Hilltown Community Health Center

BOARD MEETING
SEPTEMBER 29, 2016
WORTHINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the August 25, 2016 Meeting Minutes

3. Finance Committee Report

4. Executive Director / Senior Manager Reports

5. Committee Reports (as needed)
   - Executive Committee
   - Recruiting, Orientation, and Nominating (RON)
   - Corporate Compliance
   - Facilities
   - Personnel
   - Quality Improvement
   - Expansion
   - Strategic Planning

6. Old Business
   - Bylaws Review
   - NACHC Technical Assistance

7. New Business
   - Re-Credentialing Reviews:
     1. Michelle Taylor, RN
   - New Credentialing Review:
     1. Mary McClintock, DMD
     2. Andrew Adams, DDS
   - Financial Policies and Procedures
   - Credit and Collection Policy
   - Sliding Fee Discount Scale Policy
   - Credentialing and Privileging Policy
   - Annex 7 to the Corporate Compliance Plan: Credentialing and Privileging

Adjourn

HCHC BOARD OF DIRECTORS MEETING
Location: Worthington Health Center, Worthington, MA
Date/Time: 08/25/2016 5:30pm

MEMBERS:; Lee Manchester; Nancy Brenner, Vice President; John Follet, President; Wendy Long; Cheryl Hopson; Tim Walter; Kathryn Jensen; Wendy Lane Wright, Clerk; Lew Robbins, Treasurer
STAFF: Eliza Lake, Executive Director; Janet Laroche, Executive Assistant; Michael Purdy, CCCSO
ABSENT: Alan Gaitenby; Frank Mertes, CFO

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Approval of Minutes 07/28/2016	John Follet called the meeting to order at 5:35pm. The July 28, 2016 minutes were reviewed by the Board members present. **A motion was made by Tim Walter to approve the July 28, 2016 minutes. The motion was seconded by Nancy Brenner. The motion to approve the minutes was approved unanimously.**	The July 28, 2016 minutes were approved	
Finance Committee	Lew Robbins reported that the new dashboard is still a work in progress, but is working well. The color coding and the data being included is helpful to all. Comparing us to other health centers isn't found to be that helpful by Eliza. She believes showing where we should be or having a benchmark would be more useful. The net operating revenue for the month of July was down due to the medical dept not being fully up to speed with its providers. It's the hope that this will be rectified in the next month due to now being fully staffed. The school-based health center will once again be open in September which will contribute to improved revenue. It was explained by Eliza that patient revenue is a balancing act. Senior management keeps a very close eye		

	on making sure there are enough providers, enough patients for each provider to see, knowing the productivity of each provider and making sure we're correctly billing for the services given to each patient. Frank will be looking into the productivity of the medical dept because they have not been meeting their monthly budget for a while. It was asked if there are long waiting lists to see a medical provider? Eliza answered by saying the only department with a waiting list is behavioral health, but it's getting better now that the department is fully staffed. It was asked how the year end projections are looking? Frank will be sharing projections at the September meeting. The opening of the Amherst location next year could change our numbers dramatically. Eliza shared that $192,000 has been raised for fundraising thus far. **A motion was made by Nancy Brenner to approve the August financial report. The motion was seconded by Kathryn Jensen. Without further discussion, the motion to approve the financial report was approved.** For future reporting, Nancy suggested that the Board hear about issues reviewed during any given month. Lew asked the group if they are finding this dashboard helpful? The answer was yes and to stick with this format. It was suggested to have this dashboard included in the monthly packet prior to each meeting if possible.	The August financial report was approved.	
Executive Director Report	Eliza reported that John was very helpful to her with Jeff Hagen's unexpected departure. For the		

	short-term, those reporting to Jeff have been moved to other senior managers. In the long-term, this will be used as an opportunity to identify needs, evaluate the operations function of the health center, as well as the management structure currently in place. There is no plan to replace Jeff at this time. There's a great need for assistance with generating and analyzing data. We also need to keep the opening of Amherst in mind and what fits into the strategic planning process. The staff have been notified and have accepted the change. We've been assigned a new project officer by HRSA. Her name is Betty Davis. It was noted that she was not in attendance at the OSV which took place in June. Eliza and Frank recently spoke with her regarding the report and they reviewed all 7 of the unmets received. It's anticipated that all the conditions will be met and submitted by the deadline of October 19, except for the issue of having a contract with every hospital that our patients go to for services. Each hospital would need to meet our sliding scale guidelines. When Betty was asked about this, she didn't have a clear answer. The Board was also informed that HRSA has just released a draft manual for review by all health centers. Eliza let the Board know that the health center's NCQA recognition has lapsed by not reapplying before the deadline. The process to reapply is a complicated one and Eliza is suggesting that a consultant be hired to help with this. Our NCQA status is related to being Patient Centered Medical Home (PCMH) certified. We're still following all the PCMH guidelines, but didn't reapply in time		

	to keep up our recognition. Lee asked if this recognition allows us to receive money from the state? Eliza replied by saying the state money was exhausted years ago. There is no further money coming from the state of Mass for this. There has been a big development in the discussion of creating an ACO. A small ACO has been formed by eight health centers in MA and has been selected as pilot project by MassHealth. It's considered a 501C4 and currently has 1 staff member. There will be a meeting in September to discuss this further with other small FQHCs in Mass. Eliza and Frank will keep an eye on the developments of this and will update the Board as needed. Eliza asked the Board if her monthly report is useful? Do members want to see other information and in what format? It was discussed and agreed upon that incorporating the strategic plan would make sense. The measurement and evaluation of the organization's progress in meeting its annual and long-term programmatic goals can be accomplished once the strategic plan and objectives are created, and this structure/template can be used to report monthly to the Board. The document will then be reviewed and followed on an ongoing basis. Eliza and the Board members agreed upon this plan for reporting purposes. The annual ice cream social is scheduled for the week of Aug 29 and Board members are welcome to attend. Ice cream will be at the Huntington Health Center on Monday and Wednesday from 1-2pm and at the Worthington Health Center on Tuesday and Thursday from 1-2pm.		

	The next all-staff in-service training for staff is scheduled for November 1. With the plans for Amherst moving forward, Lew asked Eliza where she thinks the next expansion will be? She and Michael both agree that expanding into Westfield is on the list. There's also thoughts of expanding optometry services to Worthington or to the School-Based Health Center. Another idea is to open a pharmacy at the Huntington Health Center. The behavioral health department would like to expand their services into schools and the principal at the elementary school in Worthington has asked for us to bring the mobile dental clinic to their school.		
Executive Committee	There was no report this month.		
Recruitment, Orientation & Nominating (RON) Committee	Tim reported that there are currently 10 Board members of the possible 12, leaving 3 positions available for Amherst. It was suggested that needed skillsets be taken into consideration before geography when new members join. Tim asked where the Board members are listed on the health center's web site. They are listed on the leadership page. Everyone is listed, but not all members have a photo posted.		
Corporate Compliance Committee	The committee is scheduled to meet again in September. Bi-weekly email trainings continue to be sent out to all staff and Board members. An addendum will be made shortly to the corporate compliance plan by adding a new credentialing and privileging policy.		
Facilities Committee	The committee did not report this month.		

Personnel Committee	It was confirmed that the policy on nepotism is now incorporated into the corporate compliance plan.		
Quality Improvement Committee	Cheryl reported for the committee. The minutes from the July 29 meeting were distributed for review. There was no medical dept report for July. The 1422 grant is very complex and moving forward with Kim's direction. It was asked what patients are included in this grant? The patients involved in this grant are adults who have hypertension and are pre-diabetic. There was a discussion about the patient satisfaction survey sample size and how surveys are handed out and collected. The LEAN team is slowly moving forward. They will meet more regularly starting in September. Eliza is working on a dashboard for HRSA that can be reviewed at QI and reported to the Board.		
Expansion Committee	The committee did not report this month. Lee asked if the Amherst Outreach Committee is meeting again soon? Eliza responded that the next meeting is taking place September 13th at 9am.		
Strategic Planning Committee	Minutes from the August 16th meeting were not distributed at this meeting, but the July 26 minutes were. The committee will review and vote to approve both month's minutes at their next meeting. Nancy shared the first draft of the mission, vision and values that are being worked on. Ideas, words and concepts were collected from staff and incorporated into this draft. The committee plans to continue with the strategic planning process by conducting a Strengths, Weaknesses,		

	Opportunities and Threats (SWOT) analysis and will be asking for the Board's input at the next meeting.		
Bylaws Ad-Hoc Committee	The bylaws were reviewed by the attorney and distributed once again to the Board members. Some of the changes include Eliza's title, as she should be the President and CEO according the Mass state law; John's title should be Chair of the Board; the Clerk should sign the bylaws once approved; the mission statement is required to be included in order to meet HRSA requirements; changes were made to the duties of the Board; information on proxy votes; duties of the executive committee; the process to follow if the organization was to go out of business; meeting minutes should be submitted to the clerk for review before Board approval. Eliza will get back to the attorney to ask a few questions regarding some of the items listed above.		
Committee Reports	After all the committee reports had been reviewed and discussed**, Nancy Brenner made a motion to accept all committee reports presented at the August 25th meeting. The motion was seconded by Tim Walter and without further discussion was approved.**	Committee reports presented at this meeting were approved.	
Old Business	None		
New Business			
Policy Reviews	The following policy was reviewed and voted upon at this meeting: Smoke and Tobacco Free Work Place policy; Wendy Long **made a motion to approve the Smoke and Tobacco Free Work Place policy. The motion was seconded by Tim Walter.**	Policies approved: • Smoke and Tobacco Free Work Place	

	Discussion followed by letting the Board know that several patients have been seen smoking electronic cigarettes in the waiting room. This policy prohibits smoking on the premises by patients and staff. Signs will be made and posted. **With no further discussion needed, the policy was approved.**		
Board Training by HRSA	Eliza is waiting to hear from the HRSA project officer, Betty Davis to find out if we've been approved to receive free training from HRSA.		
Adjourn	A motion to adjourn the meeting was made by Cheryl Hopson and seconded by Tim Walter. The meeting adjourned at 7:00pm. The next meeting is scheduled for Thursday, September 29, 2016 at **5:30pm** at the Worthington Health Center. **Please note the change in start time for this meeting.**		

Hilltown CHC
Board Financial Report
Summary Statement of Activities
Actual v. Budget

	YTD/Aug 2016 Actual	YTD/Aug 2016 Budget	Over (Under) Budget	Notes on Year to Date Budget vs. Actual
Stmt of Activities				
Net Patient Revenue	3,074,359	3,816,935	(742,576)	All patient service areas are not meeting budgeted visits.
Grant Revenue	1,573,367	1,400,831	172,536	Timing of expenditures on grants is driving added revenue.
Other Revenue	22,164	22,420	(256)	
Total Revenue	**4,669,890**	**5,240,186**	**(570,296)**	
Employee Related Expenses	4,027,243	4,400,168	(372,925)	Some staff have not yet been hired or were hired after expected start date.
Facilities & Equipment	366,710	214,201	152,509	Grant related purchases, off-set by added grant revenue; also expenses are up.
Supplies and Cost of Goods Sold	210,108	296,381	(86,273)	Consistent with less visits.
Depreciation	111,305	89,658	21,647	Budget was low, will remain over budget for year.
Other Expenses	151,677	188,681	(37,004)	
Total Expenses	**4,867,043**	**5,189,089**	**(322,046)**	
Net Operating Gain (Deficit)	**(197,153)**	**51,097**	**(248,250)**	
Non-Operating Activities (Pledges, Donations, etc.)	433,664	94,329	339,335	Donations for Amherst are higher then budgeted.
Net Surplus Gain (Deficit)	**236,511**	**145,426**	**91,085**	

Hilltown CHC
Board Financial Report
Summary Financial Results And Analytics - Dashboard
For Period Ending August 2016

	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	YTD/Aug 2016	Cap Link TARGET	COMMENT
Liquidity Measures												
Operating Days Cash	17	15	13	14	16	17	16	13	13	15	> 30-45 Days	Not Meeting Benchmark
Current Ratio	1.45	1.37	1.29	1.23	1.26	1.23	1.34	1.58	1.71	1.71	>1.25	Doing Better then Benchmark
Patient Services AR Days	23	25	26	23	28	24	22	21	20	22	< 60-75 Days	Doing Better then Benchmark
Accounts Payable Days	30	36	28	37	45	31	26	34	34	30	< 60 Days	Doing Better then Benchmark
Profitability Measures												
Net Operational Margin	-4.7%	-3.5%	-13.0%	1.0%	-3.6%	-10.1%	0.8%	-6.8%	-0.8%	-4.2%	> 1 to 3%	Not Meeting Benchmark
Bottom Line Margin	-2.7%	3.3%	-9.8%	2.3%	8.6%	-5.8%	5.8%	28.9%	8.0%	5.1%	> 3%	Doing Better then Benchmark
Leverage												
Total Liabilities to Total Net Assets	35.0%	37.4%	38.3%	42.8%	39.8%	39.1%	33.9%	32.7%	31.0%	31.0%	< 30%	Very Close to Meeting Benchmark
Operational Measures												
Medical Visits		1,511	1,399	1,684	1,413	1,536	1,474	1,329	1,532	11,878		
Net Medical Revenue per Visit		$ 153.97	$ 141.63	$ 136.21	$ 139.13	$ 137.72	$ 137.79	$ 140.34	$ 142.50	$ 141.12		
Dental Visits		1,550	1,430	1,939	1,143	1,106	1,223	1,070	1,181	10,642		
Net Dental Revenue per Visit		$ 90.26	$ 85.06	$ 94.29	$ 115.38	$ 100.90	$ 99.09	$ 132.65	$ 114.65	$ 102.08		
Optometry Visits		200	173	232	151	220	179	132	213	1500		
Net Optometry Revenue per Visit		$ 102.47	$ 90.74	$ 91.72	$ 104.72	$ 93.13	$ 85.91	$ 97.17	$ 92.62	$ 94.47		
Behavioral Health Visits		120	113	132	64	137	177	196	215	1154		
Net BH Revenue per Visit		$ 84.18	$ 82.04	$ 82.99	$ 80.81	$ 94.18	$ 91.01	$ 90.78	$ 94.72	$ 88.97		
School Based Visits		126	115	170	105	136	90	6	15	763		
Net SB Revenue per Visit		$ 104.17	$ 77.09	$ 71.69	$ 83.49	$ 116.12	$ 80.17	$ 57.67	$ 72.53	$ 88.32		

Coming soon!

Hilltown CHC
Board Financial Report
Summary Financial Results And Analytics - Dashboard
For Period Ending August 2016

	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	YTD/Jul 2016
Stmt of Activities										
Net Patient Revenue	4,872,654	399,783	370,109	456,642	358,223	372,311	362,984	359,412	394,895	3,074,359
Grant Revenue	1,922,051	157,101	160,300	219,792	204,783	200,054	255,210	176,523	199,604	1,573,367
Other Revenue	27,116	1,248	5,229	2,382	2,379	1,160	3,601	2,785	3,380	22,164
Total Revenue	6,821,821	558,132	535,638	678,816	565,385	573,525	621,795	538,720	597,879	4,669,890
Employee Related Expenses	5,898,928	486,712	497,799	554,578	498,555	529,139	511,103	464,363	484,994	4,027,243
Facilities & Equipment	439,465	35,985	47,604	52,809	33,860	52,915	42,147	50,205	51,185	366,710
Supplies and Cost of Goods Sold	335,978	23,218	22,921	28,948	24,165	22,547	29,060	27,674	31,575	210,108
Depreciation	169,948	13,872	13,872	13,872	13,913	14,037	13,913	13,913	13,913	111,305
Other Expenses	297,152	17,857	22,907	21,841	15,181	12,587	20,871	19,192	21,241	151,677
Total Expenses	7,141,471	577,644	605,103	672,048	585,674	631,225	617,094	575,347	602,908	4,867,043
Net Operating Gain (Deficit)	**(319,650)**	**(19,512)**	**(69,465)**	**6,768**	**(20,289)**	**(57,700)**	**4,701**	**(36,627)**	**(5,029)**	**(197,153)**
Non-Operating Activities (Pledges, Donations, etc.)	135,463	38,129	16,859	8,709	68,971	24,516	31,667	192,133	52,680	433,664
Net Surplus Gain (Deficit)	**(184,187)**	**18,617**	**(52,606)**	**15,477**	**48,682**	**(33,184)**	**36,368**	**155,506**	**47,651**	**236,511**
Balance Sheet										
Cash - Operating Fund	318,389	245,291	303,536	292,187	302,002	383,435	250,449	236,412	268,745	
Cash - Restricted	38,403	69,054	57,464	57,469	37,803	35,497	51,620	189,678	210,954	
Net Patient Accounts Receivable	303,160	348,154	318,802	365,816	296,896	285,425	246,877	251,337	261,261	
Other Current Assets	194,447	236,640	186,328	290,402	310,981	188,375	241,226	288,339	244,257	
Total Current Assets	854,399	899,139	866,130	1,005,874	947,682	892,732	790,172	965,766	985,217	
Net Property & Equip.	2,769,209	2,759,963	2,749,448	2,758,701	2,782,720	2,770,750	2,758,555	2,752,385	2,741,908	
Other Long-term assets	454,180	454,911	454,226	460,419	472,698	471,539	481,403	481,642	481,816	
Total	3,223,389	3,214,874	3,203,674	3,219,120	3,255,418	3,242,289	3,239,958	3,234,027	3,223,724	
Total Assets	**4,077,788**	**4,114,013**	**4,069,804**	**4,224,994**	**4,203,100**	**4,135,021**	**4,030,130**	**4,199,793**	**4,208,941**	
Liabilities & Net Assets										
Accounts Payable	183,396	193,719	197,648	284,245	226,039	139,926	192,553	235,453	182,948	
Other Current Liabilities	374,051	398,196	421,058	485,498	493,283	539,664	356,811	350,532	383,452	
Deferred Contract Revenue	30,946	64,223	52,365	47,693	34,092	45,524	41,062	25,229	8,563	
Total Current Liabilities	588,393	656,138	671,071	817,436	753,414	725,114	590,426	611,214	574,963	
Total Long Term Liabilities	469,154	462,605	456,069	449,418	442,864	436,269	429,698	423,067	420,814	
Total Liabilities	1,057,547	1,118,743	1,127,140	1,266,854	1,196,278	1,161,383	1,020,124	1,034,281	995,777	
Total Net Assets	3,020,241	2,995,270	2,942,664	2,958,140	3,006,822	2,973,638	3,010,007	3,165,513	3,213,164	
Total Liabilities & Net Assets	**4,077,788**	**4,114,013**	**4,069,804**	**4,224,994**	**4,203,100**	**4,135,021**	**4,030,131**	**4,199,794**	**4,208,941**	

Hilltown Community Health Centers, Inc.
Finance Committee Report to Full Board
September 29, 2016

GENERAL FINANCIAL SUMMARY FOR THE MONTH AND YEAR TO DATE PERIOD ENDING AUGUST 31, 2016.

TOTAL REVENUE:

Total net revenues were $597,879 and $4,669,890, respectively. The year to date net revenue is $570,296 under budget, with patient services being $742,576 under budget and grant revenues exceeding budget expectations by $172,536.

TOTAL EXPENSES:

Total expenses were $602,908 and $4,867,043, respectively. The year to date expenses are $322,046 under budget, primarily due to less staff and supplies costs.

NET OPERATING GAIN (DEFICIT) RESULTS:

Net operating activities resulted in a loss for August of $5,029 and a YTD loss of $197,153, respectively. Net operating results include all activities related to providing health center services and all administrative expenses.

NET SURPLUS/BOTTOM LINE GAIN (DEFICIT) RESULTS:

The final net surplus resulted in a gain for August of $47,651 and a YTD gain of $236,511, respectively. The final net surplus result includes all activities, both operational and non-operational. It includes the revenue from fundraising activities that may or may not be restricted.

Meeting Minutes

COMMITTEE: Personnel **Location: Huntington** **Date/Time: 9/13/2016**

TEAM MEMBERS: John Follet, Wendy Long, Bridget Rida

ABSENT: John Bergeron, Karen Rowe, Kayla Turner

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Sick Leave Policy	**The state law requiring that part time employees receive sick leave time at a rate of 1 hr. for every 30 hrs. worked was incorporated and reviewed. Other additions include that if an employee is out of work for 3 consecutive days or uses sick time within 2 weeks of leaving his or her job, an employer may require documentation from a medical provider. Lastly, the policy states that new hires accrue time from the day of employment and may not use sick time until they have completed 90 days of employment. The practice of this has not always applied to contracted employees. The legitimacy of this was discussed and the wording in the policy was changed to "New hires paid by the hour will accrue sick time……"**	**Accepted changes will be incorporated to be ready for Board approval.**	**Bridget will submit changes to Janet Laroche in time for distribution in the monthly packet**
Appeal	**The report of the appeal process and decision concerning an employee termination was signed and filed.**		

Hilltown Community Health Centers, Inc.

Finance Department

SUBJECT: NAME OF POLICY – FINANCIAL POLICY
REGULATORY REFERENCE: ~~None~~Code of Federal Regulations 45 (CFR) Part 75and PIN 2013-01

Purpose:
The Hilltown Community Health Centers, Inc. (HCHC) is a Health Center Program authorized under section 330 of the Public Health Service (PHS) Act 42 U.S.C. 254b) ("section 330") and is required to maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separate functions appropriate to organizational size to safeguard assets and maintain financial stability. As such the Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to meet these requirements and establish guidelines for developing financial and accounting procedures necessary to safeguard the financial resources of HCHC.

Policy:
HCHC will maintain and update as necessary a Financial Procedure Manual that contains procedures for the following topics:

- Maintenance of Account Records and Record Retention
- Cash Disbursements and Receipts
- Cost Allocation
- Purchasing and Reimbursement Procedures
- Reporting
- Payroll
- Fixed Asset Accounting
- Patient Revenue and Receivables

Questions should be directed to the Executive Director or the Chief Financial Officer at 413-238-5511.

Originally Drafted: MARCH 2004 Reviewed or Revised: SEPT. 2016

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Executive Director, HCHC

_____ Date: _____
John Follet, MD
President, HCHC Board of Directors

Hilltown Community Health Centers, Inc.
(HCHC)

FINANCIAL PROCEDURES MANUAL

TABLE OF CONTENTS

HILLTOWN COMMUNITY HEALTH CENTERS, INC.

is a not-for-profit healthcare facility providing medical, dental, behavioral health and related services at Worthington Health Center, Worthington, MA; Huntington Health Center, Huntington, MA; and a School-Based Health Center located within Gateway Regional High School, Huntington, MA.

MISSION STATEMENT

Hilltown Community Health Centers' mission is to provide high quality, accessible medical, dental, optometry and counseling and behavioral health care, and related services to people in the Western Massachusetts hilltowns and surrounding areas. We seek to understand and respond to the needs of our community. All services will be delivered in a caring and professional manner within a context of a partnership between persons served and staff. To achieve our mission we promote employee growth and job satisfaction and we offer continuity of care through our relationships with other organizations.

PURPOSES OF THE CORPORATION

To provide, encourage and administer facilities for health care access for all the inhabitants of the surrounding communities as are deemed necessary, feasible and affordable.

To participate in the coordination of community and area health projects and activities including cooperation with, and the providing of appropriate space for, healthcare services.

To be ready, and to act, at all times to conserve and promote the health of the population in the communities, regardless of ability to pay.

To sponsor charitable, scientific, and educational endeavors directed toward the promotion of any project designed to improve the health of the community.

To engage in any other activity, endeavor, or course of action not inconsistent with the above.

Financial Management

HCHC's financial management systems, including records documenting compliance with Federal and state statutes, regulations, and the terms and conditions of the Federal and state awards, must be sufficient to permit the preparation of reports required by general and program-specific terms and conditions; and the tracing of funds to a level of expenditures adequate to establish that such funds have been used according to the Federal and state statutes, regulations, and the terms and conditions of the Federal award.

HCHC must;

a) Establish and maintain effective internal control over the Federal and state award that provides reasonable assurance that HCHC is managing the Federal and state award in compliance with Federal and state statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government," issued by the Comptroller General of the United States or the "Internal Control Integrated Framework," issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).
b) Comply with Federal and State statutes, regulations, and the terms and conditions of the awards.
c) Evaluate and monitor the compliance with statutes, regulations and the terms and conditions of awards.
d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.
e) Take reasonable measures to safeguard protected personally identifiable information and other information the awarding agency or pass-through entity designates as sensitive or what HCHC considers sensitive consistent with applicable Federal and state laws regarding privacy and obligations of confidentiality.

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Chart of Accounts

The chart of accounts is designed to provide management with an analysis of financial position and a statement of operating revenues and expenses on a time accrual basis. The chart of accounts is established using the total grant concept. As such, each individual funding source is segregated in the general ledger to allow management to easily distinguish revenues and expenses by funding source. This allows for easier preparation of monthly reimbursement vouchers for contracts as well as regulatory reporting (FSR, UFR, UDS, etc.)

All financial transactions are designated by an account code. The digits employed are selected from the chart of accounts.

Definition of Coding Structure (*Refer to Appendix B)*

Each account code is subdivided into four separate segments.

Consisting of:

1. Fund XX
2. Account XXXXX
3. Location XX
4. Department XX

1. Fund - 01 Used for all transactions

2. Account - The digits represent the major account classifications for balance sheet, revenue, and expense items. For example: XXXXX

    a. Assets = 1XXXX
    b. Liabilities = 2
    c. Equity (Fund Balance) = 3
    d. Revenue / Income = 3
    e. Salaries and Benefits = 5
    f. Expenses = 6

3. Location – XX Used to identify location.

4. Department – XX Used to identify each department.

Subaccount Segment

1. Alphanumeric codes that identify grants
2. UFR codes that correspond with UFR coding

Description of Accounts

Assets

All asset accounts are designated within the chart of accounts by the appropriate digit of the account-numbering scheme.

Cash Accounts are debited for bank deposits and when stop payments are placed on previously issued checks. These accounts are credited for funds withdrawn and any miscellaneous bank charges. Cash receipts are deposited into the operating account on a regular basis in accordance with the cash receipts policies. Insurance & patient payments are debited to cash on hand when received and then recorded to the General Operating Account when deposited in the bank.

A petty cash fund is established at each site. Reimbursements for expenses paid from petty cash are made from the operating account. Expenses are charged to the appropriate account at the time of reimbursement. Change Funds are set up for making change for patient cash payments, amounts are set and adjusted as needed.

Accounts Receivable accounts are debited for grant funds due, revenue billed, and any other amounts owed to the health center. Accounts receivable are credited for cash collected and any un-collectible amounts. A debit balance represents the balance owed to the health center.

Allowance for doubtful accounts is a reserve for estimated un-collectible patient receivables contained in the accounts receivable balance. The purpose of the allowance is to provide the estimated un-collectible amount of recorded receivables. The reserve is established based on the historical bad debt experience, current economic conditions, estimates and presumptions. The allowance is reviewed for revision periodically.

Prepaid expenses are debited for significant current cash outlays that are related to future periods.

The health center has established a capitalization amount for fixed assets of $5,000 or more.

Accumulated depreciation accounts are credited monthly for estimated depreciation on assets and debited to operating expenses. Accounts are reconciled at yearend to actual amounts, per the annual audit

Other assets include accounts designated for investments or cash set aside for stability or future capital projects.

Liabilities

Accounts Payable

Accounts payable are credited for the amounts owed vendors for receipt of goods and services. An entry is made to an accounts payable register for vendors' invoices received and approved for payment regardless of which program incurred the expense. Accounts payable are debited for cash disbursements against established payables. The balance (credit) reflects outstanding vendor liabilities.

Accrued liabilities are established for payroll costs, amounts withheld from employees, and other accrued liabilities. These accounts are credited for amounts due and debited upon payment or settlement. The balance (credit) represents the amount owed. At the close of each month, the estimated accrued payroll expenses incurred in the current month are booked in the general ledger as an accrued expense. All expenses are accrued at yearend.

Loans/Mortgages payable

Amounts borrowed for operating or capital purchases or improvements. These accounts are credited monthly as balances are paid or debited when new funds are borrowed.

Capital Leases

Amounts are credited to these accounts if major leases are entered into that require financing. The accounts are debited monthly as principal payments are made on these leases to reduce the amount owed.

Deferred Revenue Accounts

These accounts are credited when grants and other forms of payment are received by the health center for future services, equipment purchases, or capital projects. These amounts are debited as the services are provided or per current accounting regulations during the annual audit.

Net Worth & Fund Balances

YTD Net Income

These accounts accumulate the estimated net profit of each cost center on a monthly basis. After final adjustment at the completion of the annual audit, each balance is closed to the appropriate Fund Balance account. These accounts are zeroed out at the end of each fiscal year.

Fund Balance

These are accounts that designate the net worth of the health center. Fund balance accounts are adjusted annually at the conclusion of the annual audit. Any net profit or loss is recorded to the appropriate fund balance at the conclusion of the annual audit.

Temporarily Restricted Fund Balances

These accounts record funds that have been received or have been committed to the agency, but obligations still existed on these funds at the end of the last fiscal year. As these funds are earned or deemed used, they are recorded to regular fund balances as appropriate, per the annual audit and current accounting regulations

Revenues

Revenues are credited to revenue accounts as they are considered earned and receivable. These can be revenues for services provided to patients or related to grant conditions.

Contra-Revenues

These are accounts which are credited to adjust for patient amounts billed, but not considered collectible. These include, but are not limited to insurance allowances, free care, bad debt and billing errors.

Expenses

Expense accounts are debited for paid or accrued expenditures. Types of expenses include but are not limited to:

Salaries/Wages – These costs are recorded to accrued liabilities and distributed to individual departments based on the gross salaries/wages recorded on the payroll allocation worksheet. The payroll timesheet has been established to account for the time and effort of each individual employee. Thus, the general ledger accounts properly reflect the amount paid to employees based on departmental and funding source time and effort recorded on timesheets.

Payroll Taxes – These are mandatory payments related to payroll which normally include FICA, Medicare, Workman's Compensation Insurance and State Unemployment Insurance. Applicable costs are distributed to programs and departments in proportion to monthly salary distributions.

Fringe Benefits – Included in this account are medical, dental, disability and group life insurance; and any other employee benefits which may be offered by the health center. A description of current benefits may be found in the employee handbook. Applicable costs are distributed to programs and departments in proportion to monthly salary distributions.

Consultants and Contractual – These costs include dental labs & those individuals to whom the health center issues 1099 statements at year-end. Examples include auditing firms, legal firms, payroll service, computer consultants, skilled labor, and independent health-care providers.

Facilities Costs – Costs associated with the occupancy of the health center's buildings are included in these line items.

Utilities – These expenses include electricity, heating and cooling fuel, water supply and related expenses.

Repairs and Maintenance – Costs associated with the upkeep of the property and equipment are recorded in these accounts.

Mortgage Interest – Interest costs associated with mortgage loans related to health center buildings and improvements.

Depreciation – The estimated depreciation related to the health center's fixed assets are recorded monthly in these accounts that are broken out by type of asset (buildings, building improvements, furniture and equipment, etc).

Building & General Liability – These accounts include any type of insurance related to the buildings, their contents and general liability related to agency facilities or use.

Program Supplies – Program supplies are supplies needed for providing medical, dental or other program services and are recorded separately from general office supplies or facility supplies.

Telephone – Includes regular monthly telephone costs, beepers, answering service, internet costs and other related communication expenses.

Dues and Memberships – These se expenses include all membership dues paid to organizations for the health center or any employee of the health center.

Subscriptions & Journals – All subscriptions to magazines and professional journals.

Licenses and Fees – These expenses include all individual provider and agency licenses required by state and federal agencies for which the health center pays.

Travel – These costs include all expenses related to employee travel for health center business or necessary to the functioning of the health center operations. They include staff mileage at current approved rate, parking, tolls, motels, some meals and other related travel expenses.

Printing – Costs associated with production of letterhead, newsletters, invoices, patient receivable statements, forms, business cards and envelopes are recorded to these accounts.

Postage & Shipping – Amounts incurred to mail business correspondence or to ship items as required for operation of the health center.

Staff Recruitment/Training - All costs associated with the recruitment and/or training of staff are recorded to these accounts. This may include workshops, skill trainings and other mandatory trainings required for licensure or other purposes.

Interest - Interest costs for general operating use, such as for a line of credit are charged to this line item. It does not include any interest for building purchases or improvements.

Professional Insurance – This account includes professional liability insurance related to services provided by the health center and its employees as well as Director's & Officer's insurance.

Bad Debt - All costs associated with the write off of those patient receivable accounts deemed not collectible are included in this account. Bad Debt is recorded as a Contra-Revenue Account on the general ledger and then adjusted to an expense account on the annual audit.

Expenses are charged to the program and funding source benefiting from the goods or services. If a specific department cannot be identified, the expense is charged to the Administration, Billing, Facility or other appropriate allocation pool. If all programs and funding sources are likely to derive benefit from the goods or services, the expense is charged to the appropriate overhead department. See cost principles as outlined in 45 CFR 75 subpart E for further cost definitions and information on allowable and unallowable costs associated with Federal awards.

Maintenance of Accounting Records

The health center maintains the following accounting records:

a) Accounts Payable Register
b) Cash Receipts Journal
c) Payroll Register
d) General Ledger and General Journal Entries

Below is a description of each of these records and a brief summary explaining the procedures for how the entries are recorded.

Accounts Payable Register

All cash disbursements are initially entered in the accounts payable system upon receipt of the vendor invoice. The expenditures are charged to the appropriate expense or asset accounts. Invoices are batched for data entry. A batch report is generated for each group of invoices entered. The individual batch reports are retained until a summary batch report is generated at month's end.

Cash Receipts Journal

Front desk patient receipts (co-pays, deductibles and self-pays) are batched and posted to the cash receipts data entry journal from daily summaries prepared by front desk personnel at the end of each business day. The medical and dental departments submit separate summaries.

Third-party payments received in the mail are batched and posted to a cash receipts data entry journal from summaries prepared by the Billing Department.

Other receivables (grant funds, enhanced revenue payments, cobra payments, etc) are batched and posted to a cash receipts data entry journal from summaries prepared by the Accounting Department. *(See Cash Receipts section for description of procedures.)*

At month's end, all entries are posted to the general ledger. The cash account is debited for the total of the monthly receipts.

Payroll Register

The payroll register is obtained from the payroll processing company, currently Checkwriters. The monthly payroll entries are obtained from the data in the payroll register. A spreadsheet is prepared monthly using the payroll register and the allocations recorded on time sheets by each employee. This spread sheet allocates amounts paid to employees to the program and site in which they worked. The summarized totals for each program and site are recorded to the general ledger from these reports.

General Ledger and General Journal Entries

Entries to the general ledger are posted monthly. The general ledger is printed monthly and filed for future reference.

Some journal entries consist of those that are recurring in nature. Entries are recorded first in a data entry file. Entries are batched according to type. Each data entry batch is automatically assigned a unique number by the computerized accounting system.

Correcting and/or adjusting entries are also posted monthly. Entries are recorded first on a data entry file. Entries are batched according to type. Each data entry batch is automatically assigned a unique number by the computerized accounting system.

Record Retention

Computerized/Electronic Records:

General Ledger / Financial records are maintained on Financial Edge which is a cloud-based software under a subscription service that also provides sophisticated security protocols, disaster recovery procedures and 24 hour system availability.

Non-computerized Records:

Accounting Records

- Bank statements and deposit slips = 7
- Expense reports = 7
- Subsidiary ledger (A/P & A/R) = 7
- Checks (payroll and general) = 7
- Payroll - reports, earnings records = 8
- Vouchers (vendors) = 7
- Mortgages, notes, leases (expired) = 8
- Tax returns and working papers = Permanent
- External Audit reports = Permanent

Corporate Records:

- Bylaws, charters, operating certificates, minutes, stock & bond records, checks (for taxes, property, important contracts, agreements, copyright & trademark registrations, deeds, labor agreements, patents, proxies, pension records = As laws require.

- Correspondence
    - General = 2
    - Legal & tax = Permanent or as required.

- Insurance
    - Expired policies = 3
    - Accident and fire inspection reports = 6
    - Group disability records, safety reports = 8
    - Claims (after settlement) = 10

- Personnel:
    - Expired contracts = 7
    - Timesheets = 7
    - Disability & sick benefits records, terminated personnel files = 7
    - Withholding tax statements = 7

Further, the Office of Management and Budget Circular A-133 requires all entities that receive federal funds to retain all documents associated with the funds for a minimum of three years. Similarly, because the health center receives funding from Medicare and Medicaid, these documents must be retained for a minimum of three years after the date of final settlement on that year's cost report. As a rule, the documents associated with Medicare and Medicaid should be retained for at least 5 years. This allows for the time lag between the submission of the cost reports and the settlements from the intermediaries.

Cash Disbursements

All disbursements are made out of one general operating account. Petty cash expended is reimbursed from the account monthly or upon request of the custodian of the petty cash fund. Petty cash expenses are recorded to the general ledger at the time of reimbursement.

Disbursement Procedures

All checks drawn by the health center must be reviewed and signed by the Chief Financial Officer or the Executive Director. In his/her absence, a signature stamp may be used for essential disbursements provided a list of the checks so stamped is submitted for review. The signature stamp is kept in a locked cabinet at all times. Checks in the amount of $10,000 or more require two signatures.

Pre-approval limits and requirements are detailed on page 19 under Purchasing Procedures.

A multipart check is prepared for disbursements paid from the general operating account. The bottom two-thirds of the check is sent as payment to vendors. The top

portion of the check is stapled to the invoice to provide the health center with adequate documentation for payment of the expenditure. The detailed procedures related to the preparation, distribution, and retention of the disbursement vouchers are prescribed in the accounts payable section.

Bank account reconciliation is completed each month to ensure that all cash transactions are properly recorded, and that there are no unusual endorsements. The bank statement is downloaded electronically and is reconciled to the appropriate cash balance in the general ledger.

Petty Cash

The finance department maintains one petty cash fund. The fund is used for individual purchases. Receipts must be submitted to substantiate disbursements and attached to a completed petty cash reimbursement request. Transactions are recorded on the petty cash expenditures log. *(Refer to Appendix C)*

The petty cash fund's balance is set so that it will normally be sufficient for a full month before it requires reimbursement. The fund is reimbursed either at the end of the month or whenever the fund's balance falls to a certain amount determined by the custodian of the account. Reimbursement is made from the general operating account upon submission of a requisition prepared by the custodian of the account. The requisition must include receipts or proper documentation for expenditures from the account.

The reimbursement check is drawn to the order of Petty Cash.

Cash Receipts

The health center receives various types of cash receipts on a daily basis. These include payments received via mail or electronic transfer such as contract revenue reimbursement, contributions, payment on patient accounts, electronic wire transfers such as Medicaid receipts and grant draw downs, as well as cash from patients and other miscellaneous items.

Draw downs on Federal awards must minimize the time elapsing between the transfer of funds from the United States Treasury or the pass-through entity and the disbursement by HCHC. All advance payments on Federal awards must be deposited and maintained in insured accounts whenever possible and in interest-bearing accounts unless the following applies;

a) HCHC receives less than $120,000 in Federal awards per year.

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b) The best reasonably available interest-bearing account would not be expected to earn interest in excess of $500 per year on Federal cash balances.
c) The depository would require an average or minimum balance so high that it would not be feasible within the expected Federal and non-Federal cash resources.
d) A foreign government or banking system prohibits or precludes interest bearing accounts.

Cash receipts procedures are established to insure that receipts are adequately safeguarded and properly deposited, that all receipts are properly recorded in the patient accounting records, and that receipts are identified in sufficient detail to facilitate preparation of the monthly financial reports.

Amounts received and prepared deposits are held in a locked cabinet at all times and deposits are made at least once weekly and more often when practical.

Cash Receipts – Mail or Billing

As the mail is sorted, checks are segregated and distributed to the appropriate departments. Third-party payments and patient payments received via mail are forwarded directly to the Billing Department, together with the Explanation of Benefits (EOB), for posting to patient accounts. All other checks are forwarded directly to the Finance Department.

Upon completion of each patient receipt posting batch, the designated person in the Billing Department forwards the checks in that batch to the Finance Department. Deposit slips are prepared in duplicate and are retained in the Finance Department. A check summary voucher, a copy of the register tape listing all checks in the batch, and a cover sheet showing the total of the batch and general ledger account is included.

The amount and account code indicated on the cover sheet is used to prepare the monthly billing cash receipts journal entry to the General Ledger.

Cash Receipts – Front Desk

Self-pay receipts (co-payments, deductibles, uninsured services) are received by the medical and dental front desks daily. Payments may be made using cash, check or a credit card.

The amount to be collected appears on the patient's electronic record. Front desk staff may enter the amount collected and the form of payment on their electronic patient record or manually record the amount collected.

At the end of each day, the staff member responsible for closing each front desk reconciles the cash receipts. A transmittal receipt is prepared in triplicate showing a breakdown of cash, check and credit card payments for that day. One copy is forwarded to the Finance Department with the payments, one copy is forwarded to the Billing Department, and one copy is retained at the front desk.

A log is kept in the Finance Department to ensure that each day's cash receipts are received from the designated departments at all sites.

A person preparing the bank deposit may combine several days' front-desk cash receipts into a single deposit. Deposit slips are prepared in duplicate. One copy is included in the deposit to the bank and the other copy is retained in the Finance Department. The transmittal receipts, a copy of the register tape listing all checks, and a cover sheet showing the total of the batch and the general ledger account is retained in the Finance Department.

The amounts and account numbers indicated on the cover sheet are used to prepare the monthly front desk cash receipts journal entry to the General Ledger.

Cash Receipts – Miscellaneous

Other miscellaneous cash receipts include, but are not limited to, contract revenue reimbursements, contributions, COBRA payments, and enhanced fee payments. These checks are forwarded directly to the Finance Department for processing.

Checks are batched and prepared for deposit. Deposit slips are prepared in duplicate. One copy is included in the deposit to the bank and the other copy is retained in the Finance Department. A copy of the register tape listing all checks, and a cover sheet showing the total of the batch and the general ledger account is retained in the Finance Department.

The amounts and account numbers indicated on the cover sheet are used to prepare the monthly miscellaneous cash receipt journal entry for the General Ledger.

General Operating Account

This account is currently held by Florence Savings Bank, One Main Street, Florence, Massachusetts. Both manual and electronic transactions account for the monthly activity in the G.O.A. An excel spreadsheet is maintained to give an approximate current balance. Each month's beginning balance is adjusted to reflect the actual amount reconciled to the general ledger. If the balance in the G.O.A exceeds the amount reasonably needed for the operation of the Health Center, money is transferred to a money market account at Florence Savings Bank that earns higher interest. Funds from this money market account are transferred back to the general operating account as needed.

Other Non-Operating Revenue

On occasion, the health center receives other revenue unrelated to normal operations. This can include donations, pledges, or other non-operating receipts. Unless specifically designated for operating purposes, these funds are separated and deposited to one of the health centers designated or restricted bank accounts. Funds received in this manner are reported monthly to the Finance Committee.

Grant and Contracts Revenue and Receivable Procedures

Grants and contracts are managed based on specific instructions from each grantor or contract. Some advance funds and require progress reports for activities related to the funding. Funds received from these funding sources are recorded as deferred revenues until earned. Once funds are considered earned they are recorded by general ledger entry to the proper earned revenue account.

Other Grants or Contracts require that expenses be incurred before being reimbursed. These are vouchered on a regular schedule acceptable to the granting agency, in the format required. The vouchers could be monthly, quarterly or by some other agreed upon time line. The amounts of the vouchers are credited to the proper earned revenue account and debited to a receivable account. The proper code for the grant or contract is required to properly record the earned revenue. The revenue is also recorded to the proper department as some contracts fund more than one department or program. When payment is received, standard monthly journal entries are made to credit the proper receivable account and debit the general operating cash account.

Standard Journal Entries

Most journal Entries are recorded and posted monthly. Standard journal entries include: bank interest and fees, deposits, withdrawals, depreciation, and contracts vouchered to name a few. Adjusting or correcting entries are also posted each month. Gains or losses on investments are recorded and posted quarterly.

Journal entries are recorded first in excel spreadsheets. The entries are labelled to allow for tracing the entries in the accounting software. Each entry is assigned a number that includes the month and the number of the entry. An example would be G/L entry 10-06. This was done in October and is the sixth entry for that month. The backup documentation which supports the journal entry is also numbered similarly.

Once an entry is posted, all reports including backup are filed with all other general ledger entries for that month. These reports are kept for future reference, reconciliation and documentation.

COST PRINCIPLES

HCHC is responsible for the effective and efficient administration of Federal, state and private awards through the application of sound management practices and must comply with applicable cost principles as outlined in 45 CFR 75 subpart E.

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COST ALLOCATION PLAN

Direct Cost Allocation:

Costs are allocated to programs on a direct basis whenever possible. Department Heads or their designees submit invoices and bills with their approval and confirm that the expense is for their departments. In cases where an expense is shared by departments/programs allocation methods have been developed to allocate expenses to the departments/programs that benefit from the costs. Following are the current allocation plans and methods used by the Health Center.

Payroll is the largest expense that needs to be allocated. Salaries and wages are allocated based on individuals actual time worked in each program. Each employee completes a bi-weekly electronic time sheet listing the hours and the department those hours were worked in. This information is then entered into an excel spreadsheet that is used to generate a monthly journal entry to allocate payroll expenses to the correct departments.

Cost Allocation for Internal Management:

There are many departments that support different segments of the Health Centers. The departments that are shared by different segments of the Center are:

Facilities/Maintenance for each site, Billing Office services which are shared by Medical, Dental and Mental Health Services (all billable services), Administration/Front desks at each main site and Overhead/Indirect which is shared by all services of the agency. Each department is used by more than one program and allocation plans have been developed to allocate expenses to the programs based on what is considered fair and logical. Costs for these shared services are pooled into one cost center and then allocated to programs based on the following:

a) Facilities costs are recorded in separate cost pools for each site. Any expenses related to overall building operation are considered shared services and recorded to these pools. Costs are then allocated monthly to each program based on the square footage occupied by each program in that building. This pool can contain non-facility costs that need to be distributed by square feet.
b) Administration/Front Desk services are located at each main site and the services currently benefit two Departments/Programs at each site. These departments are Medical & Behavioral Health. Originally the Dental Department was part of the allocation, currently dental has its' own front desk, so no costs are

allocated to dental. Administrative or Front Desk costs are allocated to the programs based on the annual visits in each program during the previous fiscal year.

c) The billing office is one service that is shared by all sites, but not by all programs. The billing office services only benefit the programs that bill for patient services. For this reason the costs that are associated with the billing office are pooled and allocated based on visits or units of service provided for the month.

d) Indirect/Overhead costs are costs that benefit the whole Center. These are costs such as salaries and associated costs of the Executive Office, Finance Department or Human Resources. These expenses are pooled and allocated based on the modified direct costs (excludes cost of subcontracts over $25,000 in the base) of each program, sub-program or grant. Every program gets an even share allocated to it based on their direct expenses (with all other allocated expenses already included). This method allows each program to be allocated the same percentage of Indirect/Overhead costs as every other department in the Center.

These allocation methods are currently in place in the event that a managerial cost allocation is used, but are to be reviewed from time to time based on changes to programs, sites or need.

Regulatory Cost Allocation Methods:

Other methods as directed by regulatory agencies are used per their guidelines and requirements.

Procurement ~~urchasing Procedures~~

HCHC g~~G~~eneral procurement standards;

a) Procurement procedures reflect applicable federal and state regulations.

b) HCHC ~~must~~ maintains a written standards of conduct covering conflicts of interest and governing the actions of its employees engaged in the selection, award and administration of contracts. This policy has a formal documented process for disclosing all real or apparent conflicts of interest that are discovered or that have been brought to attention in connection with HCHC's activities. See copy of CONFLICT OF INTEREST POLICY with REGULATORY REFERENCE: 45 CFR 75.327 and 42 CFR Pt 51c.304 (b) attached as Appendix G.

No employee, officer, or agent may participate in the selection, award, or administration of a contract supported by a Federal award if he or she has a real or apparent conflict of interest. Such a conflict of interest would arise when the

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employee, officer, or agent, any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in or a tangible personal benefit from a firm considered for a contract. The officers, employees, and agents of HCHC may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts. However, HCHC may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the non-Federal entity.

c) HCHC's procurements~~procedures~~ must avoid acquisition of unnecessary or duplicative items. Consideration should be given to consolidating or breaking out procurements to obtain a more economical purchase. Where appropriate, an analysis will be made of lease versus purchase alternatives, and any other appropriate analysis to determine the most economical approach.

d) HCHC encourages the use of entering into state and local intergovernmental agreements or inter-entity agreements where appropriate for procurement or use of common or shared goods and services.

e) HCHC encourages the use of Federal excess and surplus property in lieu of purchasing new equipment and property whenever such use is feasible and reduces project costs.

f) HCHC encourages the use of value engineering clauses in contracts for construction projects of sufficient size to offer reasonable opportunities for cost reductions. Value engineering is a systematic and creative analysis of each contract item or task to ensure that its essential function is provided at the overall lower cost.

g) HCHC must award contracts only to responsible contractors possessing the ability to perform successfully under the terms and conditions of a proposed procurement. Consideration will be given to such matters as contractor integrity, compliance with public policy, record of past performance, and financial and technical resources.

h) HCHC must maintain records sufficient to detail the history of procurement. These records will include, but are not necessarily limited to the following: rationale for the method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price.

i) HCHC may use a time and materials type contract only after a determination that no other contract is suitable and if the contract includes a ceiling price that the contractor exceeds at its own risk.
    1) Time and materials type contract means a contract whose cost to a non-Federal entity is the sum of:

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i. The actual cost of materials; and
ii. Direct labor hours charged at fixed hourly rates that reflect wages, general and administrative expenses, and profit.

2) Since this formula generates an open-ended contract price, a time-and-materials contract provides no positive profit incentive to the contractor for cost control or labor efficiency. Therefore, each contract must set a ceiling price that the contractor exceeds at its own risk. Further, HCHC must assert a high degree of oversight in order to obtain reasonable assurance that the contractor is using efficient methods and effective cost controls.

j) HCHC alone must be responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements. These issues include, but are not limited to, source evaluation, protests, disputes, and claims. These standards do not relieve the non-Federal entity of any contractual responsibilities under its contracts. The HHS awarding agency will not substitute its judgment for that of the non-Federal entity unless the matter is primarily a Federal concern. Violations of law will be referred to the local, tribal, state, or Federal authority having proper jurisdiction.

k) The type of procuring instruments used will be determined HCHC but shall be appropriate for the particular procurement and for promoting the best interest of the program or project involved.

Competition;

a) All procurement transactions must be conducted in a manner providing full and open competition consistent with the standards of this section. In order to ensure objective contractor performance and eliminate unfair competitive advantage, contractors that develop or draft specifications, requirements, statements of work, or invitations for bids or requests for proposals must be excluded from competing for such procurements. Some of the situations considered to be restrictive of competition include but are not limited to:
   1) Placing unreasonable requirements on firms in order for them to qualify to do business;
   2) Requiring unnecessary experience and excessive bonding;
   3) Noncompetitive pricing practices between firms or between affiliated companies;
   4) Noncompetitive contracts to consultants that are on retainer contracts;
   5) Organizational conflicts of interest;
   6) Specifying only a "brand name" product instead of allowing "an equal" product to be offered and describing the performance or other relevant requirements of the procurement; and
   7) Any arbitrary action in the procurement process.

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b) HCHC must conduct procurements in a manner that prohibits the use of statutorily or administratively imposed state, local, or tribal geographical preferences in the evaluation of bids or proposals, except in those cases where applicable Federal statutes expressly mandate or encourage geographic preference. Nothing in this section preempts state licensing laws. When contracting for architectural and engineering (A/E) services, geographic location may be a selection criterion provided its application leaves an appropriate number of qualified firms, given the nature and size of the project, to compete for the contract.

c) HCHC must have written procedures for procurement transactions. These procedures must ensure that all solicitations:
   1) Incorporate a clear and accurate description of the technical requirements for the material, product, or service to be procured. Such description must not, in competitive procurements, contain features which unduly restrict competition. The description may include a statement of the qualitative nature of the material, product or service to be procured and, when necessary, must set forth those minimum essential characteristics and standards to which it must conform if it is to satisfy its intended use. Detailed product specifications should be avoided if at all possible. When it is impractical or uneconomical to make a clear and accurate description of the technical requirements, a "brand name or equivalent" description may be used as a means to define the performance or other salient requirements of procurement. The specific features of the named brand which must be met by offers must be clearly stated; and
   2) Identify all requirements which the offerors must fulfill and all other factors to be used in evaluating bids or proposals.
   3) HCHC must ensure that all prequalified lists of persons, firms, or products which are used in acquiring goods and services are current and include enough qualified sources to ensure maximum open and free competition. Also, HCHC must not preclude potential bidders from qualifying during the solicitation period.

Procurement Procedures;

HCHC must use one of the following methods of procurement;

a) Procurement by micro-purchases. Procurement by micro-purchase is the acquisition of supplies or services, the aggregate dollar amount of which does not exceed the micro-purchase threshold as defined by the Federal Acquisition Regulation (current threshold $3,500). To the extent practicable, HCHC will distribute micro-purchases equitably among qualified suppliers. Micro-purchases may be awarded without soliciting competitive quotations provided the acquisition price is considered to be reasonable.

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b) Procurement by small purchase procedures. Small purchase procedures are those relatively simple and informal procurement methods for securing services, supplies, or other property that do not cost more than the Simplified Acquisition Threshold as defined by the Federal Acquisition Regulation (current thresholds greater than $3,500 and less than or equal to $150,000). If small purchase procedures are used, price or rate quotations must be obtained from an adequate number of qualified sources.

c) Procurement by sealed bids (formal advertising). Bids are publicly solicited and a firm fixed price contract (lump sum or unit price) is awarded to the responsible bidder whose bid, conforming with all the material terms and conditions of the invitation for bids, is the lowest in price. The sealed bid method is the preferred method for procuring construction, if the conditions in paragraph (c)(1) of this section apply.

1. In order for sealed bidding to be feasible, the following conditions should be present:
    i. A complete, adequate, and realistic specification or purchase description is available;
    ii. Two or more responsible bidders are willing and able to compete effectively for the business; and
    iii. The procurement lends itself to a firm fixed price contract and the selection of the successful bidder can be made principally on the basis of price.
2. If sealed bids are used, the following requirements apply:
    i. Bids must be solicited from an adequate number of known suppliers, providing them sufficient response time prior to the date set for opening the bids, for local, and tribal governments, the invitation for bids must be publicly advertised;
    ii. The invitation for bids, which will include any specifications and pertinent attachments, must define the items or services in order for the bidder to properly respond;
    iii. All bids will be opened at the time and place prescribed in the invitation for bids;
    iv. A firm fixed price contract award will be made in writing to the lowest responsive and responsible bidder. Where specified in bidding documents, factors such as discounts, transportation cost, and life cycle costs must be considered in determining which bid is lowest. Payment discounts will only be used to determine the low bid when prior experience indicates that such discounts are usually taken advantage of; and
    v. Any or all bids may be rejected if there is a sound documented reason.

d) Procurement by competitive proposals. The technique of competitive proposals is normally conducted with more than one source submitting an offer, and either a fixed price or cost-reimbursement type contract is awarded. It is generally used

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when conditions are not appropriate for the use of sealed bids. If this method is used, the following requirements apply:

1. Requests for proposals must be publicized and identify all evaluation factors and their relative importance. Any response to publicized requests for proposals must be considered to the maximum extent practical;
2. Proposals must be solicited from an adequate number of qualified sources;
3. HCHC must have a written method for conducting technical evaluations of the proposals received and for selecting recipients;
4. Contracts must be awarded to the responsible firm whose proposal is most advantageous to the program, with price and other factors considered; and
5. HCHC may use competitive proposal procedures for qualifications-based procurement of architectural/engineering (A/E) professional services whereby competitors' qualifications are evaluated and the most qualified competitor is selected, subject to negotiation of fair and reasonable compensation. The method, where price is not used as a selection factor, can only be used in procurement of A/E professional services. It cannot be used to purchase other types of services though A/E firms are a potential source to perform the proposed effort.

e) Procurement by noncompetitive proposals. Procurement by noncompetitive proposals is procurement through solicitation of a proposal from only one source and may be used only when one or more of the following circumstances apply:

1. The item is available only from a single source;
2. The public exigency or emergency for the requirement will not permit a delay resulting from competitive solicitation;
3. The HHS awarding agency or pass-through entity expressly authorizes noncompetitive proposals in response to a written request from the non-Federal entity; or
4. After solicitation of a number of sources, competition is determined inadequate.

f) Contracting with small and minority businesses, women's business enterprises, and labor surplus area firms

1. HCHC must take all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.
2. Affirmative steps must include:
    i. Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
    ii. Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

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iii. Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
iv. Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
v. Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce;
vi. Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (2)(i) through (v) of this section.

g) Contract cost and price.

1. HCHC must perform a cost or price analysis in connection with every procurement action in excess of the Simplified Acquisition Threshold, (currently $150,000) including contract modifications. The method and degree of analysis is dependent on the facts surrounding the particular procurement situation, but as a starting point, HCHC must make independent estimates before receiving bids or proposals.
2. HCHC must negotiate profit as a separate element of the price for each contract in which there is no price competition and in all cases where cost analysis is performed. To establish a fair and reasonable profit, consideration must be given to the complexity of the work to be performed, the risk borne by the contractor, the contractor's investment, the amount of subcontracting, the quality of its record of past performance, and industry profit rates in the surrounding geographical area for similar work.
3. Costs or prices based on estimated costs for contracts under the Federal award are allowable only to the extent that costs incurred or cost estimates included in negotiated prices would be allowable under CFR 75 subpart E.
4. The cost plus a percentage of cost and percentage of construction cost methods of contracting must not be used.

h) Bonding requirements.

1. For construction or facility improvement contracts or subcontracts exceeding the Simplified Acquisition Threshold, (currently $150,000) the HHS awarding agency or pass-through entity may accept the bonding policy and requirements of the non-Federal entity provided that the HHS awarding agency or pass-through entity has made a determination that the Federal interest is adequately protected. If such a determination has not been made, the minimum requirements must be as follows:
    i. A bid guarantee from each bidder equivalent to five percent of the bid price. The “bid guarantee” must consist of a firm commitment

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such as a bid bond, certified check, or other negotiable instrument accompanying a bid as assurance that the bidder will, upon acceptance of the bid, execute such contractual documents as may be required within the time specified.

ii. A performance bond on the part of the contractor for 100 percent of the contract price. A "performance bond" is one executed in connection with a contract to secure fulfillment of all the contractor's obligations under such contract.

iii. A payment bond on the part of the contractor for 100 percent of the contract price. A "payment bond" is one executed in connection with a contract to assure payment as required by law of all persons supplying labor and material in the execution of the work provided for in the contract.

iv. Where bonds are required in the situations described herein, the bonds shall be obtained from companies holding certificates of authority as acceptable sureties pursuant to 31 CFR part 223.

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~~Procurement / Contracting with small and minority businesses, women's business enterprises, and labor surplus area firms.~~

Additional Procurement Procedures;

Purchase orders are not used. Regular operating supplies are ordered by the designated person within each department and do not require prior approval. Additionally, a designated person within each department checks and confirms the accuracy and completeness of deliveries. Invoices are randomly audited by the Finance Department to ensure that orders are for normal operating supplies and do not require further approval.

Requests for purchases of items that cost more than $500 and which are not considered regular operating supplies must be submitted on a Purchase Requisition form. *(See Appendix D)* All other non-regular purchases can be submitted either on a Purchase Requisition or a Check Request form *(See Appendix E)*. The purchase can be made when proper approval for the purchase has been received. See below for guidelines of required approvals based on the cost of the purchase. In most cases the purchase will be for a specific department who will then arrange the purchase. The Finance Department offers assistance and guidance whenever needed.

Payment arrangements need to be made in advance, as the health center cannot accept C.O.D. shipments. ~~Accounts with various vendors have been established and these vendors should be used whenever possible. Purchasing is done trying to use local vendors whenever possible to support the local economy. Every effort should also be made to use minority, disabled and woman owned businesses per state recommendation. Vendors awarded county purchasing contracts or state bids will be~~

~~considered first because these vendors usually have negotiated lower prices, good quality items and have been reviewed to meet the minority, disabled and woman business qualifications.~~

Price is not always the main reason for purchases. Price will be considered along with product quality, features, availability, delivery and service. Except in the case of an emergency purchase, items which cost more than $5,000 require three estimates. If three bids are not available, such as for specialty items, this must be noted on the purchase requisition. Items costing more than $2,000, up to $5,000, require two bids. Items of $2,000 or less do not require any bidding process, but it is expected best judgement is used when making any purchases. Accepting of bids will be based on all the previously noted criteria, cost will be a major factor, but not the only one and all bids can be rejected. If the purchase is made with state, federal or restricted funding, then the purchase needs to fill any requirements the funding source has set in place, if these requirements are more stringent than the Health Center policies.

Required signature authorizations on purchase requests for different levels of purchases are as follows:

PURCHASE	REQUIRED SIGNATURES/APPROVALS
Up to $500	Dept. Head **or** Designee ~~**or** Chief Finance Officer~~
$501 to $52,000	Dept. Head **and** Chief Finance Officer **or** Executive Dir~~ector~~.
$52,001 to $105,000	Dept. Head **and** Executive Dir. **and~~or~~** Chief Financial Officer. ~~Finance Committee~~
$10,~~5,~~001 & over	~~Exec~~Executive~~.~~ Dir. **and** **Chief Financial Officer and** Finance Comm. **or** Chair of Board of Directors

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Travel Reimbursement Procedures

HCHC will reimburse employees for business-related travel. The amount of reimbursement per mile is determined by the Finance Committee or Board and is subject to change. Mileage Reimbursement Requests *(See appendix G)* must be completed and signed by the employee and the employee's supervisor and submitted to the Finance Department for payment. Expenses for transportation, parking, tolls, hotels, food incurred as part of a business related trip and other related travel expenses are considered reimbursable if they comply with the Health Center travel policy as established by the Personnel Committee and listed in the Personnel Policies Handbook.

Reimbursement for travel-related expenses requires documentation of the expenditure through third-party receipts or other verifiable documentation.

For local travel, an employee who uses his or her own vehicle will be reimbursed upon completion of a Mileage Reimbursement Request. *(Refer to Appendix F)* The

employee's immediate supervisor must approve the request. Reimbursement will be at the current mileage rate established by the Finance Committee. Receipts must be presented for reimbursement of other related travel expenses, such as tolls and parking.

Overnight travel will be reimbursed, or pre-paid when required, using a Check Request Form. Payments will be limited to the cost of transportation, hotel accommodations, transfers to and from the destination (taxi or bus fares, etc.) and any other items determined to be travel related. The employee's immediate supervisor must approve the check request. Receipts or other verifiable documentation must accompany the request.

Continuing Education Reimbursement Procedures

The health center pays for continuing education and related travel expenses provided such education is relevant to the employee's responsibilities and is deemed beneficial to the health center.

Request for reimbursement, or pre-payment when required, must be submitted on a Check Request Form and approved by the employee's immediate supervisor. Third-party receipts or supporting documentation must accompany the request.

Certain direct care providers receive stipulated amounts based on their current contracts. Approval of continuing education expenses for all other staff is outlined in the Personnel Policies Handbook or at the discretion of the employee's immediate supervisor.

Accounts Payable Procedures

The health center maintains its accounting records on an accrual basis of accounting.

The Finance Department maintains copies of receiving reports. Approval must appear on the receiving report by the receiving employee attesting that the goods were received and meet specification. These documents are used to establish the propriety of payments on vendor's invoices. Upon the receipt of the invoice, the invoice is compared with the supporting documentation. Finance prepares the payment voucher and records an entry in the Accounts Payable module of the financial software debiting an asset or expense account and crediting the accounts payable account.

A payment voucher is not prepared for an open invoice until the invoice presented for payment has been matched to the approved receiving report. In the absence of a receiving report, approval may be given directly on the invoice.

Invoices for consultants and other services are approved by appropriate personnel.

Standard recurring expenses do not require supervisory approval; however, all expenses are reviewed by the Accounts Payable Manager or Chief Financial Officer prior to payment.

Travel expenses are reimbursed upon submission of a Mileage Reimbursement Request or a Check Request as appropriate. Requests must be supported by receipts and approved by the employee's immediate supervisor.

Reimbursement of miscellaneous expenses incurred on behalf of the Health Center is issued upon submission of a Check Request. Requests must be supported by receipts and approved by the employee's immediate supervisor

Upon receipt of a vendor's invoice, the receiving report on file is matched with the invoice. Approved invoices are assigned an account code and submitted to the Accounts Payable Manager for review and approval. Invoices are entered into the financial software system daily. The software system automatically assigns a unique reference number to each invoice as it is entered and a unique batch number to each batch of invoices. The reference number is written on the invoice for later identification. The batch is held until intentionally released for posting to the General Ledger. Entered invoices are then filed alphabetically.

Check Preparation

The check is a multi-part form containing the check and additional accounting information such as vendor identification, invoice number, invoice date, purchase price and invoice description.

Multiple invoices for a single vendor may be combined in one check.

Each check run is automatically assigned a unique check batch number by the software system. A batch report for each check run is printed and retained in the Finance Department.

Checks are printed weekly. Additional checks may be issued in the case of emergency or as determined by the Finance Department.

The Chief Financial Officer may review the supporting documentation before signing checks.

Payment Procedures

The bottom 2/3 of the check is mailed to the vendor for payment, together with remittance copies as may be requested by the vendor. The top portion of the check is attached to the related invoices and supporting documentation and filed alphabetically by vendor in the Finance Department.

Check not cleared

If a check is not cleared after 120 days, the payee will be notified in writing with suggested options for resolving the final distribution of funds. *(Refer to Appendix G)*

Lost Checks

Lost checks will be re-issued upon written request by the payee.

Monthly Management Reports

Upon completion of all monthly journal entries, financial reports are generated from the accounting software system. The reports include balance sheet and income statement reports. The reports are reviewed by the Chief Financial Officer prior to distribution to the Executive Director, Finance Committee, Board of Directors, and Department Heads. Reports are usually run by the fifteenth of each month so as to be ready for the monthly Finance Committee meeting.

Payroll Procedures

Payroll is based upon time sheets electronically prepared by each employee. If an employee works in more than one department/program, he or she must indicate the number of hours spent on each.

Time sheets are generated bi-weekly with a beginning date of Monday and an ending date of the following Sunday. Checks are issued bi-weekly by the payroll service, currently Checkwriters. There are normally 26 pay periods annually.

The Human Resources Department maintains all personnel records. Hilltown Community Health Centers, Inc. is an at-will employer committed to non-discrimination & affirmative action. All transactions pertaining to personnel are documented with the Personnel Action Form being the most used of all personnel forms. *(Please see Appendix H)*. The Personnel Policies Handbook details personnel procedures, benefits and other pertinent personnel information.

Employees' vacation, sick, personal and accrued holiday time is tracked through the payroll systems and appears on each check stub. Benefit leave for each employee is pro-rated based on the customary number of hours worked. (For a detailed explanation of benefits, refer to the Personnel Policies Handbook.)

Employees may voluntarily contribute to United Way through payroll deductions.

Employees may contribute to a tax-deferred 403b retirement annuity. Contributions are voluntary. Matching contributions by the Health Center, in any, are determined annually.

At the end of each 2-week pay period, employees electronically submit their timesheet. Managers then electronically approve timesheets. Once all timesheets have been approved by a manager, the Finance Department transfers the information and prints copies of each timesheet. Timesheets and a draft copy of the payroll register are reviewed by the Human Resource Manager before final submission to the payroll company.

For each pay period, payroll costs are entered into payroll and tax journals that are posted to the general ledger at month's end. Payroll allocation of employees time is determined by the department/program entered on their timesheet.

United Way pledge forms are made available annually. The Human Resource Manager keeps copies of the signed pledge forms. The total United Way contribution for each pay period is recorded in the payroll journal and is posted to the general ledger at month's end. At the end of each month, a check request is processed and a check issued totaling the payroll deductions that month.

The Human Resource Manager keeps copies of enrollments in the tax-deferred retirement annuity. Contributions are forwarded to the managing agency each pay period. The contribution list is submitted electronically; payment is made by via electronic withdrawal from the operating account.

Payroll Reports Maintained

1. Payroll register that identifies gross pay, less deductions and net pay by employee per pay period. Prepared by payroll service and held in Finance.
2. Check register. Prepared by payroll service and held in Finance.
3. Employees' earnings records that identifies cumulative gross pay and cumulative deductions and net pay for individual employees. Prepared by payroll service and held in Finance.
4. Available vacation leave, sick leave, personal hours and accrued holiday hours per employee. Prepared by payroll service and held in the Human Resources Department.
5. Individual contributions to the health center's tax-deferred retirement annuity. Report from payroll service and transmission report prepared by Finance.
6. Quarterly IRS Form 941. Prepared by payroll service and held in Finance.
7. 1099 Forms. Prepared by Finance.
8. Payroll distribution reports documenting gross payroll for each employee and the program in which they worked.

Accounting for Fixed Assets

Items which have a useful life of more than one year and a cost of $5,000 or more are considered capital items or fixed assets. These items must meet the guidelines set out in the Purchasing Procedures section on page 19. These items are depreciated in a straight-line method based on current acceptable depreciation guidelines, acceptable useful lives and approved by our annual financial audit.

Purchased items are recorded on a spread sheet each fiscal year. The spreadsheet records the date and item purchased, the vendor from which it was purchased, cost, account to which it was coded and any other information considered pertinent. Depreciation is recorded based on our interpretation of current guidelines and is adjusted as determined at time of the annual audit. Items are assigned a unique number used to identify the item when physical inventories are completed. Physical inventories are completed and documented annually ~~at least once every two years in accordance with *OMB Compliance Supplement*~~. The physical inventory matches the item to the inventory record and notes the location of the item. All discrepancies must be resolved.

When a fixed asset is retired, it is removed by netting the original value against the depreciation to determine any net loss. If the asset is sold, the amount from the sale is added to the net value at disposal and any difference is recorded as a gain or loss on the asset sold, whichever is appropriate.

As required by Federal awarding agencies, HCHC will submit reports on the status of Real Property in which the Federal Government retains an interest.

Patient Revenue and Receivable Process

Reports are generated monthly by the Billing Department. The reports detail charges, receipts, adjustments and bad debt for patient receivables. Each set of monthly reports includes a reconciliation of receivable balances which matches the amounts on the patient receivable systems. An input sheet of all transactions is prepared using these reports and is entered into the general ledger. Copies of all pertinent reports are attached to the input sheet for documentation of the monthly entries. See cash receipts section for how patient receipts are handled and recorded.

Regulatory Reporting

Systems and reports have been established to help the health center comply with all regulatory reporting. Many reports are required of the health center and all reports require different formats to report the information. The accounting system has been developed to allow for the different reporting formats and must include;

a) ~~-~~Identification, in its accounts, of all Federal awards received and expended and the Federal programs under which they were received. Federal program and Federal award identification must include, as applicable, the CFDA title and

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number, Federal award identification number and year, name of the HHS awarding agency, and name of the pass-through entity, if any.

b) Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements set forth in §§75.341 and 75.342. If an HHS awarding agency requires reporting on an accrual basis from a recipient that maintains its records on other than an accrual basis, the recipient must not be required to establish an accrual accounting system. This recipient may develop accrual data for its reports on the basis of an analysis of the documentation on hand. Similarly, a pass-through entity must not require a subrecipient to establish an accrual accounting system and must allow the subrecipient to develop accrual data for its reports on the basis of an analysis of the documentation on hand.

c) Records that identify adequately the source and application of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income and interest and be supported by source documentation.

d) Effective control over, and accountability for, all funds, property, and other assets. The non-Federal entity must adequately safeguard all assets and assure that they are used solely for authorized purposes.

e) Comparison of expenditures with budget amounts for each Federal award.

f) Written procedures to implement the requirements of §75.305.

g) Written procedures for determining the allowability of costs in accordance with subpart E of this part and the terms and conditions of the Federal award.

The major reports which are required include:

Annual, Federal Uniform Data System (UDS) Report
Annual ~~OMB Circular A-133~~ audit in accordance with Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards
45 (CFR) Part 75
Annual grant year Federal Financial Status Report (FSR)
State annual Uniform Financial Report (UFR)
IRS Tax Form 990
State tax Form PC
Federal cash draw down quarterly report PSC-272
Medicare annual cost report
Medicaid annual cost report

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The system also allows for grant reporting, salary surveys and other numerous reports which may be required from time to time. These include the annual Federal 330 grant budget renewal, DPH annual contract budget adjustments and various local and private grants.

Annual Fiscal Audit Requirements

HCHC must provide for and submit an independent annual financial audit that is conducted in accordance with Generally Accepted Accounting Principles (GAAP) and the applicable requirements prescribed in 45 CFR Part 75 Subpart F. HCHC must promptly follow up and take corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan in accordance with 45 CFR 75.511

a) Auditor procurement;
   In procuring audit services, the procurement standards prescribed under in this policy must be adhered to, as applicable. When procuring audit services, the objective is to obtain high-quality audits. In requesting proposals for audit services, the objectives and scope of the audit must be made clear and HCHC must request a copy of the audit organization's peer review report which the auditor is required to provide under GAGAS. Factors to be considered in evaluating each proposal for audit services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of peer and external quality control reviews, and price. Whenever possible, HCHC must make positive efforts to utilize small businesses, minority-owned firms, and women's business enterprises, in procuring audit services, as applicable.
b) *Restriction on auditor preparing indirect cost proposals.*
   An auditor who prepares the indirect cost proposal or cost allocation plan may not also be selected to perform the audit required by this part when the indirect costs recovered by the auditee during the prior year exceeded $1 million. This restriction applies to the base year used in the preparation of the indirect cost proposal or cost allocation plan and any subsequent years in which the resulting indirect cost agreement or cost allocation plan is used to recover costs.
c) HCHC Board of Director involvement in selection of auditor;
   Annually the HCHC Board of Directors will review and appoint the Auditor based upon the procurement standards.

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APPENDIX A

ORGANIZATIONAL CHART
&
JOB DESCRIPTIONS FOR
FINANCE DEPARTMENT

APPENDIX B1 & B2

CHART OF ACCOUNTS
AND
SUB ACCOUNT SEGMENTS

APPENDIX C

PETTY CASH RECORD FORM

APPENDIX D

PURCHASE REQUISITION FORM

APPENDIX E

CHECK REQUEST FORM

APPENDIX F

MILEAGE REIMBURSEMENT REQUEST

APPENDIX G

~~SAMPLE LETTER FOR CHECK NOT CLEARED~~
Copy of Conflict of Interest Policy

Hilltown Community Health Centers, Inc.

Administrative Policy

SUBJECT: CREDENTIALING AND PRIVILEGING POLICY
REGULATORY REFERENCE: HCHC Corporate Compliance Plan, Annex 7, Public Health Service Act, Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I), BPHC Policy Information Notice (PIN) 2001-16 and PIN 2002-22, 258 CMR 12.00, M.G.L. c. 13, § 84 and 258 CMR 8.05, 234 CMR 2.00 and M.G.L. c.112, § 45 and § 80B, 244 CMR 3.05(4) and (5), 246 CMR 3.00: M.G.L. c. 112, § 67.

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) has adopted this policy to ensure the patients of HCHC receive the highest level of clinical care possible and to have a formal documented process to follow regarding credentialing and privileging of practitioners with whom it contracts or who it employs to provide medical, oral health, vision or behavioral health care to its patients.

Policy:

1. All HCHC practitioners will be credentialed and privileged according to procedures established in the HCHC Corporate Compliance Plan, Annex 7: Credentialing and Privileging Program.
2. Documents contained in a practitioner's confidential credentialing file will be kept current. Practitioners are required to immediately report any changes in the information contained in his/her credentialing file.
3. HCHC will re-privilege all practitioners every two (2) years on the anniversary date of his/her start of employment. Such renewal of privileges shall contain a documented review of credentialing material as required by Annex 7 of the HCHC Corporate Compliance Plan and applicable regulatory guidance.

Questions regarding this policy or any related procedure should be directed to the Chief Clinical and Community Services Officer at 413-667-3009 ext. 270.

Originally Drafted: AUG 2012 Reviewed or Revised: September 2016

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Executive Director, HCHC

_____ Date: _____
John Follet, MD
President, HCHC Board of Directors

HCHC Quality Dashboard
September 2016

Measure	Description	HCHC Stated Goal/Benchmark (2013)	Current (Q2 2016) Percentage	Notes
HRSA: Quality of Care Measures				
Access to Prenatal Care	Percentage of prenatal care patients who entered treatment during their first trimester	N/A	**N/A**	This measure has not applied to HCHC because we do not offer pre-natal care, but there is some reason to think this may have changed. Will update as needed.
Childhood Immunization	Percentage of children with their 3rd birthday during the measurement year or January 1st of the following year who are fully immunized before their 3rd birthday.	85%	**66.7% (DECREASE)**	
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer	80%	**54% (21.1% INCREASE)**	Mappings were added in Azara which resulted in more test results being captured.
Children and Adolescent Weight Screening and Follow-Up	Percentage of patients aged 3 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year	80%	**1.3% (1.3% INCREASE)**	Structured data questions for both adult and adolescent nutrition and exercise were recently added to the Preventive Med section of eCW. Only (2) providers are using this section at this time. All providers will be advised to use this section at the 9/26/2016 provider meeting.
Adult Weight Screening and Follow-Up	Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented	50%	**32.5% (2.2% INCREASE)**	Structured data questions for both adult and adolescent nutrition and exercise were recently added to the Preventive Med section of Ecw. Only (2) providers are using this section at this time. All providers will be advised to use this section at the 9/26/2016 provider meeting.
Tobacco Use Screening and Cessation	Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user	55%	**33.9% (12.3% DECREASE)**	As with exercise and nutrition smoking cessation was added to Preventative Med section and will be implemented at next provider meeting.
CAD Lipid Therapy	Percentage of patients aged 18 years and older with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy	70%	**84.3%**	
IVD and Use of Aspirin or other anti-thrombotic therapy	Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior year OR who had a diagnosis of ischemic vascular disease during the measurement year who had documentation of use of aspirin or another antithrombotic	88%	**85.6%**	In validating the data in Azara I found that there were patients with 81 mg Aspirin on their active med list which were not included in the numerator.
Colorectal Cancer Screening	Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer	55%	**58.4% (7.3% INCREASE)**	Mapping was improved in Azara resulting in greater data capture.
Asthma Pharmacological Treatment		95%	**94.4%**	Azara (two patients were on intermittent albuterol). More research is needed to determine how persistant asthmas is defined and captured by Azara.
Depression Screening and Follow-up	Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	50%	**32.1%**	

HCHC Quality Dashboard
September 2016

New HIV Cases With Timely Follow Up	Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis	90%	**0.0%**	New measure for 2016 - no data yet available
Child Dental Sealant	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the reporting period	65%	**0.0%**	New measure for 2016 - no data yet available
HRSA: Health Outcomes and Disparities Measures				
Diabetes	Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was greater than or equal to 9% at the time of the last reading in the measurement year. (Taken from UDS Table 7 DM A1C)	83%	**30.0%**	This measure appears to have changed since the goal was set in 2013, and it may have gone from a positive measure of patients whose A1C is controlled (high=good), to a negative measure in which it is not (high=bad). This is being researched, and will be clarified.
Hypertension	Percentage of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 at the time of the last reading. (Taken from UDS Table 7)	90%	**71.0%**	
Birthweight	Percentage of patients born to health center patients whose birthweight was below normal (less than 2500 grams)	N/A	**N/A**	This measure has not applied to HCHC because we do not offer pre-natal care, but there is some reason to think this may have changed. Will update as needed.
HRSA: Other Measures (from 2016 Non-Compete Continuation Grant Application)				
Child Health	Reducing the percentage of pediatric patients age 3-18 during measurement years, whose BMI is greater than or equal to the 85th percentile	25%		This measure was 32.12% in 2009, our baseline year.
Oral Health	Children with one or more cavity within the last year or have social factors that place them at risk for caries will be reduced	30%	**0%**	This is a new measure. In 2016 we reported that two-thirds of our pediatric oral health patients (18 and under) are Medicaid recipients, which means that they are considered highrisk for social factors that also contribute to dental decay. The decrease is the result of increased efforts to provide fluoride varnishes to all children during medical and dental visits, and therefore is a positive sign.
Cancer	Percentage of women 40 and older with no mammogram in the years prior or in the measurement year. (This data is reported from Azara MU General Practice CQM)	10%	**37%**	HCHC uses a protocol that only recommends mammograms for women 50 and older, which has a significant impact on this number. With the NFL grant implemented in late 2015, we anticipate this number improving in 2016.
Department Prioritized Measures (with reporting entity, as applicable)				

Annex 7: HCHC Credentialing and Privileging Program

I. Introduction and History

Regular verification of the credentials of health care practitioners and definition of their privileges are required for increased patient safety, reduction of medical errors and the provision of high quality health care services. This has been previously recognized via the credentialing requirements required by the Health Centers by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Bureau of Primary Health Care (BPHC). The BPHC Health Center Program Expectations states that a Health Center credentialing process should meet the standards of a national accrediting organization such as the JCAHO or the Accreditation Association for Ambulatory Health Care, Inc., (AAAHC), in addition to the requirements for coverage under the Federal Tort Claims Act (FTCA). The JCAHO requires primary source verification of the credentials of only licensed independent practitioners. The AAAHC requires credentialing of all licensed healthcare practitioners. The Federally Supported Health Centers Assistance Act of 1992 (Act) requires that each deemed Health Center that participates in the FTCA must credential all its physicians and other licensed or certified health care practitioners. This requirement under the Act covers more health practitioners than the JCAHO or AAAHC requirement. In order to bring clarity to the requirements health centers must meet, BPHC has adopted a credentialing and privileging policy that is consistent with the broader requirement of the Federally Supported Health Centers Assistance Act of 1992. (*BPHC PIN 2001-16*)

II. Authority

The authority for this annex and all policies derived from this annex rests in the Public Health Service Act, Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I). Additional authority can be found in BPHC Policy Information Notice (PIN) 2001-16 and PIN 2002-22. Behavioral Health authority rests in 258 CMR 12.00, M.G.L. c. 13, § 84 and 258 CMR 8.05. Authority over dental activities rests in 234 CMR 2.00 and M.G.L. c.112, § 45. Medical auxiliary (RN, LPN, etc.) authority is found in M.G.L. c. 112 § 80B and 244 CMR 3.05(4) and (5). Optometry licensing, credentialing and privileging authority rests in 246 CMR 3.00: M.G.L. c. 112, § 67.

III. Definitions

Credentialing: the process of assessing and confirming the qualifications of a licensed or certified health care practitioner.

Privileging/Competency: the process of authorizing a licensed or certified health care practitioner's specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance.

Licensed or Certified Health Care Practitioner: an individual required to be licensed, registered, or certified by the State, commonwealth or territory in which a Health Center is

located. These individuals include, but are not limited to, physicians, dentists, registered nurses, social workers, medical assistants, licensed practical nurses, dental hygienists, nutritionists, and registered dieticians. "Licensed or certified health care practitioners" can be divided into two categories: a) licensed independent practitioners (LIPs) and b) other licensed or certified practitioners. As such, the credentialing and privileging requirements of these two groups may vary.

Licensed Independent Practitioner: physician, dentist, nurse practitioner, Licensed Independent Clinical Social Worker (LICSW), Licensed Mental Health Counselor (LMHC), and nurse midwife or any other "*individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.*" HCHC has the responsibility of determining which individuals (including staff that may not be covered under Federal Tort Claims Act such as volunteers, certain part-time contractors, and *locum tenens*) meet this definition based on law and the organization's policy.

The HCHC Credentialing program includes in this category the following:

1. Medical Doctors
2. Advanced Practice Providers (Nurse Practitioners)
3. Dentists
4. Licensed Independent Clinical Social Workers (LICSWs)
5. Licensed Mental Health Clinician (LMHCs)
6. Optometrists

Other Licensed or Certified Health Care Practitioner: An individual who is licensed, registered, or certified but *is not permitted by law to provide patient care services without direction or supervision*. Examples include, but are not limited to, laboratory technicians, Licensed Clinical Social Worker (LCSW), medical assistants, registered nurses, licensed practical nurses, dental hygienists, nutritionists, and registered dieticians.

The HCHC Credentialing program includes in this category the following:

1. Registered Nurses (RNs)
2. Licensed Practical Nurses (LPNs)
3. Medical Assistants
4. Licensed Clinical Social Workers (LCSWs)
5. Dental Hygienists
6. Dental Assistants
7. Nutritionists & Dieticians

Primary Source Verification: Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and reports from credentials verification

organizations. The Education Commission for Foreign Medical Graduates (ECFMG®), the American Board of Medical Specialties, the American Osteopathic Association Physician Database, or the American Medical Association (AMA) Master file can be used to verify education and training. The use of credentials verification organizations (CVOs) or hospitals that meet JCAHO's "Principles for CVOs" is also an acceptable method of primary source verification.

Verification for some items must be obtained from primary sources and should be in writing from the primary source, although oral verification can be done. In the unlikely event that only oral verification is obtained, a dated and signed note in the credentialing file stating who at the primary source verified the item, the date of verification, and how it was verified is required.

Secondary Source Verification: Methods of verifying a credential that are not considered an acceptable form of primary source verification. These methods may be used when primary source verification is not required. Examples of secondary source verification methods include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential (when the copy is made from an original by approved HCHC staff).

Credentialing and Privileging Committee: Conducts an initial evaluation of the applicant's Credentialing & Privileging file and consists of the Executive Director, two Board members, and the Credentialing/Privileging Specialist.

- Recommends to the Board of Directors approval or denial of the provider's application.
- Records its actions and comments in the Credentialing/Privileging Review Sheet.
- The Credentialing/Privileging Review Sheets are signed and dated by the Board members of the Credentialing and Privileging Committee.
- The Board of Directors considers the Credentialing and Privileging Committee's recommendations, and votes on final approval or denial of the provider's application.

Credentialing Specialist: Provides executive support to the appropriate supervisor or his/her designee as follows:

- Gathering the providers' application and required supporting documentation.
- Following up with providers regarding unanswered questions and/or information on their application.
- Obtaining primary source verification or confirmation of current licensure, relevant training and experience, current competence, and ability to perform requested privileges.
- Reviewing and preparing initial file for Credentialing/Privileging Committee.
- Maintaining files of approved providers.
- Notifying the provider and his/her appropriate supervisor (or the supervisor's designee) in advance of the providers' anniversary date, so that the re-privileging process can begin.

IV. Credentialing

A. Initial Credentialing Requirements

1. Primary Source Verification

a) Initial credentialing of LIPs requires primary source verification of the following:
(1) Current licensure;
(2) Relevant education, training, or experience;
(3) Current competence, defined as verification of current competence based on a statement from the applicant regarding disciplinary/other actions, peer recommendations, results of the interview and screening process, and a complete review of the provider's file for inconsistencies, gaps, disciplinary actions, etc.; and
(4) Health fitness, or the ability to perform the requested privileges, can be determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or a licensed physician designated by the organization.

b) Credentialing of other licensed or certified health care practitioners requires primary source verification of the individual's license, registration, or certification only. Education and training may be verified by secondary source verification methods. Verification of current competence is accomplished through a thorough review of clinical qualifications and performance.

2. Secondary Source Verification

a) Credentialing of LIPs and other licensed or certified health care practitioners also requires secondary source verification of the following:
(1) Government issued picture identification;
(2) Drug Enforcement Administration registration (as applicable);
(3) Hospital admitting privileges (as applicable);
(4) Immunization and PPD status; and
(5) Life support training (as applicable).

3. National Practitioner Data Bank

a) HCHC must also query the NPDB (as applicable) for these LIPs as part of the initial credentialing process.

These requirements are a minimum and do not restrict HCHC from credentialing other licensed or certified health care practitioners to similar standards as those used for LIPs.

The following table lists the minimum required activities identified in PIN 2002-22 for credentialing both LIPs and Other licensed or certified practitioners.

Table 1: Credentialing Requirements Matrix		
	Licensed Independent Practitioner (Physician, Dentist APRN, Optometrist, LICSW)	**Other licensed or certified practitioner** (RN, LPN, CMA, Registered Dietician, LCSW)
Activity	**Method**	
Verification of licensure, registration, or certification	Primary source	Primary Source
Verification of education	Primary source	Secondary source
Verification of training	Primary source	Secondary source
Verification of current competence	Primary source, written	Supervisory evaluation per job description
Health fitness (Ability to perform the requested privileges)	Confirmed statement	Supervisory evaluation per job description
Approval authority	Governing Body (usually concurrent with privileging)	Supervisory function per job description
National Practitioner Data Bank Query	Required, if reportable	Required, if reportable
Government issued picture identification, immunization and PPD status, and life support training (if applicable)	Secondary source	Secondary source
Drug Enforcement Administration (DEA) registration, hospital admitting privileges	Secondary source, if applicable	Secondary source if applicable

Source: BPHC PIN 2002-22

4. Advanced Practice Clinician Supervision Agreements

Advanced Practice Clinicians and physicians must have a signed Advanced Practice Clinician Supervision Agreement that complies with applicable laws and regulations.

5. Credentialing Process for Students, Trainees and Medical Residents

a) Proof of Professional Liability insurance in the amount $1M/$3M required
b) Signed contract with the school or other training facility permitting students or trainees to train at the health center
c) CORI check completed with no findings
d) Letter from the student stating ability to perform requested privileges
e) Current unrestricted license to practice in the State of Massachusetts (if applicable)
f) Current DEA certificate (if applicable)
g) Current MA Controlled Substance certificate (if applicable)
h) Government issued Photo I.D.
i) Proof of Immunizations/Titers as described in the Personnel Handbook
j) Name of HCHC's supervising provider
k) Release of Liability
l) Attestation

B. Types of Verification

1. Primary Source Verification

a) Current License or Certification as Appropriate to the Discipline: Verification of current Massachusetts license must be obtained by direct confirmation from the applicable Massachusetts licensing board. Online licensure verification is accepted.
b) Board Certification (if applicable): Board certification is verified from ABMS for physicians, or other appropriate certifying board for non-physicians. Online verification is accepted.
c) Verification of Graduation from Medical School or Training Program: Written verification will be requested directly from medical school or training program or through the AMA Master Profile or through DegreeVerify.com. If the provider is a graduate of a Foreign Medical School, he/she must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG). This information is then verified with ECFMG.
d) Verification of Completion of Residency Training (if applicable): Verification of completion of residency training is obtained from the institution(s) where the post-graduate medical training was completed or through the AMA Master Profile.
e) Professional Liability Claims History: Verification of claims history must be obtained from the current and/or previous carriers if the provider has been insured with the present carrier for less than five (5) years.

2. Secondary Source Verification

Secondary verification of information begins as soon as the application appears complete and is satisfied by presentation of original documents to the Credentialing Specialist for the following:

a) Government-issued photo ID
b) Proof of Immunizations/titers
c) Malpractice Insurance Coverage (if applicable)
d) Current DEA Certificate (if applicable)
e) Current MA Controlled Substance Registration (if applicable)
f) Hospital Privileges from the Applicant's Primary Admitting Facility (if applicable)
g) Verification of clinical privileges in good standing at the hospital designated by HCHC as its primary admitting facility must be confirmed in writing and must include the date of the appointment, scope of privileges, disciplinary actions, restrictions and

recommendations.

h) Certification (if applicable)

i) Work History (if applicable)

j) At least five (5) years of professional work history must be included in the file. Providers will be asked to explain any gap greater than one (1) year in his/her professional work history.

3. Other Verification

a) Current Competence: For initial credentialing, verification of current competence will be based on a statement from the applicant regarding disciplinary/other actions, peer recommendations, results of the interview and screening process, and a complete review of the provider's file for inconsistencies, gaps, disciplinary actions, etc.

b) Ability to Perform Requested Privileges: For new providers, verification of ability to perform requested privileges will be based on 1) a statement from the applicant's primary care provider regarding health status, and 2) appropriate education/training to perform requested procedures.

4. Database Queries

The following databases will be queried for all practitioners, as applicable:

- National Practitioner Databank (NPDB)
- OIG List of Excluded Individuals
- Government Service Admin (GSA)/ SAM.gov
- MA State Exclusion List
- Mass.gov license verification

C. Credentialing Process

The determination that a practitioner meets the credentialing requirements must be stated in writing by the Health Center's governing board. Ultimate approval authority is vested in the HCHC Board of Directors which may review recommendations from the Credentialing and Privileging Committee. This responsibility may only be delegated to an appropriate individual by resolution and will be implemented based on approved policies and procedures (including methods to assess compliance with these policies and procedures).

Credentialing of other licensed or certified health care practitioners must be completed prior to the individual being allowed to provide patient care services and will follow the same procedure as that outlined for Independent Practitioners.

The Credentialing process will proceed as follows:

- The Credentialing Specialist will request and collect all the necessary documentation.
- Once all the necessary documents have been received and the file is completed, a Credentialing Review Sheet will be placed on top of the provider's application.
- The Credentialing / Privileging Specialist will sign off that a satisfactory review has been conducted
- The supervisor or his/her designee will review all applications and sign off on the Review Sheet.

- The Credentialing Specialist will present the provider's application to the Credentialing and Privileging Committee, which will review all items in the application and sign off on the Review Sheet if approved
- If the Committee approves the application, it will issue a recommendation to HCHC's Board of Directors for approval or denial. Approval or denial by the Board of Directors will be obtained within ninety (90) days of employment.
- In some cases, the supervisor and the Credentialing Specialist may agree to submit an incomplete application to the Committee for approval on a Pending status, noting the reason for this action in the blank section of the Credentialing Review Form. The Committee may approve the pending application with the requirement that the application be completed within 30 days.

After the vote of the Board is made, the following action is made:

- Approved File**:** A letter of approval is signed by the Board and sent to the provider by the Credentialing Specialist.
- Denied File: A letter of denial is signed by the Board and sent to the provider by the Credentialing Specialist.
- Pending File: The Credentialing Specialist will obtain additional information requested so that the file can be considered for approved.

D. Other

1. Right to Review Credentialing File

Each provider shall have the right to review all information obtained during HCHC's credentialing process and correct any erroneous or incorrect information. Each applying provider shall be notified of any information obtained during the credentialing process that does not meet HCHC's standards. HCHC will accept "corrected" information, subject to objective confirmation.

2. Orientation

As part of the department orientation, all newly hired providers will shadow the department director or designee for a designated period, depending on the length of experience and credentials. The department director will perform a series of chart reviews during the first two weeks of the new provider's orientation. Any and all findings are discussed with the provider.

E. HCHC Re-Verification Process

While there is no requirement specified in any regulatory guidance to conduct a formal re-credentialing process, the requirement does exist to re-verify no less often than every two years, based on the expiration date of the practitioners' license, the following:

- current licensure, registration, or certification
- current competence, which is verified by the practitioner's supervisor through primary sources, including peer review and/or performance improvement data for LIPs, and through supervisory evaluation per job description for other licensed or certified practitioners.

When a Department Head makes an adverse decision on a practitioner's re-verification of current competence, LIPs are afforded an opportunity for a fair hearing and appellate review by the Credentialing and Privileging Committee in accordance with the appeal provisions outlined in the Grievance Policy of the Personnel Policies.

V. Privileging

A. Privileging Requirements

Policy Information Notice 2001-16 requires privileging of each licensed or certified health care practitioner specific to the services being provided at each of HCHC's care delivery settings.

1. The initial granting of privileges to LIPs is performed by the health center. Ultimate approval authority is vested in the HCHC Board of Directors which may review recommendations from either the Chief Clinical and Community Services Officer (CCCSO), the Department Head, or a joint recommendation of the clinical staff (including the CCCSO) and the Chief Executive Officer. This responsibility may only be delegated to an appropriate individual by resolution or an amendment to the by-laws and will be implemented based on approved policies and procedures (including methods to assess compliance with these policies and procedures).
2. For other licensed or certified health care practitioners, privileging is completed during the orientation process via a supervisory evaluation based on the job description.
3. Temporary privileges may be granted if the Health Center follows guidelines specified by JCAHO (see Section H).

B. Privileging of Licensed Independent Practitioners

Due to the wide range of clinical services provided by HCHC, privileging requirements will be necessarily be slightly different based on clinical specialty and position. Approval will be granted by the Credentialing and Privileging Committee of the Board for up to two years and must be renewed at that time.

1. Medical Practitioners

a) Family Practice Physicians

Initial privileging for the following procedures does not require additional documentation of proficiency beyond residency training:

Skin procedures	Gynecology procedures	Orthopedic procedures
Punch biopsy	IUD insertion and removal	Injection of knee
Shave biopsy	Endometrial biopsy	Injection of shoulder
Excisional biopsy		Injection of hip
Cryotherapy		Other joint injection
Suturing		
Incision and drainage		
Toenail removal		
Cyst removal		

b) Medicine/Pediatrics, Internal Medicine and Pediatric Physicians

Initial privileging for skin procedures including incision and drainage, cryotherapy and suturing does not require additional documentation of proficiency beyond residency training.

Initial privileging for other skin procedures including punch biopsy, shave biopsy, excisional biopsy and nail removal, and for joint injections, require documentation of appropriate training in residency, or training in a post-graduate CME or program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician. There are no specific requirements as to the number of procedures performed in order to maintain privileging.

Initial privileging to perform IUD insertion and/or endometrial biopsy requires proof of appropriate training in residency, or training in a post-graduate CME program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician. Maintenance of privileging requires competent insertion of a device or performance of an endometrial biopsy at least five (5) times per year.

c) Nurse Practitioners

Initial privileging for the procedures identified in the table below requires documentation of proficiency beyond completion of a nurse practitioner program, to include CME or other post-graduate training, or specific on-site training by a privileged clinician and observation and approval by a privileged provider.

Skin procedures	Orthopedic procedures
Punch biopsy	Injection of knee
Excisional biopsy	Injection of shoulder
Shave biopsy	Injection of hip
Cryotherapy	Other joint injection
Suturing	

Incision and drainage	
Toenail removal	
Cyst removal	

Initial privileging to insert IUDs and/or perform endometrial biopsy requires proof of appropriate training in a post-graduate CME program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician. Maintenance of privileging requires competent insertion of a device or performance of an endometrial biopsy at least five (5) times per year.

d) Applicable to All Medical LIPs

Initial privileging to perform cervical colposcopy requires successful completion of the Colposcopy Mentorship Program of the American Society for Colposcopy and Cervical Pathology (ASCCP), or demonstration of equivalent training in a post-graduate CME program; and observation and approval by a privileged clinician. Maintenance of privileging requires competent performance of a minimum of five (5) colposcopies per year.

Initial privileging to perform subdermal contraceptive implant (e.g. Nexplanon) insertion and removal requires proof of appropriate training either by the manufacturer or as part of a CME program. Maintenance of privileging requires competent insertion of at least three (3) devices per year.

Providers already on staff at the time of adoption of this policy may request a waiver of the above process for any specific procedure. For each procedure, the practitioner should submit a summary of the training they have received, the approximate time they first began doing the procedure, the approximate number of procedures they have done, and a statement as to their competency to perform the procedure. The QI Director for Medicine will be responsible for reviewing a sample of charts for visits in which the procedure was performed, and making a recommendation to the Board. Following initial privileging, each clinican is responsible for:

- Prompt reporting of any adverse outcome or complication to the Medical Director;
- Performance of the specified minimum number of procedures specified above, or evidence of appropriate CME or other training to maintain skills.

2. Behavioral Health Practitioners

a) Licensed Independent Clinical Social Workers and Licensed Mental Health Clinicians

Pursuant to 258 CMR 12.00: M.G.L. c. 13, § 84 and 258 CMR 8.05, LICSWs and LMHCs may provide all services listed below without supervision. Primary source verification of their MA license to practice shall suffice for verification of competency.

Behavioral Health Competencies		
Individual Counseling	Couples Counseling	Counseling of Children
Counseling of Adolescents Outpatient Level of Treatment of Substance Abuse	Family Counseling Outpatient Level Treatment of Mental Disorders	Group Counseling Assessment
Diagnosis	Treatment Planning	Psychotherapeutic Intervention
Psycho-education	Referrals	Case Management
Collateral Communication	Refer client for Section 12	

3. Dental/Oral Health Practitioners

a) Licensed Dentists

Pursuant to 234 CMR 2.00 and M.G.L. c.112, § 45, all applicants for dental licensure in the Commonwealth are required to submit a full, accurate, and complete application for licensure on forms provided by the Board, and to provide proof that they have:

- graduated with a DDS or DMD degree from a dental college accredited by the Commission on Dental Accreditation;
- successfully passed the national board exams, the written and clinical parts of the Northeast Regional Board Examination (NERB) (or other regional exam accepted by the Board of Registration in Dentistry), and the Massachusetts Ethics and Jurisprudence Exam.

A primary source verification of MA dental licensure shall be sufficient proof of competency in the following areas:

Oral Health Competencies for Licensed Dentists		
Perform clinical and regional oral exams including oral cancer screening	Perform patient medical and dental history	Perform oral diagnosis
Develop comprehensive treatment plans with full explanation of risks and alternatives	Order and interpret radiology tests	Order and interpret laboratory tests
Refer to diagnostic medical or dental providers when necessary	Provide consultation services	Prescribe medications for patients
Prescribe anxiolytic	Administer IM/SC	Restorative care including

Oral Health Competencies for Licensed Dentists		
medications and narcotics for patients using the Mass reference system	injections	amalgams, composites, crowns, and implant restorations
Root canals – anterior teeth	Root canals – posterior teeth	Periodontics – gingivectomies
Prosthodontics – removable/fixed full dentures, removable/fixed partial dentures, full/partial overdentures	Palliative treatment	Simple extractions
Surgical extractions	Tissue impacted teeth extractions	Abscess incision and drainage
Frenectomies	Local anesthesia	

4. Eye Care Practitioners

a) Optometrists

The minimum training requirements for privileging for Optometrists consist of

1. Graduation from an accredited optometry program
2. Successful passing of all parts of the National Board of Examiners in Optometry
3. Successful passing of the Massachusetts law exam

Optometric Privileges:		
Photo-documentation	Medical laboratory studies	Ocular imaging studies
General Optometric exam/diagnosis/optical therapy	Diagnostic pharmaceutical agents	Extended posterior segment evaluation
Visual fields testing/evaluation	Low vision management	Contact lens management
Oculomotor/perceptual/pupillary problems	Non-invasive management of lid conditions	Non-invasive care of external eye injuries/burns
Epilation of lashes	Conjunctivitis therapy with topical medications	Non-invasive lacrimal function evaluation
Corneal abrasion care	Non-perforating foreign substance removal	Management of keratitis-sicca and other epithelial keratitis (non-microbial)
Gonsioscopy	OTC oral medications for ocular disease	Emergency treatment of life/sight/threatening condition prior to referral
Ultrasound measurement /	Punctum	Anterior uveitis care

evaluation	dilation/plugs/irrigation	
Medical hyphema management	Co-manage open angle glaucoma	Co-manage acute glaucoma
Lids and periorbital skin	Keratitis	Episcleritis
Post-surgical eye care		

C. Other Licensed or Certified Practitioners

Privileging for other licensed or certified practitioners requires primary source verification of their license to practice as well as supervisory evaluation of competence per employee job description. HCHC requires job descriptions be reviewed during employee orientation. Once reviewed, they will be signed by both the employee and supervising nurse and filed in the employees file in Human Resources.

Initial evaluation will be conducted during their orientation period. Validation of competence shall be documented on a new hire 90-day performance evaluation or using a competencies checklist when indicated by law.

1. Medical Practitioners

a) Medical Auxiliaries

(1) Registered Nurses

Pursuant to M.G.L. c. 112 § 80B, privileges accorded to registered nurses, by virtue of MA Board licensing shall include, but not be limited to:

1. the application of nursing theory to the development, implementation, evaluation and modification of plans of nursing care for individuals, families and communities;
2. coordination and management of resources for care delivery,
3. management, direction and supervision of the practice of nursing, including the delegation of selected activities to unlicensed assistive personnel.

(2) Licensed Practical Nurses

Pursuant to M.G.L. c. 112 § 80B, privileges accorded to licensed practical nurses, by virtue of MA Board licensing shall include, but not be limited to:

1. participation in the development, implementation, evaluation and modification of the plans of nursing care for individuals, families and communities through the application of nursing theory;
2. participation in the coordination and management of resources for the delivery of patient care;
3. managing, directing and supervising safe and effective nursing care, including the delegation of selected activities to unlicensed assistive personnel.

(3) Medical Assistants

In accordance with 244 CMR 3.05, selected nursing activities may be delegated to unlicensed personnel such as Medical Assistants (MA). Said delegation must occur within the framework of the MA's job description and be in compliance with 244 CMR 3.05(4) and (5).

2. *Behavioral Health Practitioners*

a) Licensed Clinical Social Workers

LCSWs may provide all services listed in the table provided one hour per week of supervision by a LICSW is provided and documented. Primary source verification of their MA license to practice shall suffice for verification of competency.

3. Dental/Oral Health Practitioners

a) Dental Auxiliaries

Dental auxiliaries include the following positions:

(1) Registered Dental Hygienist (RDH)
(2) Certified Dental Assistant (CDA)
(3) Formally Trained Dental Assistant (FTA)
(4) On-the-job training Dental Assistant (OJT)

The above positions are classified as Other Licensed or Certified Practitioners for the purposes of privileging and credentialing and, as such, require supervisory evaluation of skills per job description. They are permitted by law to perform all delegated functions listed in the table below under certain levels of supervision.

- General supervision (G) - Supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of a supervising dentist during the performance of those procedures.
- Direct Supervision (D) - Supervision of dental procedures based on instructions given by a licensed dentist who remains in the dental facility while the procedures are being performed by the auxiliary.
- Immediate Supervision (I) - Supervision of dental procedures by a licensed dentist who remains in the dental facility, personally diagnoses the condition to be treated, personally authorizes the procedures, and before dismissal of the patient, evaluates the performance of the auxiliary.

Delegated Procedure	**Appropriate Supervision**			
	RDH	**CDA,**	**FTA**	**OJT**
Give oral health instruction	G	G	G	G
Perform dietary analysis for dental disease control	G	G	G	G
Take and record vital signs	G	G	G	G
Chart dental restorations and record lesions	G	D	D	D
Take intra-oral photographs	G	G	G	G

Delegated Procedure	Appropriate Supervision			
	RDH	CDA,	FTA	OJT
Retract lips, cheek, tongue and other oral tissue parts	G	G	G	G
Place temporary restorations	G	D	D	I
Irrigate and aspirate the oral cavity	G	D	D	D
Isolate the operative field	G	G	G	D
Take impressions for study casts, athletic mouth guards, custom trays	G	G	G	I
Take wax bite registrations for identification purposes	G	G	G	D
Apply topical anesthetic agents	G	I	I	I
Take oral cytologic smears	D			
Remove sutures	G	G	G	D
Place and remove periodontal dressings	G	G	G	D
Place and remove rubber dam	G	G	G	D
Irrigate and dry root canals	I	I	I	I
Expose radiographs	G	G	D	D
Remove gingival retraction cord	D	D	D	D
Apply cavity varnish	I	I	I	I
Remove temporary restorations with hand instruments	G	I	I	N/A
Place and remove wedges	G	D	D	I
Place and remove matrix bands	G	D	D	I
Place gingival retraction cord	D	D	D	D
Cement and remove temporary crowns and bridges	G	G	G	I
Insert and/or perform minor adjustment of athletic mouth guards and custom fluoride trays	G	G	G	I
Polish teeth after dentist or dental hygienist has determined that teeth are free of calculus	G	G	G	N/A
Apply anti-cariogenic agents	G	G	G	D
Remove surgical dressings	G	G	G	N/A
Apply dental sealants	G	I	I	N/A
Place surgical dressings	G	G	G	N/A
Perform pulp testing	D	N/A	N/A	N/A

Delegated Procedure	Appropriate Supervision			
	RDH	CDA,	FTA	OJT
Select and try stainless steel crowns or other pre-formed crown for insertion by dentist	I	I	I	I
Perform periodontal charting	G			
Conduct dental screenings	G			
Perform preliminary examination to determine needed dental hygiene services	G			
Perform sub-gingival and supra-gingival scaling	G			
Perform root planing and curettage	G			
Polish amalgam restorations	G			
Apply identification microdisks	G			
Perform minor emergency denture adjustments to eliminate pain and discomfort in nursing homes and other long term care facilities	G			

Table obtained from 234 CMR-2.04

Administration of local anesthesia is limited to hygienists who have been trained in accordance with 234 CMR 6.00 and requires additional privileging, in writing, by the HCHC Board of Directors

D. Privileging Revision or Renewal Requirements

The revision or renewal of a LIP's privileges must occur at least every 2 years and will include primary source verification of expiring or expired credentials, a synopsis of peer review results and/or any relevant performance improvement information. Similar to the initial granting of privileges, approval of subsequent privileges is vested with the HCHC Board of Directors.

1. The revision or renewal of privileges of other licensed or certified health care practitioners should occur at a minimum of every 2 years. Verification is by:
    a. supervisory evaluation of performance that assures that the individual is competent to perform the duties described in the job description based on the following:
        i. for LIPs: Primary source based on peer review and/or performance improvement data.
        ii. for Other Licensed or Certified Practitioners: Supervisory evaluation per job description
    b. verification of current licensure, registration, or certification through primary source
2. When a Department Head makes an adverse decision on a practitioner's re-privileging, LIPs are afforded an opportunity for a fair hearing and appellate review by the

Credentialing and Privileging Committee in accordance with the appeal provisions outlined in the Grievance Policy of the Personnel Policies.

E. Temporary Privileging

The Joint Commission has determined that there are two circumstances for which the granting of temporary privileges would be acceptable:

1. To fulfill an important patient care need

In some circumstances, temporary privileges can be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Examples would include, but are not limited to:

a) a situation where a physician becomes ill or takes a leave of absence and an LIP would need to cover his/her practice until he/she returns (locum tenens)

b) a specific LIP has the necessary skills to provide care to a patient that an LIP currently privileged does not possess

In these circumstances, temporary privileges may be granted by the Executive Director upon recommendation of either the applicable clinical department chairperson head or the CCCSO provided there is verification of current licensure and current competence, as defined above.

2. When an applicant with a complete, clean application is awaiting review and approval of the Credentialing and Privileging Committee and the Board of Directors.

In the second circumstance temporary privileges may be granted when the new applicant for medical staff membership or privileges is waiting for a review and recommendation by the Credentialing and Privileging Committee and the Board of Directors. Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the Executive Director upon recommendation of either the applicable clinical department head or the CCCSO provided:

- there is verification of
  - current licensure
  - relevant training or experience
  - current competence as defined above
  - ability to perform the privileges requested
  - other criteria required by medical staff bylaws
- the results of the National Practitioner Data Bank query have been obtained and evaluated
- the applicant has:
  - a complete application
  - no current or previously successful challenge to licensure or registration
  - not been subject to involuntary termination of medical staff membership at another organization

- not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

Temporary privileges are not to be routinely used for other administrative purpose such as the following situations:

1. the LIP fails to provide all information necessary to the processing of his/her reappointment in a timely manner
2. failure of the staff to verify performance data and information in a timely manner

In the above situations, the LIP would be required to cease providing care in the facility until the reappointment process is completed.

Hilltown Community Health Centers, Inc.

Administration

SUBJECT: NAME OF POLICY – CREDIT AND COLLECTION POLICY

REGULATORY REFERENCE: MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES 101 CMR 613.00: M.G.L. c. 118E

Purpose:
Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal document process to maintain accurate credit and collection procedures in accordance with State and Federal regulations and laws.

Original Draft: MARCH 2016 Reviewed or Revised: **JULY 2016**

Approved by the Board of Directors, Date: July 28, 2016

Approved by:

Name: Eliza B Lake
Eliza B. Lake
Executive Director, HCHC
Date: 7/28/16

Name: John Follet
John Follet, MD
President, HCHC Board of Directors

CREDIT & COLLECTION POLICY

1. General Fi ling Requirement *613.08(1) (c)*

1.1 The Hilltown Community Health Center will electronically file its Credit & Collection Policy with the Health Safety Net (HSN) Office within 90 days of adoption of amendments to this regulation that would require a change in the Credit & Collection Policy; when the health center changes its Credit & Collection Policy; or when requested by the HSN Office .

2. General Definitions *613.02*

2.1 Emergency Services – N/A

2.2 The Urgent Care Services Definition used to determine allowable Bad Debt under *613.06 is:* Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

3. General Collection Policies & Procedures *613.08(1)(c)2 and 613.04(6)(c)3*

3.1 Standard Collection Policies and Procedures for patients *613.08(1)(c)2a*

(a) The health center makes reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff provides all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provides assistance, as needed, to the patient in completing the form.

A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff ask returning patients, at the time of visit, whether there have been any changes in their income or insurance coverage status. If there has been a change, the new information is recorded in the center's practice management system and the patient advised or assisted to inform MassHealth of the change.

(b) The health center undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

(1) an initial bill is sent to the party responsible for the patient's financial obligations;
(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;
(3) efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and

(4) a final notice is sent by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments in accordance with 101 CMR 613.04 (6) (b) and deductibles in accordance with 101 CMR 613.04(6) (c), that they will be responsible for these co-payments.

(d) Low Income Patient Co-Payment Requirements. The health center requests co-payments of $1 for antihyperglycemic, antihypertensive, and antihyperlipidemic generic prescription and $3.65 for generic and brand-name drugs from all patients over the age of 18, with the exception of pregnant or postpartum women, up to a maximum pharmacy co-payment of $250 per year.

(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Health Safety Net - Partial Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, the health center determines their deductible (40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL). If any member of the PBFG has an FPL below 150.1 % there is no deductible for any member of the PBFG. The Patient is responsible for 20% of the HSN payment for all services, with the exception of pharmacy services, provided up to this Deductible amount. Once the Patient has incurred the Deductible, the patient is no longer required to pay 20% of the payment. Only one Deductible is allowed per PBFG approval period.

3.2 Policies & Procedures for Collection Financial Information from patients

613.08(1)(c)2b

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth/Connector Care Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 515.000.

(a) Determination Notice. The Office of Medicaid or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.

(b) The Division's Electronic Free Care Application issued under 101 CMR 613.04(2)(b)(3) may be used for the following special application types:

a. Minors receiving Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. *613.04(3)a*

b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address. *613.04(3)b*

Presumptive Determination. An individual may be determined to be a Low Income Patient for a limited period of time, if on the basis of attested information submitted to the health center on the form specified by the Health Safety Net Office, the Provider determines the

individual is presumptively a Low Income Patient, The health center will submit claims for Reimbursable Health Services provided to individuals with time-limited presumptive Low Income Patient determinations for dates of service beginning on the date on which the Provider makes the presumptive determination and continuing until the earlier of: a. The end of the month following the month in which the Provider made the presumptive determination if the individual has not submitted a complete Application, or b. The date of the determination notice described in 101 CMR 613.04(2)(a) related to the individual's Application. *613.04 (4)*

3.3 Emergency Care Classification - NA

3.4 Policy for Deposits and Payment Plans *613.08(1)(c)2d*

The health center's billing department provides and monitors Deposits and Payment Plans as described in **Section 5** of this policy for qualified patients as described in 101 CMR 613.08. Each payment plan must be authorized by the Billing Manager or the Chief Financial Officer.

3.5 Copies of Billing Invoices and Notices of Assistance *613.08(1)(c)2e*

(a) Billing Invoices: The following language is used in billing statements sent to low income patients: "If you are unable to pay this bill, please call 413-238-5511. Financial assistance is available."

(b) Notices: The Health center provides all applicants with notices of the availability of financial assistance programs, including MassHealth, subsidized Health Connector Programs, HSN and Medical Hardship, for coverage of services exclusive of personal convenience items or services, which may not be paid in full by third party coverage. The center also includes a notice about Eligible Services and programs of public assistance to Low Income Patients in its initial invoices, and in all written Collection Actions. All applicants will be provided with individual notice of approval for Health Safety Net or denial of Health Safety Net once this has been determined. The following language is used on billing statements sent to low income patients: "If you are unable to pay this bill, please call 413-238-5511. Financial assistance is available." The Health center will notify the patient that the Provider offers a payment plan if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(c) Signs: The Health center posts signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance and programs of public assistance and the offices of Health center Navigators at which to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices will in English and any other language that is used by 10 or more of the residents in the service area.

3.6 Discount/Charity Programs for the Uninsured *613.08(1)(c)2f*

The health center offers a Sliding Fee Discount Program (SFDP)~~s~~ to patients. ~~who are ineligible for the Health Safety Net~~. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 200~~150.1~~% of the FPIG. The Sliding Fee Discount Schedule applies to

standard charges and to amounts left unpaid by insurances in compliance with the Federal Health and Resources and Services Administration (HRSA) PIN 2014-02.

Sliding Fee Discount Schedule

	Our sliding fee scale is based on patient's household size and annual household income compared to the current federal poverty income guidelines shown below.					
	100%	101-125%	126-150%	151-175%	176-200%	>200%
SIZE OF FAMILY UNIT	**Maximum Annual Income Level Sliding Fee Discount Program**					
1	$ 11,880	$ 14,850	$ 17,820	$ 20,790	$ 23,760	$ 23,760 +
2	$ 16,020	$ 20,025	$ 24,030	$ 28,035	$ 32,040	$ 32,040 +
3	$ 20,160	$ 25,200	$ 30,240	$ 35,280	$ 40,320	$ 40,320 +
4	$ 24,300	$ 30,375	$ 36,450	$ 42,525	$ 48,600	$ 48,600 +
5	$ 28,440	$ 35,550	$ 42,660	$ 49,770	$ 56,880	$ 56,880 +
6	$ 32,580	$ 40,725	$ 48,870	$ 57,015	$ 65,160	$ 65,160 +
7	$ 36,730	$ 45,913	$ 55,095	$ 64,278	$ 73,460	$ 73,460 +
8	$ 40,890	$ 51,113	$ 61,335	$ 71,558	$ 81,780	$ 81,780 +
For each additional person , add	$ 4,160	$ 5,200	$ 6,240	$ 7,280	$ 8,320	$ 8,320
Discount Allowed	100%	80%	60%	40%	20%	0%
Charge to Patient	0%	20%	40%	60%	80%	100%

3.7 Hospital deductible payment option at HLHC – NA

3.8 *Full or 20% Deductible Payment Option for all Partial HSN Payments at HLCH Satellite or Student Health Center – NA*

3.9 Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients *613.04(6)(c)5a*

The health center charges HSN-Partial Low Income Patients 20% of the HSN payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets the Deductible.

3.10 Direct Website(s) (or URL(s)) where the provider's Credit & Collection Policy, Provider Affiliate List (if applicable) and other financial assistance Policies are posted.

Credit & Collection Policy **https://www.hchcweb.org/for-patients/established-patients/pay-your-bill/**
Insurance Affiliation List **https://www.hchcweb.org/for-patients/insurance-information/**
Sliding Fee Scale Policy **https://www.hchcweb.org/for-patients/insurance-information/**

3.11 Provider Affiliate List effective the first day of the acute hospital's fiscal year beginning after December 31, 2016 - NA

4. Collection of Financial Information *613.06(1)(a)*

4.1 Inpatient, Emergency, Outpatient & CHC Services: *613.06(1)(a)1* The Health center makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.

4.2 Inpatient Verification - NA

4.3 Outpatient/CHC Financial Verification *613.06(1)(a)2b*

The Health center makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:

1. Verification of gross monthly-earned income is mandatory. When possible this is done through electronic data matching using the eligibility procedures and requirements under 130 CMR 502 or 516. If the information received is not compatible or is unavailable, the following are required:

a. Two recent pay stubs;
b. A signed statement from the employer; or
c. The most recent U.S. tax return.

2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:

a. A copy of a recent check or pay stub showing gross income from the source;
b. A statement from the income source, where matching is not available;
c. The most recent U.S. Tax Return.

3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

5. Deposits and Payment Plans *613.08(1)(f)*

5.1 The health center does not require pre-treatment deposits from Low Income patients. *613.08(1)(g)1*

5.2 Deposit Requests for Low Income Patients: The Health center does not require a deposit from individuals determined to be Low Income Patients *613.08(1)(g)2*

5.3 Deposit Requirement for Medical Hardship Patients: The Health center does not require a deposit from patients eligible for Medical Hardship. *613.08(1)(g)3*

5.4 Interest Free Payment Plans on Balances less than, and greater than, $1000. A Patient with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than $25. A Patient with a balance of more than $1,000, after initial deposit, must be offered at least a two-year, interest-free payment plan. . *613.08(1)(g)4*

6. Populations Exempt from Collection Action *613.08(3)& 613.05(2)*

6.1 MassHealth, Emergency Aid to the Elderly, Disabled, and Children EAEDC enrollees: The health center does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, except that the health center may bill patients for any required co-payments and deductibles. The Health center may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed

programs, and receipt of the signed application, the Health center will cease its collection activities. *613.08(3)(a)*

6.2 Participants in Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) under 300% FPL: are also exempt from Collection Action. The Health center may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Health center will cease all collection activities. *613.08(3)(b)*

6.3 Low Income Patients except Dental-only Low Income Patients.

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income equal or less than 150.1% of the FPL, are exempt from Collection Action for any Eligible Services rendered by the Health center during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Health center may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. *613.08(3)(c)*

6.4 Low Income Patients with HSN Partial

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 200.1% and 300.1% of the FPL are exempt from Collection Action for the portion of their bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 101 CMR 13.04(6)(b) and (c). The Health center may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. *613.08(3)(d)*

6.5 Low Income Patient Consent to billing for non-reimbursable services: The Health center may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed in writing to be responsible. 613.08(3)(e)

6.6 Low Income Patient Consent Exclusion for Medical Errors, including Serious Reportable Events (SRE

The health center will not bill low income patients for claims related to medical errors occurring on the health center's premises. *613.08(3)(e)1*

6.7 Low Income Patient Consent Exclusion for Administrative or Billing Errors The health center will not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error. *613.08(3)(e)2*

6.8 Low income Patient Consent for CommonHealth one-time deductible billing. At the request of the patient, the health center may bill a low-income patient in order to allow the patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009. *613.08(3)(f)*

6.9 Medical Hardship Patient & Emergency Bad Debt Eligible for Medical Hardship: The Health center will not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. *613.08(3)(g)*.

6.10 Provider Fails to Timely Submit Medical Hardship Application

The health center will not undertake a collection action against any individual who has qualified for Medical Hardship with respect to any bills that would have been eligible for

HSN payment in the event that the health center has not submitted the patient's Medical Hardship documentation within 5 days. *613.05(2).*

7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt *613.06(1)(2)(3) and (4)*

The Health center makes the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications. Any collection agency used by the health center is required to conform to the above policies.

The minimum requirements before writing off an account to the Health Safety Net include:

7.1 Initial Bill: The health center sends an initial bill to the patient or to the party responsible for the patient's personal financial obligations. *613.06(1)(a)3bi*

7.2 Collection action subsequent to Initial Bill: The health center will use subsequent bills, phone calls, collection letters, personal contact notices, and any other notification methods that constitute a genuine effort to contact the party responsible for the bill. 6*13.06(1)(a)3bii*

7.3 Documentation of alternative collection action efforts: The health center will document alternative efforts to locate the party responsible or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable." *613.06(1)(a)3biii*

7.4 Final Notice by Certified Mail: The health center will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable" *613.06(1)(a)3biv*

7.5 Continuous Collection Action with no gap exceeding 120 days: The health center will document that the required collection action has been undertaken on a regular basis and to the extent possible, does not allow a gap in this action greater than 120 days. If, after reasonable attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, the health center may deem the bill to be uncollectible and bill it to the Health Safety Net Office. *613.06(1)(a)3bv*

7.6 Collection Action File The health center maintains a patient file which includes documentation of the collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made. *613.06(1)(a)3d*

7.7 Emergency Bad Debt Claim and EVS Check – NA

7.8 HLHC Bad Debt Claim and EVS Check – NA

7.9 CHC Bad Debt Claim and EVS Check. The health center may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to:

1. An uninsured individual who is not a Low Income Patient. The health center will not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The health center will not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

2. An uninsured individual whom the health center assists in completing a MassHealth application and who is subsequently determined into a category exempt from collection action. In this case, the above collection actions will not be required in order to file.

(b) The Health center provided Urgent Services as defined in 101 CMR 613.02 to the patient. The Health center may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.
(c) The responsible provider determined that the patient required Urgent Services. The health center will submit a claim only for urgent care services provided during the visit.
(d) The Health center undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and
(e) The bill remains unpaid after a period of 120 days. 613-06(4)

8. Available Third Party Resources *613.03(1)(c)3*

8.1 Diligent efforts to identify & obtain payment from all liable parties: The health center will make diligent efforts to identify and obtain payment from all liable parties. *613.03(1)(c)3*

8.2 Determining the existence of insurance, including when applicable motor vehicle liability:
In the event that a patient seeks care for an injury, the health center will inquire as to whether the injury was the result of a motor vehicle accident; and if so, whether the patient or the owner of the other motor vehicle had a liability policy. The health center will retain evidence of efforts to obtain third policy payer information. *613.03(1)(c)3a*

8.3 Verification of patient's other health insurance coverage: At the time of application, and when presenting for visits, patients will be asked whether they have private insurance. The health center will verify, through EVS, or any other health insurance resource available to the health center, on each date of service and at the time of billing. *613.03(1)(c)3b*

8.4 Submission of claims to all insurers: In the event that a patient has identified that they have private insurance, the health center will make reasonable efforts to obtain sufficient information to file claims with that insurer; and file such claims. *613.03(1)(c)3c*

8.5 Compliance with insurer's billing and authorization requirements: The health center will comply with the insurer's billing and authorization requirements. *613.03(1)(c)3d*

8.6 Appeal of denied claim. The health center will appeal denied claims when the stated purpose of the denial does not appear to support the denial. *613.03(1)(c)3e*

8.7 Return of HSN payments upon availability of 3rd-party resource: For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the health center will promptly report the recovery to the HSN. *613.03(1)(c)3f*

9. Serious Reportable Events (SRE) *613.03(1)(d)*

9.1 Billing & collection for services provided as a result of SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services provided as a result of a SRE occurring on premises covered by a provider's license, if the provider determines that the SRE was: a. Preventable; b. Within the provider's control; and c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c). *613.03(1)(d)1*

9.2 Billing & collection for services that cause or remedy SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as

required by 105 CMR 120.332 for services directly related to: a. The occurrence of the SRE;
b. The correction or remediation of the event; or c. Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis. *613.03(1)(d)2*
9.3 Billing and collection by provider not associated with SRE for SRE-related services: The health center will submit claims for services it provides that result from an SRE that did not occur on its premises *613.03(1)(d)3*
9.4 Billing & collection for readmission or follow-up on SRE associated with provider: Follow-up Care provided by the health center is not billable if the services are associated with the SRE as described above. *613.03(1)(d)4*

10. Provider responsibilities *613.08(1)(a)(b) & (h)*
10.1 Non-discrimination: The health center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. *613.08(1)(a)*
10.2 Board Approval Before seeking legal execution against patient home or motor vehicle. Before seeking legal execution against a low-income patient' s home or motor vehicle, the health center requires its Board of Directors to approve such action on an individual basis. *613.08(1)(b)*
10.3 Advise patient on TPL duties and responsibilities: The health center will advise patients of the responsibilities described in 101 CMR 613.08(2) at the time of application and at subsequent visits. *613.08(1)(h)*

11. Patient Rights and Responsibilities *613.08(1)(2)*
11.1 Provider Responsibility to advise patient on right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship: The health center informs all patients of their right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship. *613.08(2)(a)1*
11.2 Provider responsibility to provide individual notice of eligible services and programs of public assistance during the patient's initial registration with the provider. The health center informs all Low Income Patients and patients determined eligible for Medical Hardship of their right to a payment plan as described in 101 CMR 613.08(1)(f). *613.08(1)(e)2a [change*
11.3 Provider responsibility to provide individual notice of eligible services and programs of public assistance when a provider becomes aware of a change in the patient's eligibility for health insurance coverage: The health center provides patients with individual notices of eligible services and programs of public assistance when we become aware of a change in the patient's eligibility for health insurance coverage. *613.08(1)(e)2c*
11.4 Provider responsibility to advise patient of the right to a payment plan: The health center advises patients of their right to an payment plan. 613.08(2)(a)2

11.5 Provider responsibility to advise patient on duty to provide all required documentation: The health center advises patients of their duty to provide all required documentation. *613.08(2)(b)1*

11.6 Provider responsibility to advise patient of duty to inform of change in eligibility status and available third party liability (TPL): The health center informs all patients that they have a responsibility to inform the health center and/or MassHealth when there has been a change in their MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(1), insurance coverage, insurance recoveries, and/or TPL status. *613.08(2)(b)2*

11.7 *Provider responsibility to* advise patient on duty to track patient deductible: At the time of application, Low Income Partial patients are advised that it is their responsibility to track expenses toward their deductible and provide documentation to the health center that the deductible has been reached when more than one family member has been determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one provider. *613.08(2)(b)3*

11.8 Provider responsibility to inform the HSN Office or MassHealth of a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to inform the HSN Office or MassHealth of a TPL claim/lawsuit as well as to: *613.08(2)(b)4*

11.9 Provider responsibility to advise patient on duty to file TPL claims on accident, injury of loss: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to file TPL claims.*613.08(2)(b)4a.*

11.10 Provider responsibility to inform patient on Assigning the right to recover HSN payments from TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to assign the right to recover HSN payments from the TPL proceeds. *613.08(2)(b)4bi*

11.11 Provider responsibility to inform patient to provide TPL claim or legal proceedings information: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to provide TPL claims or legal proceedings information. *613.08(2)(b)4bii*

11.12 Provider responsibility advise patient to notify HSN/MassHealth within 10 days of filing a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible to notify HSN/MassHealth of it within 10 days. *613.08(2)(b)4biii*

11.13 Provider responsibility to advise patient of duty to repay the HSN for applicable services from TPL Proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible for repaying the HSN for applicable services from TPL proceeds. *613.08(2)(b)4biv*

11.14 Provider responsibility to provide individual notice of financial assistance during the patient's initial registration with the provider: The health center provides individual notice of financial assistance during the patient's initial registration. 613.08(1)(e)1a
11.15 Provider's responsibility to provide individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage: The health center provides individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage. *613.08(1)(e)1c*
11.16 Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that recovery from TPL payments is limited to the HSN expenditures for eligible services. *613.08(2)(c)*

12. Signs *613.08(1)(f)*
12.1 Location of the signs. The Health center has posted signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the health center location at which to apply for such programs. *613.08(1)(f)1*
12.2 Size of the Signs: The signs are large enough to be clearly visible and legible by patients visiting these areas. *613.08(1)(f)1*
12.3 Multi-lingual signs when applicable: All signs and notices have been translated into the languages spoken by 10% or more of the residents in our health center's service area. These are: English. *613.08(1)(f)1*
12.4 Wording in Signs: The health center signs notify patients of the availability of financial assistance and of programs of financial assistance. *613.08(1)(f)1*

12.5 Providers must make their Credit & Collection Policy and provider affiliate list, if applicable, available on the provider's website. 613.08(1)(f)2
https://www.hchcweb.org/

13. Sample Documents & Notices on Availability of Assistance *613.08(1)e) & (f)*
13.1 Sample of Assistance Notice on Billing Invoice Attached *(Attachment 1) 613.08(1)(e)1b*
13.2 Sample of Eligible Services and programs of assistance – notice on billing invoice.– Attached *(Attachment 2) 613.08(1)(e)2b*
13.3 Sample of Assistance notice in collection actions (billing invoices) – Attached *(Attachment 3) 613.08 (1)(e)3*
13.4 Sample of Payment plan notice to Low Income or Medical Hardship patients – Attached *(Attachment 4) 613.08(1)(e)4*
13.5 Sample of Posted Signs –attached *(Attachment 5) 613.08(1)(f)*

Hilltown Community Health Centers, Inc.

Administration

SUBJECT: NAME OF POLICY – SLIDING FEE DISCOUNT PROGRAM (SFDP)

REGULATORY REFERENCE: HRSA/BPHC [Public Health Service Act 330(k)(3)(G) and Code of Federal Regulations – 42 CFR Part c.303(f)]

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical, optometry, behavioral health and dental services (Uninsured or Underinsured). The HCHC Navigators and the Billing Manager's role under this policy is that of patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives.

HCHC will offer a Sliding Fee Discount Program to all who are unable to pay for services, including amounts unpaid after an insurance payment. ~~.~~ HCHC will base program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

Policy:

To make available discount services to those in need.

No patient will be denied health care services provided by HCHC due to an inability to pay or on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin.

Questions regarding this policy or any related procedure should be directed to the Chief Financial Officer at 413-238-4116

Originally Drafted: JANUARY 2013 Reviewed or Revised: SEPT.~~MAY~~ 2016

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Executive Director, HCHC

_____

John Follet, MD

President, HCHC Board of Directors

Procedure: The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification:** HCHC will notify patients of the Sliding Fee Discount Program by:
   • Notification of Sliding Fee Discount Program in the clinic waiting area.
   • Notification of the Sliding Fee Discount Program will be offered to each patient upon registration as a patient of HCHC.
   • Notification of financial assistance on each invoice and collection notice sent out by HCHC.
   • An explanation of our Sliding Fee Discount Program and our application form are available on HCHC's website.

2. **All patients** seeking healthcare services at HCHC are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**

3. **Request for discount:** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for medical, dental, optometry and behavioral health clinic visits. Sliding Fee Discounts are not available for Optometry or Dental hardware and not for those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. Information and forms can be obtained from the Front Desk, Billing Department and from Navigators.

4. **Administration:** The Sliding Fee Discount Program procedure will be administered through the Finance Department / Billing Manager or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application with Navigators and /or the Billing Manager. Dignity will be respected and confidentiality maintained for all who seek and/or are provided charitable services.

5. **Alternative payment sources:** All alternative payment resources must be exhausted, including all third-party payment from insurance(s) and Federal and State programs, including Health Safety Net (HSN).

6. **Completion of Application:** The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. Every effort will be made to collect the required family income information in conjunction with any Mass Health and/or HSN applications. By signing the application, persons authorize HCHC access in confirming income as disclosed on the application form. Providing false information may result in the Sliding Fee Discount Program discounts being revoked and the full balance of the

account(s) restored and payable under the HCHC Credit and Collection Policy.

7. **Eligibility:** Sliding Fee Discounts will be based on income and family size only. HCHC uses the Census Bureau definitions of each.
    a. Family is defined as: a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together and any person who is claimed as a dependent for Federal tax purposes; all such people (including related subfamily members) are considered as members of one family.

    b. Income includes: earnings, unemployment compensation, workers' compensation, Social Security, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as SNAP benefits and housing subsidies) do not count as income.

    c. Income verification: Applicants must provide one of the following: prior year W-2, prior year federal tax return (1040, etc.), two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business and prior year Federal Form 1040 Schedule C. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

8. **Discounts:** Those with incomes at or below 100% of poverty will receive a full 100% discount. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee discount schedule will be applied to any standard charges or any remaining charges after any insurance payment. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines (FPG), http://aspe.hhs.gov/poverty.

9. **Nominal Fee:** Patients receiving a full discount **will not** be assessed a nominal charge per visit.

10. **Waiving of Charges:** In certain situations, patients may not be able to pay the discount fee. Waiving of charges may only be used in special circumstances and must be approved by HCHC's CEO, CFO, or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event).

11. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with HCHC. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

12. **Refusal to Pay:** If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, HCHC can implement procedures under the HCHC Credit and Collection Policy.

13. **Record keeping:** Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Billing Department Manager's Office.

14. **Policy and procedure review:** Annually, all aspects of the SFDP will be reviewed, including the nominal fee from the perspective of the patient to ensure it does not create a financial barrier to car. T~~t~~he SFDP~~amount of Sliding Fee Discount Program provided~~ will be reviewed by the CEO and/or CFO and presented to the Board of Directors for further review and approval. The review process will include a method to obtain feedback from patients. The Sliding Fee Scale will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future budget planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as

barriers preventing eligible patients from having access to our community care provisions.

~~14.~~15. **Referral contracts:** All HCHC referral contracts must include a clause detailing that HCHC patients receive services on a discounted fee equal to or better than the SFDS criteria of the Health Center Program. If the referral provider offers the services discounted on a SFDS with income at or below 250% FPG, as long as health center patients at or below 200% of the FPG receive a greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule, and patients at or below 100% of the FPG receive no charge or only a nominal charge for the services, the referral arrangement is in compliance.

HILLTOWN COMMUNITY HEALTH CENTER SLIDING FEE SCHEDULE

2016 FEDERAL INCOME POVERTY GUIDELINES

	Coverable by Federal Grant Resources *					Coverable by State Health Safety Net (HSN)**	
						Full HSN	Partial HSN
	100%	101-125%	126-150%	151-175%	176-200%	up to 150%	up to 300%
SIZE OF FAMILY UNIT	**Maximum Annual Income Level Sliding Fee Discount Program**					**Maximum Annual Income Level HSN**	
1	$ 11,880	$ 14,850	$ 17,820	$ 20,790	$ 23,760	$ 23,760	$ 47,520
2	$ 16,020	$ 20,025	$ 24,030	$ 28,035	$ 32,040	$ 32,040	$ 64,080
3	$ 20,160	$ 25,200	$ 30,240	$ 35,280	$ 40,320	$ 40,320	$ 80,640
4	$ 24,300	$ 30,375	$ 36,450	$ 42,525	$ 48,600	$ 48,600	$ 97,200
5	$ 28,440	$ 35,550	$ 42,660	$ 49,770	$ 56,880	$ 56,880	$ 113,760
6	$ 32,580	$ 40,725	$ 48,870	$ 57,015	$ 65,160	$ 65,160	$ 130,320
7	$ 36,730	$ 45,913	$ 55,095	$ 64,278	$ 73,460	$ 73,460	$ 146,920
8	$ 40,890	$ 51,113	$ 61,335	$ 71,558	$ 81,780	$ 81,780	$ 163,560
For each additional person , add	$ 4,160	$ 5,200	$ 6,240	$ 7,280	$ 8,320	$ 8,320	$ 16,640
Discount Allowed	100%	80%	60%	40%	20%	100%	80%
Charge to Patient	0%	20%	40%	60%	80%	0%	20%

Policy and Procedure:

* "Sliding Fee Discount Scale" (SFDS) is used by the federal Section 330 program to allow for discounts to patients with incomes below or at 200% of the Federal Poverty Level(FPL). The SFDS can also be applied to any remaining balance after an insurance payment.

** MA Health Safety Net Office (HSN) for discounts to eligible patients with incomes below or at 300% of the FPL. (per 114.6 CMR 13.04)

HCHC STRATEGIC PLANNING MEETING
Location: Worthington Health Center, Worthington, MA
Date/Time: 06/21/2016 5:30pm

COMMITTEE MEMBERS PRESENT: Wendy Lane Wright, BOD Clerk; Nancy Brenner, BOD Vice President; Eliza Lake, HCHC Executive Director; Frank Mertes, HCHC CFO; Alan Gaitenby, BOD Member.
ABSENT: None.

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Meeting Open at 5.30 pm by Nancy Brenner w/ a proposal to anchor committee's work in the National Association for Community Health Centers Strategic Planning Toolkit's five steps	Eliza Lake prefaced committee's walk-through of the five steps suggested in the Toolkit (i.e. Self Assessment, Environmental Scan, Impact Evaluation, Goal Setting, Action Plan) w/ 'report' on how strategic plan has been used by senior management at management retreats. Frank Mertes stated that in his experience (prior to his recent arrival at HCHC) financial management has been inimically tied to strategic plans. Discussion of each of the 5 steps (above) just what they are (for our context) and how/whether we will approach – Frank Mertes and Eliza Lake helped committee assess the necessity/capacity/redundancy of each. Discussion of how HCHC has improved – and how that dovetails to opportunities/threats that face us (and will in the future). Discussion of production of strategic goals and ultimately an action plan as a result of five steps.	None	
"Vision" and "Mission Statement" sub-committee necessary?	The Toolkit's five steps are driven by articulated "vision" and "mission statement," Nancy Brenner raised the idea of whether a subcommittee ought to be formed to kick start the process. Consensus was that the subcommittee **was not** necessary, and that the strategic planning committee	None (no committee)	

	would (w/ input) develop these.		
Full Board involvement throughout w/ all 5 steps?	Should the Board be involved in each step along the way or strategic (and required) moments? No, Strategic planning comm. will do the bulk, report as needed, and seek input (and/or decisions) when necessary	None	
Are we ready to start? Referring to self-evaluation and defining roles checklists in toolkit	Sequential processing of self-evaluation and role definition questions produce an affirmative answer – we're ready to start.	(whole committee) Move on to Vision and Mission Statement production/refinement.	
Generation of input (beyond Strategic Planning Committee) for "Vision" and "Mission Statement" production/refinement	After "Defining roles" we move on to Vision, Mission, Values in toolkit and how this comm. is going to go about figuring this out – discussion of mechanisms, i.e., how do we engage the staff? Survey (very simple)? Eliza Lake proposes that we solicit staff response to Vision, Mission, Values in the next three weeks. . .and we should ask the Board too. . . and we discussed how to ask patients (but it looks too challenging for a short term effort)	Eliza Lake will solicit feedback from management/staff/Board for the 5 "Getting Started" questions from toolkit	Eliza Lake - try to get that back by early July
Strategic Plan Timeline?	When is reasonable to project a finished plan? End of the year is suggested as goal.	None	
Next Meeting and Adjourn	Schedule next meeting to 7/20, 5.30 WHC, meeting adjourns at 7.00pm	None	

HCHC STRATEGIC PLANNING MEETING

Location: Worthington Health Center, Worthington, MA
Date/Time: 07/26/2016 5:30pm

COMMITTEE MEMBERS PRESENT: Wendy Lane Wright, BOD Clerk; Nancy Brenner, BOD Vice President; Eliza Lake, HCHC Executive Director; Frank Mertes, HCHC CFO; Alan Gaitenby, BOD Member; ***John Follet, BOD President***
ABSENT: None.

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Meeting Open at 5.30			
Eliza Lake passed out copy of ***BOD and staff results/responses*** (un-synthesized) to "strategic planning self-assessment" as jumping point into "Vision, Mission, Values" portion of strat. Planning (refer to worksheet); Eliza Lake passed out copy of existing Mission Statement	Nancy Brenner begins on the journey by helping us to concentrate our efforts on vision statements. Sequential processing of staff and BOD's responses to look for language. Terms such as "access for all (i.e. no barriers)," "empowerment." Frank Mertes raises concerns w/ use of "empowerment" as it implies a power imbalance. Eliza Lake suggest "engagement" is better, e.g. "communities engaged for health," or "an engaged community for health."	To be continued in context of mission statement and beyond.	Nothing specific – or as they develop.
Mission Statement	Discussion of the role of a mission statement as it relates to the vision. Instead of listing all services, Frank Mertes proposes "integrated health" as a good replacement, e.g., "Creating access to high quality integrated health care in our communities." Wendy Lane Wright suggests perhaps growing the mission statement w/ another sentence. Eliza suggests we could grow it through the "access" component, but there seemed to be	We proposed to continue cogitating on mission statement	None – or rather - continued

	some attachment to the shorter original. John Follet raises the issue that "health care" maybe is too specific and might be read so as to exclude behavioral and community services. More discussion of mission statement as a broader statement of what we do. Eliza reads us several versions from HCHC analogs in Ma. and elsewhere (which were longer than our version). "Health care" seems to be the term we are fixated on, it doesn't tell the whole story – or enough of it. "Healthy Communities" is a term of art that we might use, or "health". New version possibly, "Creating healthy communities through access to integrated [high quality] health care," "Promoting and creating access to health and well-being for individuals, families, and our communities."		
Onto Values	Eliza suggests we define our terms by again looking to analogs, brainstorm, iteration, and synthesis into a statement. Values should be a concatenated list. John suggests that we are moving to a more "empathic model" moving beyond the old doctor / patient services (and power relationship) for hire. "*Empathy/Respect*" comes up a lot. "Curiosity" comes up a lot too – but perhaps is too invasive. "*Collaboration/teamwork/Integration*" too. "*Innovation*" and "*efficiency*" and "*curiosity"* too. "Creativity" too. "*e*" too – John says "cooperative" also is used here. For staff / operations – as well as patients, "dignity," "respect, "empathy". Some more, "transparency," "*open communication and accountability*."	We are going to write a sentence for each of our italicized values for next.	
Adjourn and schedule	8/16 WHC @ 5.30		

next meeting			

HCHC STRATEGIC PLANNING MEETING
Location: Worthington Health Center, Worthington, MA
Date/Time: 08/16/2016 5:30pm

COMMITTEE MEMBERS PRESENT: Wendy Lane Wright, BOD Clerk; Nancy Brenner, BOD Vice President; Eliza Lake, HCHC Executive Director; Frank Mertes, HCHC CFO; Alan Gaitenby, BOD Member
ABSENT: None.

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Meeting Open at 5.30			
Eliza Lake moves that we table approving all the mins previously 'til we have a chance to edit last meeting mins (since we just now are seeing them)	None	Comm. members to review last meeting mins. for subsequent approval	All
Review of Vision Statement from last time?	Last time we came up w/ "Communities engaged for health"	We agreed it was fine	None –
Review of Mission Statement from last time (and our subsequent thinking on it)	A synthesis arose (from our previous efforts and today) around – "Creating access to integrated high quality health care and promoting well-being for individuals, families and our communities."	We agreed it was fine	Nothing
Onto Values – "empathy and respect"	Some proposals were offered from our homework. Discussion of the role of values for both strategic planning and marketing. Wendy Lane Wright's, "We are committed to dignity for everyone. We partner w/ individuals and families to build their strengths, fostering greater health and well being in support of their chosen paths to more fulfilling,	None	Nothing

	productive, lives." Eliza Lake's, "We respect the strengths of the people we serve and employ." Discussion of how to get "empathy" in there. Alan Gaitenby suggested a shorter version, "HCHC listens, considers, and cares." Wendy Lane Wright suggests, "*We listen, consider, and care. We respect the individual strengths of the people we serve and employ.*" We liked the last one.		
Values – "collaboration and teamwork"	Eliza Lake suggests, "We provide efficient, effective, and integrated care through teamwork and collaboration, and foster partnerships w/ comm. members." Wendy Lane Wright, "We know that the greatest results come from the combined efforts of diverse orgs. And individuals." Discussion of synthesizing those, "*We commit to working together. We provide effective integrated care through teamwork and collaboration.*"	None	Nothing
Values – "innovation, efficiency, and curiosity"	Discussion starts w/ "We encourage curiosity, innovation, and growth." Another sentence is suggested, including the phrase, "best practices" and "encouraging learning". Some discussion of whether "innovation" ought be a value. We need to include something about sustainability (in a financial way). "*We encourage, curiosity and growth; we strive to continually improve through innovation and the use of best practices.*"	None	Nothing

Values – "Sustainability"	Some proposals started by Wendy Lane Wright, quickly coalesced around, "We ensure sustainability through efficient management." Another word/phrase seems needed to speak to stuff beyond management, like "operations" or "practices" for instance. "*We ensure sustainability through efficient management and practices.*"	None	Nothing
Values – "open communication and accountability"	Frank Mertes and Eliza Lake propose some proto versions, we landed on, "We hold ourselves accountable. We commit to our work and each other through dedication and open communication." Discussion around "commit" as it doesn't seem to satisfy, synonyms don't work. Alan Gaitenby, "We hold ourselves accountable through open communication and commitment to excellence." Eliza Lake picks up the ball here, "We dedicate ourselves to. . . " Synthesis, "*We work to the best of our abilities and commit to open communication*." But, we're not psyched w/ the last one, needs some help.	To be re-visted	All – next meeting

What next? Share our Mission, Visions, Values w/ full board, senior management, and maybe all staff??	Discussion of how to engage w/ other stakeholder(s), w/out opening a pandora's box. . .i.e. how to structure the sequencing. Decide to share w/ Board and go from there (at August meeting next week). After board meeting, then onto staff w/ our proposals.		
Next meeting? 9/6/16 5.30 pm WHC	Adjourn		