (**If the money is given to the client, to in turn pay their bills, you count as income**. (refer back below)*

All other sources of **cash** income except those specifically excluded.

Regular monetary contributions from individuals not living in the household.

Family Planning Confidential Contact

- Anyone requesting confidential services must have fees assessed based on their own income.
- Age is not an issue when determining confidentiality
- Count as family unit of one
- Document “No Mail” client

Financial Eligibility
Documentation of Income

Failure to bring proof of income or Third Party Confirmation Letter will result in the individual being charged 100%. Charges will remain at 100% if proof of income is not presented within 30 days (or another timeframe)

Financial Eligibility

- Non-Sliding Scale services do not require financial eligibility
- It is recommended that household income be checked on all patients including Medicaid eligible patients (in case there are non-Medicaid eligible services or the client eligibility cannot be confirmed).

Frequency of Financial Eligibility Screening

- Financial Eligibility is good for one year unless changes in employment or income occur
- Ask at each visit if there have been changes
- If changes have occurred update the eligibility screening

Frequency of Financial Eligibility Screening

- If no changes have occurred since previous screening, then no action is necessary unless 12 months have passed since last screening (indicate “no change”, sign and date)
- May use reported income through other programs offered in the agency rather than re-verify income (within the 12 months)

QUESTIONS

Presumptive Eligibility (for Pregnant Women)

- Effective for applications taken on or after August 15, 2014, pregnant women applying for presumptive eligibility are no longer required to attest to U.S. citizenship or eligible immigration status.
- Use new guidelines for applications taken on or after August 15, 2014.

Presumptive Eligibility continued

- In order for a pregnant woman to be authorized presumptively she must:
  - A. Attest to pregnancy.
  - B. Attest to North Carolina residency or intent to reside in North Carolina.
  - C. Not be an inmate of public institution.
  - D. Not be receiving Medicaid in another aid/program category, county, or state.

Presumptive Eligibility

E. Have household gross income equal to or less than 196% of the federal poverty levels listed in IV.F of Administrative Letter 06-13. The unborn(s) is included in the family size and the amount of household income is based on the pregnant woman's statement.

F. Presumptive eligibility is limited to one presumptive period per pregnancy.

Print Form

Patient Record # _____
Date Care Initiated _____

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Eligible _____ Ineligible _____
Due Date_____

PRESUMPTIVE ELIGIBILITY DETERMINATION FORM FOR PREGNANCY – RELATED CARE

Patient Information: Address _____ (Street Address / City / State / Zip) County _____ Phone _____ E-Mail _____

Household Members:

Line No.	HOUSEHOLD MEMBERS								TAX FILING STATUS				
	NAME (First, MI, Last)	DATE OF BIRTH (mm/dd/yyyy)	RELATIONSHIP TO APPLICANT	SEX	RACE* (optional)	ETHNICITY** (optional)	SOCIAL SECURITY # (optional)	NC RESIDENT? (y/n)	Will this person file federal income taxes for current year?	Claimed as tax dependent on current year's tax return? (y/n)	If tax dependent, who will claim?	Meet any tax exceptions?	Claim anyone not living in home? If so, who?
1													
2	UNBORN CHILD												
3													
4													
5													
6													

*Asian = A American Indian or Alaska Native = I Native Hawaiian or other Pacific Islander = P Caucasian or White = W Black or African American = B Unreported = U

**Not Hispanic/Latino = N Hispanic Cuban = C Hispanic Mexican = M Hispanic Puerto Rican = P Hispanic Other - H

Financial Eligibility Information:

TOTAL COUNTABLE MONTHLY INCOME = $	NUMBER IN HOUSEHOLD:	POVERTY INCOME LEVEL: $

Health Insurance Information (optional):

Company Name	Policy Holder's Name	Policy Number	Group Number	Insurance Type(s)	Policy Begin Date

I attest that I am pregnant with _____ fetus(es). I understand that this is a temporary determination of my eligibility for Medicaid and that if I do not file an official application for Medicaid by the last day of the month following the month this form is signed my eligibility will stop on that date. I also understand that I am eligible only for outpatient prenatal care related to my pregnancy. I certify that I have provided true and accurate information about my household, income, and state residency.

The federal government requires the State to provide information about your language preference. Please help us by providing the language you prefer to speak (circle one) English Spanish Other Specify_____)

_____ Application Date

_____ Applicant's Signature

_____ Provider Name/NPI #

_____ Completed by (print):

_____ Title

_____ Signature/Date

DMA-5032 (revised 7/2014)

Presumptive Eligibility

- As a reminder the health department is responsible for “collecting” the information that is needed to complete the presumptive application. They are not responsible for "verifying" the applicant’s information. The verification of the presumptive application and decision to assign Medicaid for Pregnant Women (MPW)/ Medicaid lies with your local Department of Social Services.

How Can We Increase our Revenue?

- Client Education
- Establish Expectations for Payment
- Explain the Need for Payment
- Develop a Payment Plan
- Follow Billing Policies
- Send Statements on a Regular Basis
- Credit/Debit Cards

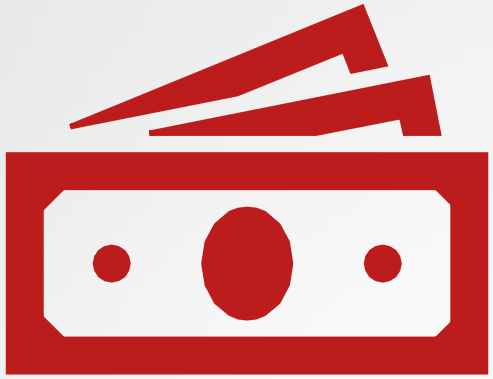
General Billing Information

Revenue Sources may include:

- Cash
- Check
- Major Credit Cards
- Medicaid
- Third Party Insurance
- Company Billing
- NC Debt Set-Off Clearinghouse (debt over $50.00)

General Billing Information

- Medicaid is billed as the payer of last resort. Verification that Client is covered by Medicaid should be done at or before each visit. The health department bills Medicaid and accepts payment in full.



Collecting Co-Pays and Applying Sliding Fee Scales.

REMEMBER! *Family Planning Clients* should never pay more in copays, deductibles or co-insurance than what they owe based on the sliding fee scale.

5 Steps For Collecting Co-pays And Applying The Sliding Fee Scale

1. Find out the client's income, family size and whether she/he has insurance.
2. Check the client's insurance eligibility and determine the client's co-pay amount based on her/his insurance plan.
3. Determine where the client's income puts her/him on the sliding fee scale.
4. If the co-pay is less than the client would pay on the sliding fee scale, she/he should pay the co-pay, and the agency should bill the insurance company the fee for the services. *(Family Planning ONLY)*
5. If the co-pay is more than what the client would pay based on the sliding fee scale, the client pays what she/he would pay based on the sliding fee scale, and the agency should bill the insurance company the fee for the services. *(Family Planning ONLY)*

ACTIVITY

Sample County Health Department

25 Main St Anytown, NC 12345

Demographic & Financial Eligibility Form

Name	
Alias	
St Address	
PO Box	
City	
State	
Zip	
Phone	
Alt. Phone	

Number in Household:

	Relationship to Client	Income	Frequency of Pay
1			
2			
3			
4			
5			
6			
7			
8			
Total			

Percent of Pay for Today's Visit

Signature of Client Today's Date

Signature of Witness Today's Date

N. C. Division of Public Health
Women's and Children's Health Section
Women's Health Branch, Family Planning & Reproductive Health Unit
Annual Gross Family Income
Sliding Fee Scale --101% to 250% of Poverty
Be Smart Family Planning Eligibility Included

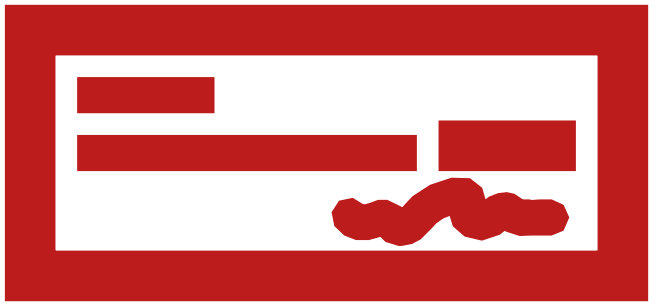
Effective 2/2019

Family Size	Federal Poverty	Partial-Pay Bracket Twenty Percent From	To	Partial-Pay Bracket Forty Percent From	To	***Be Smart Family Planning Eligibility****	Partial-Pay Bracket Sixty Percent From	To	Partial-Pay Bracket Eighty Percent From	To	Full Pay
1	$12,490	$12,491	$17,174	$17,175	$21,858	***$24,356***	$21,859	$26,541	$26,542	$31,224	$31,225
2	$16,910	$16,911	$23,251	$23,252	$29,593	***$32,975***	$29,594	$35,934	$35,935	$42,274	$42,275
3	$21,330	$21,331	$29,329	$29,330	$37,328	***$41,594***	$37,329	$45,326	$45,327	$53,324	$53,325
4	$25,750	$25,751	$35,406	$35,407	$45,063	***$50,213***	$45,064	$54,719	$54,720	$64,374	$64,375
5	$30,170	$30,171	$41,484	$41,485	$52,798	***$58,832***	$52,799	$64,111	$64,112	$75,424	$75,425
6	$34,590	$34,591	$47,561	$47,562	$60,533	***$67,451***	$60,534	$73,504	$73,505	$86,474	$86,475
7	$39,010	$39,011	$53,639	$53,640	$68,268	***$76,070***	$68,269	$82,896	$82,897	$97,524	$97,525
8	$43,430	$43,431	$59,716	$59,717	$76,003	***$84,689***	$76,004	$92,289	$92,290	$108,574	$108,575
9	$47,850	$47,851	$65,794	$65,795	$83,738	***$93,308***	$83,739	$101,681	$101,682	$119,624	$119,625
10	$52,270	$52,271	$71,871	$71,872	$91,473	***$101,927***	$91,474	$111,074	$111,075	$130,674	$130,675
11	$56,690	$56,691	$77,949	$77,950	$99,208	***$110,546***	$99,209	$120,466	$120,467	$141,724	$141,725
12	$61,110	$61,111	$84,026	$84,027	$106,943	***$119,165***	$106,944	$129,859	$129,860	$152,774	$152,775

**** at or below 195% of federal poverty level***

QUESTIONS

Managing Outstanding Accounts Receivable



Identifying Outstanding Accounts

- Aged Accounts Receivable Report
  - Medicaid
  - Insurance
  - Patient Pay-When was the last visit?-When was the last payment?
    - You should have a written procedure for how you handle your aged accounts receivable report.
    - You should run reports in your system monthly to identify outstanding Accounts.
    - Once you have identified outstanding accounts you will need to work them.

Bad debt writeoff

Bankruptcy

- Legal notification from Bankruptcy court
- No further collection of outstanding account unless payment schedule is set up by Bankruptcy court
- Note or flag on patient's account
- Account may be written off if mandated by court
- Patient may volunteer to pay
- Additional visits are charged

NC Debt Setoff Clearing House

- North Carolina General Statutes Chapter 105A: Setoff Debt Collection Act
- NC Income Tax Refund or Lottery (over $600.00)
- Mandated Fees (charged to individual)
- Requires Name and SSN/ITIN
  - Not a breach of confidentiality since debt is listed as county, not Health Department
- Requires Local Policy

Requirements for Debt Submission

- Must have SS# or ITIN
- Debt Must be at least 90 Days Old
- Amount Must be at least $50.00
- Must Give Proper Notice of the Debt to the Debtor
- Must Give Rights of Appeal to Debtor
- http://www.ncsetoff.org

NC Debt Setoff

Debt Can Remain on File with NC DOR Until Paid

Balances are NOT REMOVED from the Patient's Ledger

Transfer the Balance to NC Debt Setoff Guarantor

NC Debt Setoff

- Leave on Ledger
- Patient Notified
- 90 Days Old
- Requires Written Policy

Bad Debt Write-off

- Remove from Ledger
- Patient Not Notified
- Age According to Policy
- Requires Written Policy

QUESTIONS

Billing Efficiency, Tips & Tricks

What is one tool I can use to improve Billing Efficiency?

- The Coding and Billing Guidance Document is a great resource and a quick guide to help answer questions.
- https://publichealth.nc.gov/lhd/

Coding and Billing Guidance Document

- This document was developed to provide local health departments (LHD) with guidance and resources specific to public health coding and billing of services rendered. This information was developed using current program Agreement Addenda, Medicaid bulletins and Clinical Coverage Policies, and Current Procedural Terminology (CPT) and International Classification of Diseases or Diagnosis (ICD-10) code books.

Here is what you will find in the Coding and Billing Guidance Document.

- Documentation if you did it document it!
- New versus Established client
- Billing
- Standing Orders
- Sliding Fee Scale
- Establishing Fees
- ICD Coding Resources
- Program Specific Guidelines

And much more

In-Network/ Credentialing

- If you are not in-network with an insurance company, you may receive a reduced rate or denied payment. (For Example-BCBS pays the patient if you are not in-network)
- If your providers are not credentialed…….you may not be paid.
- Who is responsible for the credentialing process in your agency?… … …Sometimes its the provider or may be someone assigned to be responsible for credentialing.
- Keep files on each provider with all needed information
- Create a spreadsheet and keep updated with re-credentialing deadlines for providers.

- http://www.caqh.org/solutions/caqh-proview

Electronic Billing

Check your edit report……were some claims kicked out of file – if so, research and find cause and resend……Medicaid and Insurance

Claims passed through submission to clearinghouse……did payor accept the claims…….check for report of claims accepted by payor…..example BCBS

There are usually reports you can run for each file submitted …..accepted/rejected by clearinghouse and accepted/rejected by payor. These reports usually provide the reason for rejection. Take care of these immediately and rebill…….some insurances have a 90-day deadline for billing (BCBS, UHC, etc.)

Electronic Billing

NCTracks – you can see if rebilled claims paid/denied the following day if needed.

NCTracks – bill directly on-line for difficult claims or those close to deadline.

Insurances – bill directly on-line for difficult claims or those close to deadline.

Billing Follow up

- Payments were received……but
- Denied claims should be reviewed, researched and resubmitted immediately. Get them corrected and rebilled asap.
- Denied claims……..are you seeing patterns of denials……red flag should go up. Are these data entry errors, coverage errors or NCTracks errors. Identify as early as possible so corrections can be made or issue can be reported to NCTracks (via Consultants).
- How to handle denied claims should be addressed in your policy.

Run your reports on a regular basis –this is important because you only have 90 days to bill in most circumstances (third party insurance).

Research claims showing at 31-60 and 61-90 days……..hopefully you will not see anything older than that.

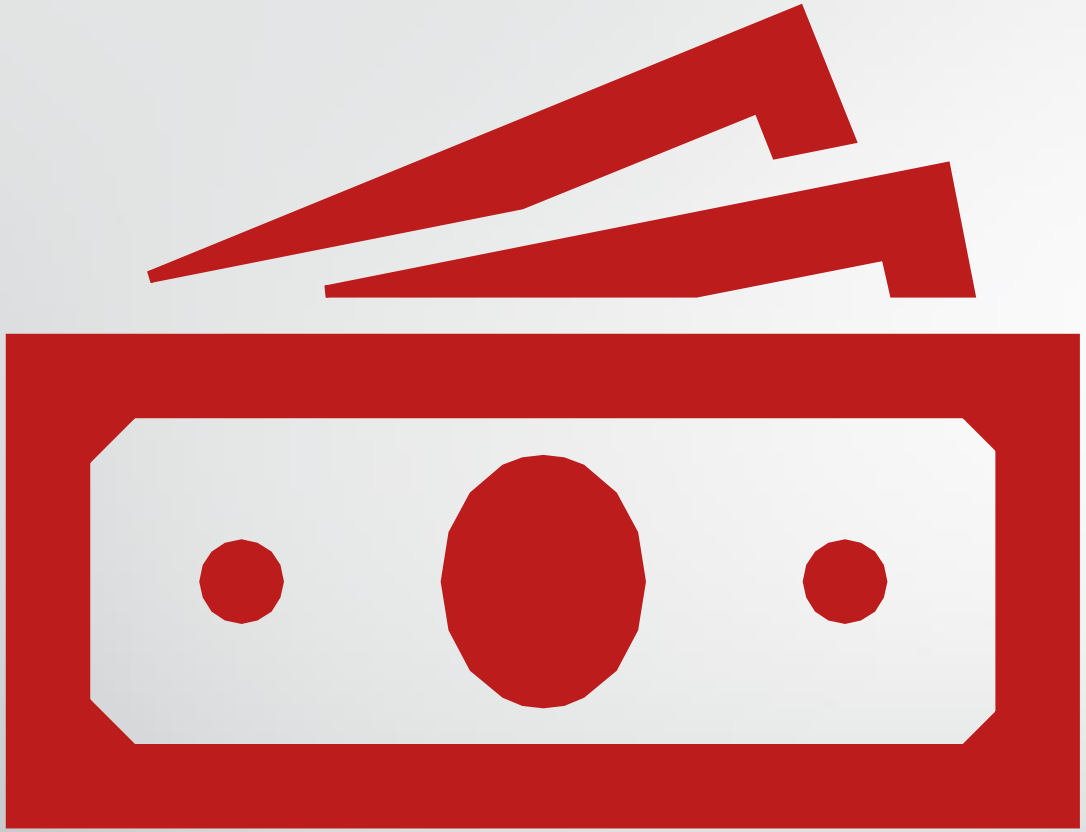
Are there a number of claims with the same sent date? Are there claims with a "claimed" date but NCTracks did not receive?

Are there claims that paid but the payment did not post?

Are there denied claims that have not been worked?

Aged Accounts Reports:
IMPORTANT REPORT – RUN THIS OFTEN

Increase your revenue with In-house Audits



Make sure you are getting paid for your services!

In-house Audit should include your clinical staff and your billing staff.

WHY?

To make sure you **are** coding correctly and getting paid for your services.

Form an in-house Audit Committee

- Form a committee and have a Lead identified
- Ask each clinic to send the committee lead charts from their clinic. (Self-pay, Medicaid, Insurance, and Medicare). You determine the number you want to look at.
- Have a team review the charts for clinical marks and billing to see if everything is being documented and billed correctly, paid correctly, and posted correctly.
- Once the review is complete the committee will need to compile the data and write a report on the findings.

What are some of the questions you should ask when auditing?

- What is the Family Size?
- Look at the total annual income.
- What is the percentage of pay?
- Once the registration received all the above information did the client/Interviewer sign and date the income documentation?
- Was the correct date of service keyed into the system?
- Were all services entered as indicated on the encounter/e-superbill in the system?
- Was all the CPT codes and Diagnosis codes correct in the encounter/e-superbill?

- Was the Sliding Fee Scale applied correctly?
- Was the Client charged appropriately?
- Did they pay? if so was it posted to the correct date? Was the amount posted correctly in the system?
- Did you bill correctly to Medicaid, Medicare, or insurance with the correct rate?
- Did Medicaid, Medicare, or insurance pay or deny the claim?
- If the claim denied did you rebill?
- Were Copays taken, was the RA posted correctly?

Once you have reviewed all your records you can compile the data and identify areas that may need improvement.

Compile a report of your findings so you will understand what improvements are needed.

Once the committee has reviewed the finding they can come up with a improvement plan.

Who receives this plan?

The Health Director	The DON	The supervisors in each clinic	The billing supervisor	The finance officer

The purpose of the In-house Audit is to catch any errors before they can get too big. It will also improve your billing, revenue and coding. This is a great way to train staff on how to make sure your billing is being keyed correctly. Audits should be performed every quarter.

Coding & Billing; The Basics

CPT & ICD-10: What's What?

- CPT codes = what you did
- ICD-10 codes = why you did it
- ICD-10 codes ***justify*** CPT codes
- **Correct CPT and ICD Must Be Used**
- When you bill the incorrect CPT or ICD-10 code you will hold up your revenue.
- To bill efficiently, you should review before you send to the payor.

New vs Established

New

- No care provided in last 3 years that requires History & Physical

  Includes billable Preventive and E&M visits

Established

- In past 3 years, billed

  99381-99387, 99391-99397
  99211-99215
- Client can be New to a program but established with the agency

The Encounter

Providers **may not** charge for an office visit unless they see the client face to face.

Individual staff member's ID # or initials should be on the paper encounter form when a service is billed or reported. This is used to capture the number and type of services provided by each staff member.

Paper encounter forms may be very useful when cross-checking services provided to services billed. They are also needed by consultants performing coding & billing audits.

What are Modifiers?

- A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code.
- Modifiers enable health care professionals to effectively respond to payment policy requirements established by other entities (Medicaid, Insurance, Medicare, etc)

How do I know which modifier to use?

Any CPT coding book will include a section on modifiers. In addition the Coding & Billing Guidance Document prepared by DPH/LTAT/PHNPDU includes a chapter on modifiers.

Each modifier description provides details on when it is appropriate to use.

Medicaid Specific Modifiers

- **FP - Family Planning**
  - Use modifier FP to indicate that a service or procedure is related to Family Planning services.
- **UD - 340-B Drug or Device**
  - Use modifier UD , in addition to FP, when billing Medicaid, as indication that the drug or device was purchased under a 340-B purchasing agreement.
- **EP - Early & Periodic Health Screen**
  - Use modifier EP to identify early and periodic screens, and services provided in association with an early and periodic screen to NC Medicaid. This modifier is also used to identify preventive services such as vaccine administration.

Medicaid Specific Modifiers

- **SL - State Supplied Vaccine**
  - Use modifier SL when reporting to Medicaid, as indication that the vaccine was state supplied.
- **OB - Reportable Maternity Office Visit**
  - Use modifier OB to report or bill office visits with a $0.00 charge that are associated with a package code or OB global package code.

NC Health Choice Specific Modifier

TJ - Health Choice Early & Periodic Health Screen

Use modifier TJ to identify early and periodic screens, and services provided in association with an early and periodic screen to NC Health Choice. This modifier is also used to identify preventive services such as vaccine administration.

Remember, the TJ modifier is not needed when providing FP services to a NCHC recipient.

QUESTIONS

Regulations & Resources

- Local Fee and Eligibility Policy
- Consolidated Agreement
- Medicaid Participation Agreement
- Program Rules and Regulations
- NC General Statues (NCGS)
- North Carolina Administrative Code (NCAC)
- LTAT/PHNPDU Administrative & Nurse Consultants

Local Technical Assistance and Training Branch

Administrative and Nursing Consultants Map

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