North Carolina Association of Local Health Directors
Full Association Meeting
Date: August 20, 2015
Cardinal Room, DPH, Six Forks Road, Raleigh, NC

Minutes

Meeting Called To Order: 9:32 a.m.

Approve Minutes of Previous Meeting: Motion to approve minutes of the July 16, 2015 meeting was made and seconded; motion carried.

Approve Treasurer/Financial Report: Motion to approve the Treasurer/Financial Report was made and seconded; motion carried.

President's Report – Buck Wilson

- Retiring Health Directors: Glenn Martin, Rockingham County, will be retiring at the end of October but return in December in a part-time consultant capacity. MiMi Cooper, Randolph County, will be retiring December 31.
- There continues to be extensive focus on the Medicaid cost settlement process. Status currently is that DMA will be processing payments of the 2011 and 2012 10% hold-backs within the next 30 days. The 2013 hold-back and the 2014 full cost settlement is still on "hold" due to the current disagreement regarding the statistical methodology for arriving at the settlement amounts.
- Introduced Trey Sutton and Jim Flowers from DMA, who discussed status of the cost settlement and the next steps from their perspective. Mr. Sutton stated the 2011 hold-back payments should go out within the next week and then followed by the 2012 hold-back payments. They would like to proceed with settling the 2014 cost reports at 90% using the new statistic. Decision was made within the department to seek a ruling from CMS regarding how they should be treating the discrepancy. Once they receive that ruling they could proceed with any adjustments. They have questions about why some types of claims were not submitted in the cost reporting process and they are establishing a work group with 4 health departments to discuss things they are seeing that could lead to higher claims or settlements.

  Question: Is there any indication of a timeline for a response from CMS on their ruling?

  Response: The email question would be sent out today and they anticipate a response within 1-2 weeks and they would stress the urgency.

  Question: Will the Association have an opportunity to see the wording in the letter/questions to CMS?

  Response: Sees no problem with that as long as their attorney is in agreement. They would like to be as transparent as possible in the process.

  Question: What's the impact on the 2014 cost reports?

  Response: Unable to answer that until DMA receives a CMS response.

  Question: Is the 1-2 week anticipated response from CMS for acknowledging the request or issuing a ruling?

  Response: Hopefully, they would issue a ruling.

  Question: Could you clarify what specifically is the question that is being asked to CMS?

  Response: Basically, it centers on what constitutes charges and what should be included & excluded from CMS perspective.

  Question: We (LHDs) get the cost settlement a 100% from CMS, has DMA received any of the Federal dollars during this process?

  Response: The State has not claimed any federal dollars on the settlements. All of the interim claims payments that have been made throughout the year, yes there are federal dollars drawn down as part of the claims payment.

Question: We use to derive settlement payments based on encounters and now that is based on charges, correct?

Response: Yes, the SPA language contained a transition from "encounters" to "charges" after two years.

Question: And that applies to public governmental services the same way as it applies to others? Our understanding is that CMS allows for public governmental services like local health departments to derive that formula a little differently than the private setting.

Response: Each public entity claiming cost settlement from the feds requires a cost reporting mechanism that CMS must approve.

Question: Our confusion is trying to understand how the SPA is applied retroactively to 2013 and 2014?

Response: The SPA is effective retroactively to March 1, 2011. Unfortunately, CMS had a 37 month approval process that is unusually long. There have been other lengthy approvals but this has been an extremely lengthy process and may be a point of discussion with CMS if they don't get a response they like.

Question: Both LHDs and DMA share risks in maximizing settlements and LHDs realize that we don't want the state or LHDs to be in a pay-back situation, but LHDs have already taken that risk for a number of years by providing (and paying for) services that have already been rendered; it would be helpful to hear that DMA acknowledges that we share in the risk and advocates to CMS on our behalf.

Response: Yes, DMA acknowledges that and will advocate on our behalf particularly if they do not get the answers they are seeking. We don't want to end up in a pay-back situation. Working with a small work group of LHDs (which meets on Monday) may help provide some opportunities for closing some gaps in the process to maximize cost reporting.

Question: Have there been questions to DMA from county commissioners about the delays in cost settlement payments for services that have already been provided because those questions are being asked of some health directors?

Response: DMA has not proactively reached out to them but could have those conversations when needed. This may be a greater issue if we don't get the response from CMS that is desired.

Question: In terms of potentially "not getting the answer we want to the question to CMS," who is 'we' and what "answer" are we talking about?

Response: We're talking about the Department (DHHS) and our commitment is to getting as many dollars into the state as possible. There's not a misalignment of interests between DPH and DMA; it's a misalignment of interpretation and that's why we are seeking legal counsel.

Question: Given the length of time for approving the SPA, why should we believe a response will be within 1-2 weeks from CMS? Also, is DHHS senior counsel not able to answer the interpretation question and why is it necessary to seek guidance from CMS?

Response: It's simply a normal course of business to seek guidance from the regulators when there is a question of interpretation. The 1-2 week response time period is based on past experience with similar issues.

Question: Appreciate the willingness to share the questions to CMS with the association officers because often the way a question is asked can determine the way it may be answered. Are settlements by county or statewide average? Also, depending on the answers received there may need to be some "going back and forth" to advocate for position.

Response: Settlements transitioned to a per county basis several years ago. If they don't get the answer we like, they will advocate on our behalf and keep us apprised though that may take longer.

Question: Clarify your offer to settle using the most conservative definition while we are waiting on a definitive response?

Response: For 2014, we would settle at 90% using the most conservative top level statistic. In terms of timeline, they can start doing that now with the cost reports that they have now within the next 30 days and proceed with getting the remaining cost reports that were put on hold.

Question: Want to clarify that we (LHDs) would not be signing anything that would obligate us to accepting only that amount of money in the interim settlement payments.

Response: No, that is not the intent. The tentative settlement at 90% is only to free up cash flow to LHDs.

Comment: Clarification that the 90% is using the new more conservative top level statistic which is not 90% of what we might have expected.

Comment: We appreciate you meeting with us in person to discuss this one-on-one. We appreciate your willingness to advocate for us because we sometimes perceive that we are working against each other.

Comment: The counties participating in the small workgroup that had been referenced are: Granville-Vance Health District, Craven County, Wake County and Cabarrus County. We've also asked Steven Garner to participate in those discussions.

Question: Regarding the 90% settlement using the more conservative top level statistic, is there a way to know what that amount would be on a percentage basis?

Response: It would vary by county and it's hard to give a general percentage amount estimate. DMA has shared the comparison information with DPH but it may not have filtered down to LHDs yet. Per Danny, the variance is quite large for some counties and some counties could be in a pay-back situation.

Question: When was the SPA approved?

Response: It was approved in April 2014.

Question: We found out about it in March 2015, is there a reason why it took so long for us to know about it?

Response: DMA was unable to get some of the data they needed from NC Tracks until around November 2014. It was at that point they were able to see the disconnect in the interpretation and realized the discrepancy.

Question: But there was a change in the definition and irrespective of how that may impact each county, should we not have known about that change so we could try to plan and prepare accordingly? That gap in time is important because each county handles their cost settlement payments differently…some budget it, some place it in a fund balance and we need to know what we are dealing with.

Response: We understand that frustration and are committed to better communication going forward.

Comment: Lynette asked them to send her the question before it goes to CMS she would get it to appropriate folks in the association officers.

- HB 372 – Conference Committee will be established and President Wilson encouraged health directors to reach out to representatives to educate them on public health impacts. Lynette will be sending out additional information as this develops. Key issue is that PCM was taken out while they left CC4C in. We need to keep stressing the importance of these programs, particularly since they have a strong interest in addressing infant mortality. Another concern is that fee for service programs such as postpartum newborn screening will stop if CCNC is discontinued.
- Concerns were voiced about health departments serving Carolina Access patients and auto-assignments. It was recommended that this issue be reviewed and discussed in a future committee meeting.
- Thanks to Wanda Robinson for serving on the Children with Special Needs Task Force.
- The association is being represented today at the County Commissioners' Conference in Greenville.

<u>NC Division of Public Health Report – Danny Staley</u>:

- Thanked the membership for their support and encouragement over the past several months.
- Still unanswered questions on Jones Street with the budget and various bills that can impact public health.
- New challenges: (Syndemic) Opioid Overdose epidemic and viral hepatitis C. In four years we've seen a 400% increase in opioid deaths in the U.S. Some progress being made with programs like Project Lazarus and Naloxone distribution/availability. The big increase in Hep C is driven by increased availability of heroin and IV drug use at the local level. An alarming fact is the cost of treating Hep C. It takes $84,000 to treat a case per patient. Much of this cost dramatically impacts Medicaid.
- New Secretary of DHHS is Rick Brajer and DPH has been updating him on key efforts in process such as the coal ash response efforts.

- New Deputy Secretary for Health is Dr. Randall Williams. He is familiar with public health and has served on the Wake County Board of Health and State Commission for Public Health. He has plans to visit all county health departments.
- Still working on hiring the Section Chief for Women & Children's Health.
- Coal Ash response; DPH has been engaged with DENR reviewing well samples and providing health risk appraisals to well owners. DPH has tried to work with local health departments who are having community meetings to present information about the testing process and risk assessment. Still some question about additional baseline testing of coal ash impoundments; particularly new impoundments. Have extended 1500 feet in some cases.

State Health Director's Report – Dr. Megan Davies

- Two conference calls have been held with affected counties. Another call will be in September. A communication plan has been developed and sent out to LHD. Currently just process health evaluations. Local health directors and environmental health directors of affected counties should be getting copies of the evaluations. Over 300 wells are being tested. The next big step is source contamination assessments and DENR is addressing that per impoundment site areas. In situations where coal ash impoundments are not determined as the source of well contamination, health departments will work with the well owner as we normally do to help them assess options to reduce those levels, follow-up testing, etc. In those situations, Duke Energy would not be providing any financial assistance to the well owner. It's projected that DENR will begin making those determinations by the end of this year.

NC Division of Public Health Report – Phyllis Rocco:

- 54% response rate on the ICD-10 readiness survey that was conducted recently. 85% responded that they were ready for ICD-10 in October. 98% had participated in the webinars that DPH had provided and 50% participated in the Rural Health trainings. Staff will reach out to those indicating that they would not be ready to see how they may assist.

State Environmental Health Report – Larry Michael:

- Personnel Updates
- Food Protection:
  - Shane Smith, formerly worked in Wayne County. Home-based in Goldsboro.
  - Patrick (Pat) Muse retired from Macon County. He has worked in the On-site Wastewater, Swimming Pool, Child Care, and Tattoo Programs. Pat served as the Food, Lodging, and Institutional Program Specialist and Environmental Health Supervisor during his time in Macon County. Home-based in Macon Co.
  - Veronica Bryant, worked in both Mecklenburg and Gaston Counties. She has served on the Executive Committee of West Piedmont Environmental Health Section and the EH Section of NCPHA. Home-based in Gaston.
- On-Site Water Protection:
  - Scott Greene (formerly of Guilford County and prior to that, the State) began work as an Environmental Health Regional Specialist. Scott will be assigned a territory and assist with Program Reviews for Accreditation across the State.
- Retirements—Jim Hayes (Sept 1), Warren Richardson (Sept 1)
- Legislative
  - At least 20 bills this session impact EH
  - Most potential to impact EH practice H765
- H765 (Section 4.14) On-Site Wastewater Amendments and Clarifications
- Turning Point--Invited to comment at House Environment Public Hearing (July). In addition to DPHs comments, the following also spoke to support the rulemaking process (already underway) to address privatization, rather than the amendments and additions in the bill:

    - NCPHA
    - NC EH Supervisor's Association
    - NC Association of County Commissioners
  - The draft rule revisions aim to streamline and expand permitting options while protecting public and environmental health.
  - The bill is in Conference Committee
  - The push from industry is based on backlog concerns. A short survey has been sent to LHD to assess backlog status, customer complaints, etc.
- <u>Position Statement</u>
  - Carbon Monoxide guidance to be released at the end of August
- <u>IT</u>
  - Process of purchasing servers that will support migration from DENR to OITS hosting. Also moving from Oracle database to Microsoft SQL for about half the cost (saving $87,000/year).

<u>Executive Director's Report – Lynette Tolson</u>

- Accreditation invoices have been sent and thanks to the 55 departments that have paid. If unsure, please contact Lynette.
- The September 15th association meeting will be in conjunction with NCPHA Annual Conference in Winston-Salem. It will be held in the Ardmore 1 Room at Embassy Suites at 2pm.

<u>NCAPHA Report – Jerry Parks</u>

- Will be meeting after today's association meeting.

<u>NCPHA - Lisa Harrison</u>

- Reminded health directors to submit names of staff who will be attending the Thursday night dinner for recognition of those who have been involved in communicable disease/traveler monitoring over the past year. Encouraged LHDs to support these staff attending the conference either fully or one-day registration. If the staff are attending only for the dinner, NCPHA will cover that cost.

<u>Action/Information Items - Committee Reports</u>

Core Public Health –Denise Michaud:

Action/Motion: Request approval of Healthy Communities Agreement Addendum for SFY16-17 with items noted in attachment information. Motion was approved.

Information:

- 2015 Summit Update (Safe Water from Every Tap: Where Does NC Stand 40 Years After the Safe Drinking Water Act?) – Martin Armes and David Brown(US PH Service, ret)
  - See attachment A; some NC residents still lack access to clean drinking water; roughly ¼ of the state population relies on private wells for their potable water, a source not regulated by the Safe Drinking water Act of 1974; October 26-27 Summit at the NC Biotech Center, RTP; free admission by invitation; contact Martin Armes at (919) 608-7260 or martinarmes@nc.rr.com
- Health Communities Agreement Addenda SFY 16-17 – Tish Singletary
  - See attachment; note Scope of Work (page 3) E. conduct Fruit and Vegetable Outlet Inventory assessment; other additions: C3 – increase the number of LHDs that provide Diabetes Self-Management Education, C8 – conduct asthma home trigger assessments in collaboration with local clinical partners, C10 – conduct POS assessments of tobacco retail environments, C12 – provide or support gatekeeper training for suicide prevention; additional Performance

Measures/Reporting Requirements (note Performance Indicator A.11 – naloxone toolkit should be available by COB Friday, August 21)

- Ebola funding (AA 613) – Nikki Marshall
  - Attending Preparedness Coordinator meetings to provide information re: allowable purchases; CDC has not provided a comprehensive list; primary intent is for Ebola (examples: PPE and supplies, development/update plans and associated personnel costs, tablets, cell phones; food, radios not allowed); send questions to nikki.i.marshall@dhhs.nc.gov
- 80% by 2018: How the American Cancer Society is Working to Increase Colon Cancer Screening Rates in NC – Anna Jones
  - See attachment and power point presentation; download Colorectal Cancer Facts & Figures via cancer.org
  - National collaborative effort for 80% of eligible people to be screened for colorectal cancer by 2018; over 450 organizations nationwide have pledged to help meet this goal (pledge included in attachment C); rate at which people are diagnosed with colon cancer in the US has dropped 30% in the last 10 years for those aged 50 years and older; researchers credit this drop to more people getting recommended screening tests; NC Colorectal Cancer Roundtable organized by a collaborative effort among American Cancer Society, NC Cancer Prevention and Control Branch and Dr. Marcus Plescia; 4 Task Groups: Healthcare Provider Education, Health Policy, Public Education and Outreach, Access to Care; will meet with the Steering Committee and Task Groups in October; contact Anna Jones at (919) 280-6200 or anna.jones@cancer.org
  - 80% by 2018 is one of the strategies (C7) in the SFY 16-17 Healthy Communities AA

Public Health Promotion & Prevention –Janet Clayton:

Action/Motion: None

Information:

- Phyllis Rocco of the NCDHHS-DPH, presented a Community Health Assessment Update. As part of the update, she provided a summary of the CHA process. She reminded Health Directors that the Action Plan template had been updated and emailed; however, those with a 2014 CHA may use the old one as long as the required components were addressed. Also, if LHDs were on a 3 year cycle only 2 SOTCH reports were required between CHAs cycles for accreditation purposes, and if on a 4 year cycle, 3 SOTCH reports were required. She has been working with the accreditation staff to clarify this with site visitors. Health Directors asked if there was a way to have the submission in a format similar to the HDSAI with hyperlinks. There was also a concern voiced regarding the 50 page maximum. Concerns were also shared regarding the review turnaround time and hospitals needing to release the information due to their requirements. Mrs. Rocco stated that if there is a hospital deadline approaching to notify her, and she will notify the reviewing consultant to make them aware of the hospital's needs. Eleanor Howell will be joining us in October to follow-up on the data questions and with a possible update regarding the BRFSS per Dr. Ruth Petersen.

- Sorien Schmidt of Enroll America shared with the committee the "Health Department Release and Referral Process for ACA/healthcare.gov Marketplace" and the referral form used in the process. This process has worked well with Guilford County Department of Health and Human Services. Open enrollment this year is 11/1/15-01/31/16. Renewals must be completed by 12/15/15. She

encourages individuals to visit www.GCAConnector.org to schedule appointments. The CAC trainings have been removed from the website and will be available 8/26/2015.

Technology – Beth Lovette:
Action/Motion: None
Information: Did not meet

Policy and Finance – Lisa Harrison
Action/Motion: Motion to move forward with attorney representation from Parker Poe and Associates to advocate on behalf of the Association of Local Health Directors for cost settlement decisions with DMA and to allow Lynette and the officers to access the association's legal account for purposes of legal action with DMA regarding maximizing cost settlement from 2013, 2014, and moving forward. Motion was approved.
Information: Summary and Next Steps Concerning Medicaid Cost Settlement
Buck Wilson summarized the efforts to date that the officers have organized to ensure a better understanding across new staff and leadership at DMA/DHHS. Last week, the officers met separately with Deputy Secretary Dave Richard, the new director of DMA. Although the meeting was a good opportunity to explain the LHD and DPH position on cost settlement disagreement with DMA, there had not been a decision made yet on the top level statistic for 2013 and 2014 as we had hoped. There ***was*** confirmation that the 2011 and 2012 'hold-back' (10%) is in process and should drop before September 30, 2015.

Buck Wilson further updated the committee about a meeting that took place Wednesday, August 19, at 10am with attorneys at Parker Poe Adams & Bernstein, LLP ("Parker Poe") in Raleigh. Attorneys Renee Montgomery and Matt Wolf met with Buck Wilson, Doug Urland, Dennis Joyner, Lynette Tolson, and Lisa Harrison. It was a productive and helpful meeting to catch up on all written documentation and summarize issues and concerns to date. The attorneys will be working on a strategy for us between now and Monday, August, 24th, 2015. The next action step will be to have Ms. Montgomery and Mr. Wolf write a letter on behalf of the Association of Local Health Directors to DMA outlining and advocating for our position.

A motion from committee was presented (Sue Lynn Ledford) and properly seconded (Jim Bruckner) to "Move forward with attorney representation from Parker Poe and Associates to advocate on behalf of the Association of Local Health Directors for cost settlement decisions with DMA." During discussion of the motion, it was pointed out we have a fund of $34,000.00 accessible from previous allocations for legal expenses. A friendly amendment to the original motion included specific reference to allowing Lynette and the officers to access this account for purposes of legal action with DMA regarding maximizing cost settlement from 2013, 2014, and moving forward.

For point of record, additional discussion reiterated how although we are pleased with the efforts to maximize cost settlement with friendly relations with DMA, at the same time, we are all getting very tired of being patient and are ready for action that is effective in seeing dollars come to local public health sooner rather than later.

There was a question about distributing something in writing that might summarize the issue to date as complex as it is to understand DMA's position, DPH's position, and the disagreement on the top level statistic. Buck answered that we will share information that we have in writing to help translate further all the points made on both sides.

The second item for discussion focused on our desire for state-level advocacy and education about Case Management Programs – specifically OBCM which could be at Risk during discussions of Medicaid reform and future Medicaid payment options to providers. In summary from an email Lynette shared from the NC General Assembly fiscal research division:

> *The Pregnancy Medical Home is part of the overall payments to NCCCN for care management. The Senate budget eliminated the NCCCN/CCNC contracts effective 12/31/15. It reinstated the direct payments for CC4C to the Health Departments which existed prior to the implementation of the Pregnancy Medical Home. The effective date for the contract termination was moved from 12/31/15 to 5/1/16 when Medicaid Reform, HIE and CCNC contracts were moved from the budget to HB 372 as part of the Senate amendments. The rationale for eliminating the NCCCN/CCNC contracts relates to the expectation that when Medicaid is transformed from a FFS system to a capitated system and care is managed by either PLE's or MCO's that the care management functions, including pregnancy home, that CCNC/NCCCN previously provided would become part of the process that these new organizations would be responsible for as part of a contract that would contain specific health, quality, satisfaction and economic measures that would need to be achieved or maintained. The bill is not specific as to the outcome measures, but leaves that up to the new Department of Medicaid. One final note is that once Medicaid moves from FFS to capitation, the State will no longer be allowed to pay a provider for Medicaid services outside the contract that it has with a PLE or MCO for covered services, unless it pays for those services with 100% State dollars.*
> *- Steve Owen, Senior Analyst, North Carolina General Assembly, Fiscal Research Division*

Lisa shared a written summary of the importance of OBCM and local health departments' role in delivering the program, its importance to maternal child health and infant mortality. Local health departments have been managing staff carrying out case management of pregnant women for many years before CCCN arrived on the scene to manage *Per Member Per Month (PMPM)* Medicaid dollars which now pay for these services separate from cost settlement from Medicaid. OBCM was initially instituted in local health departments in response to the infant mortality rate and disparities across populations.

While the legislature is meeting and discussing Medicaid Reform every day, it is important to educate and advocate for OBCM remaining in local health departments. Dollar, Lambeth, Hise, Tucker, and Jackson are the main legislators having the decision-making power during discussion in conference committee. Colleen pointed out an article by Paul Beuscher that delineates more specific data on the case management approach affecting infant mortality including some return on investment numbers.

Please review data and information about OBCM. Lisa or Lynette will include the data in the one-pager and will share with the listserv as soon as possible.

With regard to policy and finance related to public health at the Federal level, Lisa shared a one-page hand out of NACCHO's 'Notes from Washington.'

Planning and Innovation –Colleen Bridger

Action/Motion: None

Information:

- Presentation was made by Javier Diaz, Counsul General of Mexico, based in Raleigh about their "ventanillas de salud" or health windows. Each of the 50 Consulates in the US have one of these windows. They focus on prevention and health promotion oriented to: nutrition, obesity, diabetes, women and children's health, mental health and substance abuse and HIV. They make referrals to

community clinics and assisted 31,500 people last year. They provide services in Raleigh primarily, but also have a mobile unit that travels across the state.
We discussed how to improve referrals to local health departments and decided that Lynette will solicit links to each Health Department's brochure (in English and Spanish when available) and add these links to the Association's website.

- Dr. Megan Davies spoke to us about Avian Influenza planning being led by the Department of Agriculture. The current plan has Ag running point with support from DPH. If there is a poultry worker exposed to Avian Influenza, DPH will instruct the person on how to self-monitor, give them a state number to call if they become symptomatic and loop the local health department in if a person becomes symptomatic. The timing is unfortunate because the latest predictions show the greatest likelihood of Avian Influenza spreading to NC during the fall, just in time for our regular flu season. While there hasn't been any human transmission at this point, it is theoretically possible. So, we may have some false positives (i.e., poultry worker with seasonal flu, not avian flu) to deal with. They are planning a webinar for early September to address more specific guidance such as who do we call to report sick birds, what do we do with health concerns related to the odor of "composting" the depopulated carcasses, and talking points. Stay tuned for more information.

Education & Awards – Dave Jenkins:
Action/Motion: None
Information: None

Nominations & Bylaws – Doug Urland:
Action/Motion: None
Information: None

Action/Information Items - Public Health Regions

Region I – Janice Patterson:
Action/Motion: None
Information: None

Region II – Jimmy Hines:
Action/Motion: None
Information: None

Region III - Ann Absher:
Action/Motion: None
Information: None

Region IV – Dorothea Wyant:
Action/Motion: None
Information: None

Region V – Merle Green:
Action/Motion: None
Information: None

Region VI – Tommy Jarrell:
Action/Motion: None
Information: None

Region VII – Chris Szwagiel:
Action/Motion: None
Information: None

Region VIII – Carolyn Moser:
Action/Motion: None
Information: None

Region IX – Jerry Parks:
Action/Motion: None
Information: None

Region X – Davin Madden:
Action/Motion: None
Information: None

Liaison Reports

NC SOPHE –

- Annual conference will be Oct. 8-9 in Hickory and will be celebrating their 50th year anniversary.

ANCBH – Barbara Ann Hughes, President

- Our Treasurer Bob Blackburn has asked me to let you know he has received most of your dues for this year. I have a list of a few of you that he is missing. I can let you see the list at the end of this meeting.
- A board committee will be working on a model evaluation form for local health directors. Thanks to several of you for forwarding to me the documents you are using. Would one or two of you step forward to review the work of our committee? Offer feedback
- NEED YOUR HELP: Murray Summers, one of the persons who designed our website has told us that the group that has been hosting it will be moving it from present platform. He gave estimates from $500 -$2,500 for a revision. NALBOH is offering some assistance, but a smaller site. Do you have anyone you could recommend that could work with us to revise but restore our site? Do you ever look at it? What information should it provide and to whom?
- **NALBOH:**
- Eleven North Carolinians attended the NALBOH conference in Louisville, Ky. August 5-7. Our Keynote speakers were Carter Blakely, Deputy Director, Office of Disease Prevention and Health Promotion, Office of Assist. Secretary of Health, US DHHS. She spoke to Healthy People 2020: Translating National Goals into Local Action. Dr. James Hodge, Jr. JD, LLM, an Associate Dean for Grants and External Funding and Professor of P.H. Law and Ethics in Arizona, Addresses the Top 10 of Modern Local Public Health Legal Innovations, and Dr. Ali S. Kahn, Dean, Univ of Nebraska Medical Center and a retired Assist. Surge9n General. He spoke to us via Skype from West Africa, where he is working with countries to rid them of Ebola. (His expertise). Numerous breakout sessions were interesting. Our NC delegation met for an hour of sharing and getting to know each other and our challenges.
- Barbara Ann Hughes was elected President-Elect and Debbie Peet from Utah as a Director. Nancy Tearwood, Ohio will become a new Director.) The next NEWS BRIEF will be ready for distribution to members of your board of health the last week in Sept. Please ask someone in your department to write a short article about something you are doing that you wish to tell other public health folks about. Send it to me and I will forward it to NALBOH directly or you can send to the attention of Jamie Michael. <Jamie@badgerbay.com. Almost certainly the conference will be held here in NC in 2017, our 25th Annivesary. Next year possibly St. Louis.

NC Institute for Public Health – Anna Schenck
Training

- Reminder that they are still taking requests for Boards of Health training.
- Several upcoming courses: Physical Assessment of Adults and STD Nurse Clinician Training; Evidence-Based Strategies for Obesity Prevention; Management and Supervision Update Webinar Series; 32nd Annual School Nurse Conference; and Intro to PH Nursing.
- There will be an upcoming free lecture with Dr. Daniel Barnett, a faculty member from Johns Hopkins, discussing disaster response and the impact on public health.
- Three Practice Pathways "PHieldtrips" are scheduled for this fall and thanks to Orange County for hosting.

Accreditation

- Joy Reed is serving as interim Accreditation Administrator while they are recruiting for the new Technical Assistance Manager who will oversee the accreditation work.

Meeting Adjourned: 11:37 a.m.
Next Meeting: September 15, 2015 2:00 pm
Location: Ardmore 1 Room; Embassy Suites Hotel, 460 N. Cherry Street, Winston-Salem, NC

Medicaid Cost Settlement to NC Local Health Departments
General summary of the issues – the high points
August 20, 2015

- Since 1993, DPH, DMA and LHDs have worked together on cost-based reimbursement to local health departments for services delivered to the Medicaid population.
- Prior to the change in cost report and settlement methodology beginning in 2011, the cost report statistic used to derive the Medicaid population in NC was based on *service visits*. For 2011 and 2012 cost reports, the interim statistic used was based on *encounters*. With encounters the numerator is the number of Medicaid covered encounters provided to Medicaid eligible clients whether the claim was ultimately paid or not paid. The denominator is all encounters to clients identified as not eligible on the date of service.
- In 2013, the statistic used was based on *charges*. The charge statistic is the preferred method by DMA. DMA determined in February 2015 that the calculation methodology would be applied differently. In this calculation the numerator is limited to the number of Medicaid paid charges provided to Medicaid eligible clients. The denominator includes all unpaid charges for covered services provided to Medicaid eligible clients and all services provided to non-Medicaid clients. This is the new interpretation that DMA believes should be applied retroactively beginning with fiscal year 2013 cost reports.
- Even though Medicaid regulation allows exception for public providers, which will exclude LHD requirements to have a uniformed charge structure, DMA required LHD to adopt and implement this structure. (It is *important for us not to drop this point moving forward...)*
- The 2011 cost reports, recently audited, were originally completed based on the sample cost report submitted to CMS for approval. DMA required a change to the 2012 cost report which re-assigned certain clinical individuals from direct clinical cost to clinical administrative cost. This change was applied to all 2012 and 2013 cost reports; however, DMA was trying to retroactively apply these changes to the 2011 cost reports and, in addition, reclassifying other direct clinical staff that was not originally discussed. In recent discussions, it is our understanding that the **original method agreed-upon** will be used to determine the 10% hold-back amount and for 2011 and 2012 those **10% hold-backs will be paid by September 30, 2015 without further delay or discussion.** *(It is important to check that this is really the case when payment drops).*
- The main challenge right now regarding the formula – hence, the reason for the ongoing delay in both the 2013 10% 'hold-back' ***and*** the SFY 13-14 cost settlement in its entirety, is that DMA is now applying a different interpretation about how to define the "Medicaid population" – (there is a question using only paid claims in the numerator as well as the question about personnel staff performing direct clinical services; e.g. clinical management support, clinician assistant staff and other direct clinical staff that are being reclassified inappropriately which will reduce the amount of allowable Medicaid cost).

- During initial reviews of the cost reports, the Centers for Medicaid and Medicare Services at the federal level (CMS) requested all administrative allocations be changed from using an FTE approach to cumulative total approach.
- DMA and LHDs have agreed to a work group/billing team that is based on the assumption that going forward, DMA's new interpretation will be used which means the purpose of the billing group is to identify additional paid or payable claims that can be included in the numerator.
- Attorneys have been retained by the NC Association of Local Health Directors to ensure proper advocacy and interpretation of the disagreement for local health department reimbursement approaches.

Perspective and questions from local health departments (LHDs)

- Health departments cannot afford for the rules to change and be applied retroactively without notice on a significant payment mechanism for providing direct Medicaid service delivery in NC.
- Cost settlement for 2014 alone represents more than 40 million dollars of federal money that has not been paid which supports local public health agencies for services already rendered.
- DMA should understand the impact on all health departments and ***especially*** on rural underserved areas –if they continue to calculate the cost settlement based on retroactively applying a reinterpretation of the guidance initially given and agreed upon, public health staff will be affected and will be cut.
- In the future, what alternative calculation method can be used to more appropriately determine the Medicaid share of cost? How will that change the funding to local health departments as part of the critical safety net for prevention and public health services across our state?
- Regardless of the interpretation of CMS regulations: Aren't cost settlement dollars in North Carolina **100% Federal?? Yes**. Why is DMA working so hard in NC NOT to pay us or change the rules and make them retroactive at this point? Is that legal? Why is there more risk placed at the local level to shoulder the cost rather than at the state level? (Another perspective on risk: NC does not match or contribute to cost settlement in any way – some states do... if there were a pay-back situation, NC DMA /DHHS should consider that an option for public safety net entities and not be so worried about the potential risk to have to pay CMS if the formula interpretation has any issues).
- Working together with DMA means to us: We take the highest amount of reimbursable cost settlement from CMS to cover public governmental safety net services in local health departments. **IF** there is ever a payback situation and CMS asks NC to recalculate or reinterpret the top level statistic, DMA, DPH, and LHDs should ***work together*** to ***justify to CMS*** the legal and ethical approach taken to interpret what the top level statistic was and work together with and/or against CMS to prove the cost reporting

approach decided upon was indeed correct. This justification back to CMS is done all the time in home health and among other providers – it's not as black and white or as scary as an auditor may want to believe. Our understanding is that even among the changes in CMS guidelines, there is gray in interpreting Medicaid regulations on a state-by-state basis, and in that gray, the state of NC is allowed to provide interpretation that ***works best for NC providers*** as long as we can justify its derivation based on CMS guidelines.

Definitions of Medicaid and Medicaid Cost Reports / Cost Settlement

"**Medicaid** is a health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors, and people with disabilities." NC Division of Medical Assistance (DMA) [http://www2.ncdhhs.gov/dma/medicaid/].

Medicaid works on a state-by-state basis as a collaboration of payment to providers from federal and state levels. In cost settlement situations, State Medicaid agencies require various health providers to submit annual **Medicaid cost reports for cost reconciliation and cost settlement purposes.** "Each state Medicaid agency must ensure that payments for the administration and delivery of services to Medicaid recipients are accurate and efficient in order for those services to be reimbursed on a reasonable cost basis..." however, each state has unique program organization and different approaches about how Medicaid reimbursement is determined, allocated, and distributed. [https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/?redirect=/CostReports/].

Cost Settlement according to NC SPA: "To assure payments made by Medicaid to the local health departments do not exceed the upper payment limits set forth at 42 CFR 447.321, Health Department services reimbursed under a fee schedule and furnished to Medicaid recipients will be cost settled annually to Medicaid allowable costs. Medicaid allowable cost is determined using a CMS approved cost reporting methodology in accordance to 42 CFR § 413 and the CMS Provider Reimbursement Manual."

August 20, 2015
NCALHD Attendance Roster - Health Director Initial by County
(Bold Indicates NCALHD Dues paid)

County	Health Director	County	Health Director
Alamance	Stacie Turpin Saunders	**Jackson**	Paula Carden
Albemarle District	Jerry Parks	**Johnston**	Marilyn Pearson
Alexander	Leeanne Whisnant	**Jones**	Wesley Smith
Anson	Fred Thompson	**Lee**	Terrell Jones
Appalachian District	Beth Lovette	**Lenoir**	Joey Huff
Beaufort	James Madson	**Lincoln**	Maggie Dollar
Bladen	Cris Harrelson	**Macon**	Jim Bruckner
Brunswick	David Stanley	**Madison**	Tammy Cody / Marianna Daly
Buncombe	Jan Shepard	**MTW District**	Terrell Davis
Burke	Rebecca McLeod	**Mecklenburg**	Marcus Plescia
Cabarrus Health Alliance	William Pilkington	**Montgomery**	Mary Perez
Caldwell	Denise Michaud	**Moore**	Robert Wittmann
Carteret	David Jenkins	**Nash**	William Hill, Jr.
Caswell	Fred Moore	**New Hanover**	David Rice
Catawba	Doug Urland	**Northampton**	John White, Int
Chatham	Layton Long	**Onslow**	Angela Lee
Cherokee	Towanna Roberts	**Orange**	Colleen Bridger
Clay	Janice Patterson	**Pamlico**	Dennis Harrington
Cleveland	Dorothea Wyant	**Pender**	Carolyn Moser
Columbus	Kim Smith	**Person**	Janet Clayton
Craven	Scott Harrelson	**Pitt**	John Morrow
Cumberland	Buck Wilson	**Randolph**	Mimi Cooper
Dare	Sheila Davies	**Richmond**	Tommy Jarrell
Davidson	Monecia Thomas	**Robeson**	William Smith
Davie	Suzanne Wright	**Rockingham**	Glenn Martin
Duplin	Ila Davis	**Rowan**	Nina Oliver
Durham	Gayle B. Harris	**RPM District**	James Hines, Jr.
Edgecombe	Karen Lachapelle	**Sampson**	Wanda Robinson
Forsyth	Marlon Hunter	**Scotland**	Bengie Haire
Franklin	Chris M. Szwagiel	**Stanly**	Dennis Joyner
Gaston	Chris Dobbins	**Stokes**	Wanda East, Int.
Graham	Alicia Parham	**Surry**	Samantha Ange
Granville-Vance District	Lisa Macon-Harrison	**Swain**	Alison Cochran
Greene	Michael Rhodes	**Toe River District**	Lynda Kinnane
Guilford	Merle Green	**Transylvania**	Elaine Russell
Halifax	Cardra Burns	**Union**	Phillip Tarte
Harnett	John Rouse	**Wake**	Sue Lynn Ledford
Haywood	Carmine Rocco	**Warren**	Andy Smith
Henderson	Steve Smith	**Wayne**	Davin Madden
Hertford	Ramona Bowser	**Wilkes**	Ann Absher
Hoke	Helene Edwards	**Wilson**	Teresa Ellen
Hyde	David Howard	**Yadkin**	Kimberly Harrell
Iredell	Jane Murray		

August 20, 2015
NCALHD Attendance Roster - Health Director Initial by County
(Bold Indicates NCALHD Dues paid)

	DPH Liaisons	Megan Davies		NCALHD Exec Dir	Lynette Tolson
		Danny Staley	[illegible]		
		Phyllis Rocco	[illegible]		
		Larry Michael			
		[illegible]			
		Peter Anderson		Maribeth	Wooten

Guests Liaisons from other Organizations

[illegible]					
Jacqueline Wynn	NC AHEC				
Susan Hayes	Randolph Co				
Megan Davies	DPH				
[illegible]	DPH				
Sue [illegible]	CHA				
Suzanne [illegible]	ECU/NCPHA				

North Carolina Association of Local Health Directors, Inc.
Balance Sheet

	Aug 31, 15
ASSETS	
Current Assets	
Checking/Savings	
CD-SECU *4185	40,000.00
Checking-SECU *6586	209,839.45
Money Market-SECU *0321	159,595.53
Savings-SECU *1387	42.31
Total Checking/Savings	409,477.29
Accounts Receivable	
Accounts Receivable	57,647.00
Total Accounts Receivable	57,647.00
Other Current Assets	
Undeposited Funds	5,500.00
Total Other Current Assets	5,500.00
Total Current Assets	472,624.29
Fixed Assets	
Intangible Assets	7,300.00
Total Fixed Assets	7,300.00
TOTAL ASSETS	**479,924.29**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
Accounts Payable	11,355.83
Total Accounts Payable	11,355.83
Total Current Liabilities	11,355.83
Total Liabilities	11,355.83
Equity	
Opening Bal Equity	50,793.88
Temporarily Restricted Funds	
Legal Fund	34,388.00
Total Temporarily Restricted Funds	34,388.00
Unrestricted Net Assets	288,990.50
Net Income	94,396.08
Total Equity	468,568.46
TOTAL LIABILITIES & EQUITY	**479,924.29**

North Carolina Association of Local Health Directors, Inc.
Income & Expense Budget vs. Actual

	Jan - Aug 15	Budget	$ Over Budget	% of Budget
Ordinary Income/Expense				
Income				
Interest/Dividend Income	2,006.29	2,280.00	(273.71)	88.0%
Meeting/Conference Income	13,500.00	900.00	12,600.00	1,500.0%
Membership Income				
NACCHO Rebate	2,807.68	2,500.00	307.68	112.31%
NCALHD Dues	60,108.36	60,000.00	108.36	100.18%
Total Membership Income	62,916.04	62,500.00	416.04	100.67%
Total Income	78,422.33	65,680.00	12,742.33	119.4%
Expense				
Administrative Services Expense	34,400.00	51,600.00	(17,200.00)	66.67%
Awards	598.37	1,000.00	(401.63)	59.84%
Bank Charges	15.00	12.00	3.00	125.0%
Gifts	0.00	150.00	(150.00)	0.0%
Licenses and Permits	504.00	504.00	0.00	100.0%
Meeting/Travel Expense				
Meetings/Conferences	18,948.97	3,500.00	15,448.97	541.4%
Travel	747.57	1,000.00	(252.43)	74.76%
Total Meeting/Travel Expense	19,696.54	4,500.00	15,196.54	437.7%
Miscellaneous	10.00	100.00	(90.00)	10.0%
Professional Services				
Accounting Fees	696.68	2,000.00	(1,303.32)	34.83%
Consulting	3,333.32			
Technology	181.50	3,500.00	(3,318.50)	5.19%
Total Professional Services	4,211.50	5,500.00	(1,288.50)	76.57%
Sponsorships/Marketing	266.66	1,800.00	(1,533.34)	14.81%
Website	60.00	300.00	(240.00)	20.0%
Total Expense	59,762.07	65,466.00	(5,703.93)	91.29%
Net Ordinary Income	18,660.26	214.00	18,446.26	8,719.75%
Net Income	**18,660.26**	**214.00**	**18,446.26**	**8,719.75%**