Hilltown Community Health Center

Administrative Offices
58 Old North Road
Worthington, MA 01098
413-238-5511
www.hchcweb.org

BOARD MEETING
March 7, 2019
HUNTINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the February 7, 2019 Meeting Minutes (Vote Needed)

3. Finance Committee Report (Vote Needed)

4. Committee Reports (as needed) (Vote Needed)
    - Executive Committee
    - Quality Improvement
        1. QI/Risk Management Minutes for January 2019
    - Fundraising
    - Credentialing/ Privileging-New Employee:
        1. Carlos Coppin, Dental Assistant (Vote Needed)
    - Personnel
    - Facilities
    - Recruiting, Orientation, and Nominating (RON)
    - Strategic Planning
    - Corporate Compliance

5. Chief Executive Officer / Senior Manager Reports

6. Old Business

    1. New Access Point Application Update

7. New Business
    - Policies (Vote Needed)
        - Sliding Fee Scale 2019
        - Credit & Collection policy
    - Reschedule July Board Meeting (Originally scheduled on 7/4/2019)
    - Draft UDS with summary
    - Approval of the United Way Grant

8. Executive Session

9. Adjourn

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 02/07/2019 5:30pm
Worthington Health Center

MEMBERS: John Follet, President; Alan Gaitenby; Kathryn Jensen, Clerk, Lee Manchester; Nancy Brenner, Vice President, Matt Bannister; Wendy Long; Seth Gemme
STAFF: Eliza Lake, CEO; Michael Purdy, Risk Manager; Frank Mertes, CFO; Tabitha Griswold, Executive Assistant
ABSENT: Maya Bachman
Guest: Kate Albright-Hanna

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Approval of Minutes 01/03/2019	John Follet called the meeting to order at 5:36pm. John Follet motioned to introduce Kate Albright-Hanna, potential new Board Member. Introductions to Kate Albright-Hanna were made. The minutes from the meeting of January 3, 2019 were reviewed. **Wendy Long moved acceptance, Nancy Brenner seconded. The minutes of the monthly meeting of 1/3/2019 were approved by those present.**	January 3, 2019 minutes were approved.
Finance Committee	• John Follet summarized the recent Finance Committee as the health center finances are doing "OK", however not making great strides but have stabilized. John Follet stated that the Operating Deficit for the year was approximately $376k which is only $20k below the budget for the year. John Follet commended Frank Mertes with creating a budget that anticipated the year's shortfalls. • John Follet noted that the bottom line was positive because the money that was fundraised supported it. John	

	Follet noted that the figure of operating days of cash is still low but so is the A/P very low, meaning that there is not a lot of bills hanging over the health center. John Follet wanted to assure the Board that the figure is safer than it might look. Much of the current stability was due to the loan that HCHC received from MassHealth to pay bills in Fall 2018. • John Follet reviewed departmental income statements for 2018, and noted that the overall picture shows that the number of visits has increased in dental and Behavioral Health (BH) but the revenue has diminish from years before. This is largely due to certain dental procedures that insurances are no longer paying HCHC to conduct. Revenues in BH were down due to greater proportion of reimbursement being from public payers. In Medical, HCHC had an increase in revenue due to a rate increase from state. Eliza Lake added that State Representatives have filed a dental rate increase for community health centers. She noted that if that were to go through that would be very helpful to HCHC. • John Follet noted that the overall the amount that HCHC has spent for expenses was less than what was budgeted. However, since last year HCHC has spent more because it is a bigger operation, because of the Amherst expansion. John Follet stated that the financial state of the organization is overall stabilized but there are still some challenges in the New Year. • With the recent resignation of a Board Member brought up the conversation of the Vanguard investment account and the Board. The Finance Committee has questioned the Board's role in overseeing the investments. Several Board Members will be attending a MassLeague symposium this weekend and that may be the place to bring that question. Eliza Lake stated that the current policy and procedure does not really speak to the management and use of the investments, however recent uses has not violated the current policy. The Board asks that moving forward clarification on the oversight of the investment needs to be made.	Finance committee report was approved. Board Members attending Symposium will report back on any relevant information on this matter.

	Kathryn Jensen moved that the report of the Finance Committee be accepted. Alan Gaitenby seconded the motion. The motion was approved by those present.	
CEO Report	• Eliza Lake reported that the Town of Amherst has come to tentative agreement. Frank Mertes sent a proposal for repayment of back owed rent but has not received a response. Eliza Lake reported that the Town has indicated that it is willing to take responsibility for $110k of the construction costs for their building but requested back rent through June 2017 to be paid. Frank Mertes reported that the proposal states that rent back pay would be repaid in increases by years. Eliza Lake reported that once HCHC knows of the exact amount in repayment then the capital campaign can be continued to make up the shortfall. • Eliza Lake reported on the $300k MassHealth payback of the 2018 cash advance. After recent conversations with MGH/Partners, they are tentatively willing to help with payback terms by providing HCHC with a loan with a longer term. This plan may include a grant of $50k. While the repayment to MassHealth could potentially be renegotiated, they would never offer a grant opportunity like Partners. Eliza Lake also reported on CDH willingness to support the HC's legislative priorities. Frank Mertes sent the proposal to Partners but has not received a response. Frank Mertes noted that the proposal was clear that the loan would not be collateralized. • Dr. Beth Coates, MD has asked again for the annual leave she's been taking for the past few years. The process is for the CEO and Board to review and approve or not approve. She's agreed to be flexible as possible in the timing of her leave. The timing for this is not best as the health center will be losing a provider in the spring, but the SBHC providers will be available to help during some of the summer months. **A motion to approve the leave request for Dr. Beth Coates for a two month sabbatical was made by**	Leave for Dr. Beth Coates was approved.

Nancy Brenner. The motion was seconded by Alan Gaitenby. With no further questions or discussion, the motion was approved.

- Dr. Lora Grimes, MD has given notice. Her last day will be in April. As she does not know her start date at her new location, HCHC has offered to hire her back as per diem. There is an MD candidate coming in March to interview. With the leaving of Dr. Grimes, there will only a NP and a part time physician in WHC. There has been a proposal of no Tuesday clinical hours on the table, but management is working to develop a plan that has the minimum of disruption.

- Eliza Lake reported on a New Access Point (NAP) grant that was released by HRSA in January 2019. This grant will provide funded health centers with $650,000 in ongoing annual operational funds; HCHC did not get this type of funding for the Amherst site. In this funding round, HRSA created zip codes that are designated as "hot spots." They also provided applicants with a spreadsheet to give a "needs" score worth 20 points towards the 100 point scoring on the grant. In MA, because health data shows relatively good health status, we may only get 10 points. Eliza Lake has received and overwhelming amount of agreement in the need for a Health Center in Ware, including people that live there. Eliza Lake feels confident in applying for this grant as the only health center in Hampshire County, having connections with providers in Ware already, and the proximity to Amherst. Frank Mertes found from colleagues that Fitchburg is may be applying for the NAP grant, as well. Eliza Lake presented the map of all the HCs in MA and every HC in W. Mass and where their patients come from. Eliza Lake feels that we would be competitive in this grant. Eliza Lake proposes moving forward with the grant application process that starts in March with the submission of a one-page abstract. The proposal would be for a small medical practice and to be financially conservative. Frank Mertes explained from previous experience that the HC could eventually obtain other grants to expand to include dental services. If the

	grant were to be awarded, the HC would have 120 days to open. Eliza Lake stated that further growth is needed for viability and that the HC is more comfortable after learning lessons from Amherst. **With unanimous vote by members present to support the pursuit of this opportunity, Eliza Lake will report back in a month. Eliza Lake will submit the first document needed for NAP application, as needed, but will bring the application before the Board prior to submission.**	
Executive Committee	John Follet reported that the committee has not met.	
Recruitment, Orientation & Nominating (RON) Committee	Wendy Long reported that with the recent resignation of a Board Member, there is now a vacant position in the RON Committee, as well as the Finance Committee. The Committee continues to search for an Amherst-based Board Member. The prospect of teleconferencing meetings would help with this recruitment. Eliza Lake reported to continue conversations with colleagues of health centers with similar geographical issues. Wendy Long presented potential new Board member, Kate Albright-Hanna, with positive feedback from other Board members, noting her ties to the community, and her strong marketing and fundraising background. **Alan Gaitenby moved to approve the acceptance of the new Board member. Nancy Brenner seconded the motion. Kate Albright-Hanna was approved as a Board member by those present.**	Nomination of Kate Albright-Hanna was approved.
Corporate Compliance Committee	Eliza Lake reported that senior management will meet on this agenda in the upcoming weeks.	
Credentialing / Privileging Committee	John Follet to approve credentialing for Elizabeth Peloquin, an NP student. Michael Purdy reported that she is attending American International College. **Nancy Brenner moved the credentialing for Elizabeth Peloquin be accepted. Wendy Long seconded the motion. The credentialing was approved by those present.**	Credentialing for Elizabeth Peloquin, NP Precepting Student was approved.

Facilities Committee	Alan Gaitenby reported that this committee has not met. Eliza Lake reported that there has been reconfigured staffing situation in Worthington, integrating providers with support staff in shared workspaces. Frank Mertes reported that water issues are getting better, and there was a frozen pipe during the last deep freeze but it was minor. Eliza Lake reported that there was a minor plumbing issue during DPH visit.	
Personnel Committee	John Follet reported that this committee has not met.	
Strategic Planning	Nancy Brenner reported that this committee has not met. Eliza Lake reported that Senior Management recently reviewed the Action Plan and it will be sent to committee next week.	
Fundraising Committee (ad hoc)	Nancy Brenner reported that this committee met yesterday and talked about messaging brainstorm for our fundraising efforts to evolve for annual meeting, which could be used for first push for fundraising. The Committee took ideas from last month and are working with those phrases. The messaging would be used to both market HCHC to patients (current and potential) and to conduct fundraising in both the Hilltowns and the Valley. The Committee will develop a few possibilities, and will them present them to staff and select community leaders to get feedback.	
Quality Improve-ment/Risk Management Committee	Kathryn Jensen reported that the QI Committee has two issues of concern, as reported in the materials provided in the packet. First, data collection continues to be a challenge, both in terms of consistent coding by providers and in the ability to collect and analyze the data in the electronic health records. The situation has improved from previous years, but there continues to be challenges that need to be addressed. Second, during the January meeting worrisome understaffing was discussed, particularly at the Worthington Health Center. The sense of the staff present on the Committee is that medical support staff are underpaid. Eliza Lake reported that the health center is currently advertising for four new MAs. Michael Purdy reported that out of the 28 resumes the HC has received for the position, six of those resumes were viable. Frank Mertes has contacted fellow health centers and found that the health center's reimbursement for these positions are right in line with other health centers, the one difference being the hours of operation compared to other sites. Senior Management reports recognizing the issue and working	

	hard to address it. In regards to the understaffing in RNs, Senior Management is recruiting more MAs to support the RNs. Eliza Lake reported that referrals are completely caught up and remaining so. There is a new receptionist with referrals background that starts on Monday, February 11th, to support the behavioral health specific referrals. Eliza Lake reported on the UDS, which the major Federal report is due by Friday, February 15th. Eliza Lake met with EMR Specialist and Clinical Operations Director to use and DRVS to run all the required measures. Eliza Lake reported that most of the measures look to be right in line with previous years. Michael Purdy reported that MAs work with previsit planning is required for the best collection of some quality measures, and since the health center has been understaffed there is a little dip in those numbers. There was a general Board discussion about the data, and they were informed that they will receive the full UDS report at the next Board meeting. Kathryn Jensen was impressed with staff interest in quality of record keeping.	
Committee Reports	After all the committee reports had been reviewed and discussed**, Alan Gaitenby moved the committee reports be accepted. Matt Bannister seconded the motion. The measure was approved by those present.**	Committee reports presented at this meeting were approved.
Old Business	No old business was discussed.	
New Business DPH Policies	Eliza Lake noted that following a recent unannounced DPH visit, some policies were brought to the attention of Senior Management for required revisions. Some of the new policies were already in place for the School-Based Health Center, but needed to be expanded to the whole organization. **Matt Bannister moved acceptance of the submission. The motion was seconded by Kathryn Jensen. Without any further discussion needed, the following policies were approved.** 1.) Patient Complaint and Grievance Policy 2.) Emergency Transfer of Patients Policy 3.) Serious Incident Reports to the Department of Public Health (DPH) Policy	All policies were approved.

	4.) Voluntary and Involuntary Commitment Policy.	
Employee Credentialing	There was no employee credentialing to report.	
Executive Session	The recent resignation of a Board Member was discussed.	
Next Meeting	**Nancy Brenner moved the meeting be adjourned. John Follet seconded the motion, which was approved by those present. The meeting was adjourned at 7:40 pm.** The next scheduled meeting will be on March 7, 2019 at the Huntington Health Center.	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

CEO Progress Report to the Board of Directors
Strategic and Programmatic Goals
March 2019

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

Community Care Cooperative (C3) ACO: There have not been any new developments with C3 this month; the conversations about marketing for Amherst and possible shared services have continued this month and are in process/discussion. We also are working with C3 to implement a required process of screening MassHealth patients for their need for various Social Determinants of Health (SDoH), which can include housing, food security, domestic violence, etc. HCHC has always done some screening on these issues, and has been able to refer internally for those in need of assistance. In the last couple of years our Community Health Workers (CHWs) have been piloting the use of a nationally-developed tool called PRAPARE, which was designed specifically for health centers. We are in conversations with C3 about whether we can continue to use this tool, or use the one they suggest, which is less robust. A pilot is being launched in Huntington that will ask MassHealth patients to come in 15 minutes early for their physical exams; a CHW would meet privately with the patient and administer the tool, identify areas of need, and then enter the findings into the patient's medical record in time for the visit with the provider. The initial goal is universal screening for all MassHealth patients, but eventually we would (of course) like to do this for all patients, regardless of payer.

Hospital Engagement: I have been very actively engaged in the **Community Health Needs Assessment** process that all Pioneer Valley hospitals are currently conducting together. In addition to my membership in the Regional Advisory Committee, and its Health Equity Subcommittee, I have participated in or attended four community forums during which the hospitals solicit community input. I have listened to the community concerns about health care and other issues in Westfield, Northampton, Amherst, and Ware, and will hear over the next few months about the results of these and other forums. No surprisingly, there are common themes – transportation, rural isolation, etc. – but also some new ones: civic engagement, intergenerational connection, and real concern about both vaping and the new availability of marijuana. The reports that will come out of this process are important for HCHC, as we rely heavily upon the hospitals' needs assessments in completing our own.

I met today with Ron Bryant, the CEO of both **Baystate Noble Hospital** and Baystate Franklin Medical Center. We talked about possible partnerships between our organizations in order to better serve the southern Hilltowns, which are part of Noble's service area. He also asked me to chair with him the Community Benefits Advisory Council for the hospital, which I am considering. I did present to him our concerns about the communication issues our providers have consistently had with his Emergency Department, and we agreed that we will continue the conversation to address these concerns, which may be sufficiently addressed by Noble's transition to Baystate's electronic health record system at the end of this month.

Cooley Dickinson Health Care has approved our application to put our dental brochures in the waiting rooms of their 30 medical practices. They have asked for 500 copies, and we are also following up on the idea of their sending an email to their practices letting them know of the dental services that HCHC provides. They will get back to us about whether they are willing to promote our Behavioral Health services.

Frank and I spoke yesterday to Partners about their potential help with our financial situation, which I will report on below.

Goal 2: HCHC Expansion

John P. Musante Health Center (JPMHC):

- Frank and I had a meeting scheduled for yesterday with Paul Bockelman, Amherst Town Administrator, but he canceled it. I informed him that the reason we had set up the meeting was to get a response to our license agreement/lease amendment proposal, and that he could respond by email instead, but I believe I will need to set up another meeting to get the Town's response. We will do so as soon as possible.
- We have identified two spaces in the Bangs Center for our Behavioral Health provider, and are moving ahead with applying for the required DPH license. Not knowing how long that process will take, she is seeing patients in Huntington (where we need the coverage) until the license has been received.
- I gave a tour of the site to the newly elected/formed Amherst Town Council on Monday, and believe that there are at least three members who are extremely interested in working closely with us to identify potential patients.
- I have continued to meet with community organizations, and have identified some further opportunities for outreach. Anecdotal reports are that there are growing numbers of new patients, but we haven't pulled the data to confirm it. Our marketing efforts in the local media and in social media will start this month, and will coincide with that being placed by C3. We are focusing efforts on new patients just in Amherst, as the other sites are struggling with capacity right now.

New Access Point Funding (NAP) Opportunity: We have spent a considerable amount of time pursuing the NAP for Ware, and have made real progress in garnering support from community organizations, and have identified a couple of possible locations, which Frank and I toured last week. I have not had success in connecting with the hospital yet, which appears to be the result of their misunderstanding the application process – they were misinformed that if more than one health center applied for funding, both applications would be ineligible for consideration. There is also a close relationship between the Town and the hospital, so Frank and I will be presenting to the Selectboard on March 19th, and will then circle back around to the hospital. I am very excited that we have started serious talks with a large social service agency that is interested in developing a shared space. This would enable patients to access clinical and social services in one place, and would enhance both our ability to serve patients and our outreach to them. I will report more in the meeting, but we have not learned anything in this process that has made us doubt our plan to apply for funding.

Goal 3: Improved Organizational Infrastructure

Financial Stability:

- Last Friday we heard back from Partners about the possible support that they, or rather, Mass General Hospital (MGH) might be able to give us, as a result of the conversations we've had since November. I am happy to report that they will be giving us a $50,000 grant, which we can send straight to MassHealth as a payment toward our cash advance. This grant alone could reduce our payback by about $900 week. MGH also suggested, however, that we explore the possibility of a loan from a local bank or a non-profit focused lending organization, and that MGH could guarantee the loan. We had a call to discuss the details on Tuesday, and will be exploring all the possible options. We are obviously very grateful for their support, and have asked them to think about the extent and form of recognition that they would like in exchange for their generosity.
- I am including as part of this report an email I sent to all the medical providers last week, outlining the steps that management is taking to address the current problems in the Medical Department. Although this is a level of detail that the Board is not required to know, I am including it because 1) this is obviously a very important drive of the organization's success, both in meeting its mission and in being financially sustainable, 2) providers ask if the Board is sufficiently aware of the problems that the organization is facing, so I want to be transparent in showing you the conversations that are occurring, and 3) I want you to appreciate the hard work that people are doing to make sure that we weather these challenging times. The team working has been meeting weekly, and everyone feels that this is a good plan, but it will be continually updated as conditions and information change. We do have an MD coming for interviews this month, but know that she will have many options and we are in a very competitive market. We have developed a proposal for a new compensation model for providers and MAs, in the hope that it will help with our recruitment efforts.

Other Reports

The Mass League has said that if you would like to choose a month for a training in preparation for the Operational Site Visit in November, they would be happy to come out.

State and National Outlook:

- **Congressman Jim McGovern** (1st District) will be visiting the Musante Health Center on the morning of Wednesday, March 20th. This visit was just confirmed last Friday, and will be the first Congressional visit since I have been at HCHC. I had dropped by his Northampton office to discuss his support for our NAP application, and his staff quickly arranged this visit. The Mass League will send some staff members out to cover the federal legislative priorities of health centers, and I will present him with information about the site in Amherst and, briefly, our interest in expanding to Ware. We will be inviting local press, and hope that it will provide good visibility for our work in Amherst and elsewhere. I will then meet with his staff in DC the next week, as well as visits with Congressman Neal's, and Senator Warren's and Senator Markey's offices.

- **Senator Jo Comerford** will be visiting the Musante Health Center on Friday, March 15th. This developed after I visited her office in Boston this month, and met with her Legislative Director, who had come from Health Care for All. They are very supportive of our work and FQHCs, and I just learned that she mentioned me in a webinar that she conducted this evening on health care – I will have to go listen to it and report back, but I heard that it was positive.
- I will be speaking next Tuesday at a Mass League event in Boston for all newly elected legislators. They asked me to talk for five minutes about the importance of HCHC to the rural communities we serve, the barriers our patients face in receiving care, and the financial burden this places on us as an organization. I have developed five slides that they are including in the presentation, and hope that I am able to represent our needs well enough in such a short time!

Plan for Medical Department Staffing and Operations - Update

Eliza Lake

Fri 3/1/2019 4:18 PM

To: Beth Coates, MD <bcoates@hchcweb.org>; Sheri Cheung <scheung@hchcweb.org>; Miranda Balkin <mbalkin@hchcweb.org>; Lora Grimes <lgrimes@hchcweb.org>; Marisela Fermin-Schon <mfermin@hchcweb.org>; Brenda Chaloux, NP <bjaeger@hchcweb.org>; Nicole Makris <nmakris@hchcweb.org>; Sophal Lam <slam@hchcweb.org>; Melissa Lodzieski <mlodzieski@hchcweb.org>
Cc: Jon Liebman <jliebman@hchcweb.org>; Michael Purdy <mpurdy@hchcweb.org>; Frank Mertes <fmertes@hchcweb.org>; Cynthia Magrath <cmagrath@hchcweb.org>; Dawn Flatt <dflatt@hchcweb.org>

Good afternoon:

I want to update you on the recent and on-going management conversations about the current staffing and capacity issues that HCHC faces. There are meetings at least weekly to develop and implement a plan to address these issues, so I anticipate sending updates regularly for the foreseeable future.

- We are, as you all are acutely aware, very short of Medical Assistants right now. We committed a number of weeks ago to increasing the total number of MAs by four, which does not include replacing recently emptied positions - this would bring the total up to 17 MAs across all departments (ie, medical and eye care). Frank Mertes also did a full market survey of current rates for MAs employed by primary care offices in the Western Mass region to ensure that we are competitive.
- We are developing changes to our recruitment plan for medical providers, and are actively advertising for at least one MD (family practice or med/peds) and an FNP. We know that this is not a quick process in the best of worlds, so we are exploring other ways to ensure that we have appropriate coverage, particularly in Worthington. Options that we are exploring include:
    - Exploring the possibility of *per diem* provider(s) that could provide coverage for sick visits and pediatric care in Worthington until we are able to hire someone who can take a panel.
    - Researching the current options for *locum tenens* provider(s), although we are very aware of the concerns (and fairly recent experiences) with poor quality care that can sometimes occur. We want to therefore be aware of the options, but will not move forward with this until we have ruled out other possibilities.
    - Closure of Worthington's medical practice for one day a week is a possibility, but we all agree that this is not ideal, especially from the patient perspective, and may be used only for short periods of time if there are gaps that we are unable to fill. The specifics are still under discussion, and are also affected by the availability of support staff. This is, however, the least appealing option.
- In the meantime, there are a number of actions occurring in preparation for or after Lora's departure:
    - Beth, Melissa, Jon, Dawn, and Cynthia are working with Lora to identify those of Lora's patients that will need to be transferred immediately to another Worthington provider, those that can be asked to transfer care to Amherst (due to their residence in the Valley), and those that can be asked to transfer to Huntington.
    - Cynthia is working on a script that a limited number of receptionists will use to call all of Lora's pediatric patients to explain that until we have found a replacement (see above), we will be able to see children at the SBHC or in Huntington.
    - All new adult patients will be offered appointments in Amherst as soon as possible, or in Huntington for the fall. This will be the case until we have increase provider capacity.
    - WHC sick visits will be transferred to HHC if there is not enough capacity for Beth and Melissa to see them - we want to maintain continuity of care/site as much as possible, but do not want to overwhelm providers if we can avoid it. The overflow would be directed to HHC or Amherst as appropriate.
- Frank, Cynthia, and I will now be doing a similar analysis of the structure and staffing of the reception department, to ensure that we have the appropriate number of staff members, and that the systems in place adequately address outstanding issues like the fax inbox, scanning, medical record retrieval, etc. This deliberative process (which will take a little bit of time, unfortunately), is similar to the process used to address the referral issues we faced in the fall, and the process by which we addressed a plan for the

MAs. In the fall we knew that there would be interaction between these changes/improvements, so now is definitely the time to address the issues that we know have a profound impact on your day-to-day work. We have been, but will continue, also taking a look at our nursing capacity with Dawn, and will be closely monitoring that situation.

- We agreed in principle to, and will work on the implementation of, a system to ensure that providers know where and when MAs, nurses, and receptionists will be working each week. We agreed that such a schedule could be sent out weekly. We also agreed that when there are unexpected changes to this schedule (due to illness or other issues), we need to have a robust system to communicate these changes to the affected staff asap. We will let you know more about this as soon as we've ironed out some details.
- Finally, we are finalizing our marketing plan for March-May, with a particular focus on increasing MassHealth patients in Amherst. C3 is spending $13,000 on ads in four local newspapers, and we are working on more specific ads, also on social media and potentially radio, for the same time period. These are the months when patients can switch PCPs easily, and we hope to dramatically increase our enrollment. We are continuing a regular schedule of community presentations and flyering, and are initiating a brief survey of JPMHC patients to determine how they heard of us, so we can continue to target our efforts.
- Other changes/requests:
    - Cynthia will add sick visit slots and "nursing visit" slots to HHC schedules.
    - Dawn will work with the nurses to review how to use the "nursing" slots for hospital/ED follow ups and other patients they are concerned about, and when to release them so that they can be filled with other routine patients. Cynthia will review this with Reception.
    - Providers are asked not to change those slots.
    - HHC providers are asked to try to stretch out return visits as they are able, to open up a little more time in the HHC schedules.

I hope that this information is helpful, and we will be providing regular updates over the next weeks and months. I truly appreciate your patience and commitment in this difficult period, and have confidence that we can work together to continue to provide high-quality care and improve HCHC's operations.

Thank you,
Eliza

Eliza B. Lake, MSW
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QI-RISK MANAGEMENT COMMITTEE
Location: Huntington Health Center
Date/Time: 01/15/2019 9:15am

TEAM MEMBERS: Kathryn Jensen (chair), Board Representative; MaryLou Stuart, Dental Representative; Jon Liebman, ANP; Kim Savery, Community Programs Representative; Michael Purdy, CCCSO; Tabitha Griswold, Executive Assistant; Franny Huberman, Behavioral Health Representative; Dawn Flatt, Director of Clinical Operations; Cynthia Magrath, Practice Manager; Eliza Lake, CEO

ABSENT: NONE

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of December 18, 2018 Minutes Review of November 20, 2018 Minutes	The meeting was called to order by Kathryn Jensen at 9:20 am. The minutes from the December 18, 2018 meeting were reviewed. Franny Huberman motioned for correction to meeting minutes in regards to being noted that Serena Torrey leaving and the interviews taking place were not to replace her because Franny Huberman already stepped into the position, but to replace Franny Huberman. Kathryn Jensen motioned that correction approved. Jon Liebman seconded the motion. The minutes from the November 20, 2018 meeting were reviewed. Kathryn Jensen made a motion to approve the minutes and Jon Liebman seconded the motion. With no discussion needed, the November 20, 2018 minutes were approved unanimously.	December 18, 2018 Minutes were approved unanimously, with correction made. November 20, 2018 Minutes were approved unanimously
Upcoming HRSA Visit	Eliza Lake reported on the preparation for the HRSA operational site visit in November 2019. This visit should be much easier to prepare for than previous visits as a Site Visit Protocol Checklist has been given to Health Centers. Eliza Lake wanted to note that some of these items in the checklist may not be required work for some of the committee members but she wanted to make them aware of it. The Committee reviewed the HRSA Site Protocol Checklist and all of the elements to the Program Requirement related to QI. There was more discussion around the following items: • Eliza Lake will gather information as to what "QI Assessments" HRSA will be looking for, currently the understanding is that the QI Semi Annual report has sufficed. As per past HRSA site visits the patient sample was picked at random by HRSA for review. • Incident report tracking and process will reviewed by Michael Purdy, Dawn Flatt and Eliza Lake, and the group will identify any LEAN projects that maybe be indicated by the trends in incidents reported.	Annual review of Incidents to be completed

	• Evidence based practice policy will be reviewed to see if it is being utilized and is up to date. • Changes/clarifications to the grievance process are being made currently. • Eliza Lake mentioned that MA League can come out and do a training on the 18 Program Requirements. This training can be for staff, the Board, or some combination of both. Kathryn Jensen was concerned with follow through after QI meetings. Eliza suggested that with the additional of the new Executive Assistant, follow-up can be tracked and monitored by this position more closely, including any identified LEAN projects. Katheryn Jensen found that the third column in the minutes were very helpful in regards to follow up after a meeting. HCHC's Credentialing/Privileging policy will be updated soon to comply with recent changes in the HRSA Compliance Manual. Kathryn Jensen asked if there is deadline for credentialing to be done. Eliza Lake responded that it is to be done in the following month. Eliza will be following up with Bridget Rida, HR on this.	by February meeting Tabitha will develop a HRSA Site Visit Protocol check list for next meeting. Eliza will be report back on the Credentialing/ Privileging process.
Old Business	No old business was discussed.	
Risk Management-Incidents Follow-ups	Michael Purdy reported for risk management. One new incident was reported. A patient with varicella was recently seen. Patient was instructed to enter the Health Center through the side door and into an exam room. The attending Medical Assistant did not take precautions and the MA did have not confirmed varicella immunity. Michael reported that they will be looking back at the vaccination policy. Michael believes that it was never approved by the Board. Jon and Miranda are going to review this policy. An training is being planned at the Medical Provider Meeting on protocol. Department heads will be developing a plan to ensure follow-up on any incidents reported. The Medical Department is under staffed, as well as the Dental Department, with insufficient staffing ratios. There are job postings for Medical Assistants and RNs currently, but there will be a delay in getting them up and running. Meetings with department heads are starting today regarding these issues with the staffing shortage. Jon Liebman stated that there are several hundred patients who are being transitioned to new primary providers, due to Melanie Krupa leaving. Providers have currently increased their hours to accommodate these patients, but that still does not solve the issue of patient follow-up. A new MD is in the interview process. Jon Liebman and Michael Purdy will follow-up with Frank Mertes, CFO regarding the pay rate requested by the interviewee.	Michael will report back next month with a follow up on the incident.

	Jon Liebman reported that there are still issues with the lack of data gathering. Michael Purdy plans on seeing how C3 is going to pulling numbers. He suggested that bench marks could at least be pulled for the time being.	
New Business	No new business reported.	
Patient Satisfaction Survey	Patient Satisfaction survey to be sent out in March. In regards to the HRSA Site Visit planning, the focus is on Medical patients. Eliza Lake is going to locate the Incident Report spread sheet to review with Dawn Flatt and Michael Purdy. Also looking at a more efficient way to distribute survey to patients i.e. tablet or laptop during patient visit.	
Adjourn	Katheryn Jensen moved that the meeting be adjourned, the meeting was adjourned at 10:00am. The next meeting is scheduled for **Tuesday, February 19, 2019** at 9:15am at the Huntington Health Center.	

Respectfully submitted,
Tabitha Griswold
Executive Assistant

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 /Revised: MARCH 2019

Approved by the Board of Directors, Date: March 7, 2019

Approved by:

Name: Eliza B Lake
Eliza B. Lake
Executive Director, HCHC
Date: 10/4/18

Name: John Follet
John Follet, MD
President, HCHC Board of Directors
Date: 10/4/18

Health Safety Net (HSN) 2018 Credit and Collection (C&C) Policy Cross Reference Index

CONTACT INFORMATION

Provider Name: HILLTOWN COMMUNITY HEALTH CENTER, INC.

Contact Name: FRANK MERTES	**Title: CHIEF FINANCIAL OFFICER**
Contact #: 413-238-4116	**Contact Email: FMERTES@HCHCWEB.ORG**
CFO Name: FRANK MERTES	**CFO Email: FMERTES@HCHCWEB.ORG**

The descriptions below are for convenience only -- please refer to the applicable provisions of 101 CMR 613.00 for the actual requirement.

Part #	Exceptions	Reference	CC/FAP Page # (or N/A)	101 CMR 613.00 Credit & Collection Regulatory Requirements
1. General Filing Requirements - Section 613.08(1)(c)				
1-1		613.08(1)(c)	Page 2	Electronic Filing with Table of Contents
2. General Definitions of Emergency Care and Urgent Care - Section 613.02				
2-1	Hospitals Only	613.02	Page 2	Emergency Services definition to be used in determining Allowable Bad Debt under § 613.06
2-2		613.02	Page 2	Urgent Care Services definition to be used in determining Allowable Bad Debt under § 613.06
3. General Collection Policies & Procedures - Sections 613.08(1)(c)2 and 613.04(6)(c)3				
3-1		613.08(1)(c)2a	Page 2	Standard collection policies and procedures for patients
3-2		613.08(1)(c)2b	Page 3	Policies and procedures for collecting financial information from patients
3-3	Hospitals Only	613.08(1)(c)2c	N/A	Emergency Care classification; elective or scheduled services differentiated
3-4		613.08(1)(c)2d	Page 4	Policy for deposits and payment plans
3-5		613.08(1)(c)2e	Page 4	Copies of billing invoices and notification of assistance
3-6		613.08(1)(c)2f	Page 4	Description of any discount or charity program for the uninsured
3-7	Hospitals Only	613.08(1)(c)2g	N/A	Acute hospital's deductible payment option at each HLHC, satellite, and/or student health center (specified in Part 3-8)
3-8	Hospitals Only	613.04(6)(c)5a	N/A	Full or 20% deductible payment option for all partial HSN patients at HLHC, satellite, and/or student health center
3-9	CHCs Only	613.04(6)(c)5a	Page 5	Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients
3-10		613.08(1)(c)2h	Page 6	Direct Website(s) or URL(s) where the Provider's Credit and Collection Policy, Provider Affiliate List (if applicable), and other financial assistance policies are posted
3-11	Hospitals Only	613.08(1)(d)	N/A	Provider Affiliate List, effective the first day of the Acute Hospital's fiscal year beginning after December 31, 2016
4. Collection of Financial Information - Section 613.06(1)(a)				
4-1		613.06(1)(a)1	Page 6	Inpatient, Emergency, Outpatient, & CHC Services
4-2	Hospitals Only	613.06(1)(a)2a	N/A	Inpatient Verification
4-3		613.06(1)(a)2b	Page 6	Outpatient/CHC Verification
5. Deposits & Payment Plans - Section 613.08(1)(f)				
5-1		613.08(1)(g)1	Page 7	Deposits may not be required for Emergency Services or Low Income Patients
5-2		613.08(1)(g)2	Page 7	Deposits requests from Low Income Patients
5-3		613.08(1)(g)3	Page 7	Deposits requirement from Medical Hardship patient
5-4		613.08(1)(g)4	Page 7	Interest-free payment plans on balances less than, and greater than, $1000
6. Populations Exempt From Collection Action - Section 613.08(3) and 613.05(2)				
6-1		613.08(3)(a)	Page 7	MassHealth and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) enrollees
6-2		613.08(3)(b)	Page 7	Participants in the Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) income equal to or less than 300% FPL
6-3		613.08(3)(c)	Page 7	Low Income Patients, except Dental-Only Low Income Patients
6-4		613.08(3)(d)	Page 7	Low Income Patient with HSN Partial
6-5		613.08(3)(e)	Page 8	Low Income Patient consent on billing for non-Reimbursable Health Services
6-6		613.08(3)(e)1	Page 8	Low Income Patient consent exclusion for medical errors including Serious Reportable Events (SREs)
6-7		613.08(3)(e)2	Page 8	Low Income Patient consent exclusion for administrative or billing errors
6-8		613.08(3)(f)	Page 8	Low Income Patient consent for CommonHealth one-time deductible billing
6-9		613.08(3)(g)	Page 8	Medical Hardship patient & Emergency Bad Debt eligible for Medical Hardship
6-10		613.05(2)	Page 8	Provider fails to timely submit Medical Hardship application
7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt - Section 613.06(1)(2)(3) and (4)				
7-1		613.06(1)(a)3bi	Page 8	Initial Bill
7-2		613.06(1)(a)3bii	Page 8	Collection action subsequent to Initial Bill
7-3		613.06(1)(a)3biii	Page 8	Documentation of alternative collection action efforts
7-4		613.06(1)(a)3biv	Page 8	Final Notice by Certified Mail
7-5		613.06(1)(a)3bv	Page 9	Continuous collection action with no gap exceeding 120 days
7-6		613.06(1)(a)3d	Page 9	Collection action file
7-7	Hospitals Only	613.06(2)	N/A	Emergency Bad Debt claim and Eligibility Verification System (EVS) check
7-8	Hospitals Only	613.06(3)	N/A	HLHC Bad Debt claim and EVS check
7-9	CHCs only	613.06(4)	Page 9	CHC Bad Debt claim and EVS check
8. Available Third Party Resources - Section 613.03(1)(c)3				
8-1		613.03(1)(c)3	Page 9	Diligent efforts to identify and obtain payment from all liable parties
8-2		613.03(1)(c)3a	Page 9	Determining the existence of insurance including, when applicable, motor vehicle liability insurance
8-3		613.03(1)(c)3b	Page 9	Verification of patient's other health insurance coverage
8-4		613.03(1)(c)3c	Page 10	Submission of claims to all insurers
8-5		613.03(1)(c)3d	Page 10	Compliance with insurer's billing and authorization requirements
8-6		613.03(1)(c)3e	Page 10	Appeal of denied claim
8-7		613.03(1)(c)3f	Page 10	Return of HSN payments upon availability of third party resource
9. Serious Reportable Events - Section 613.03(1)(d)				
9-1		613.03(1)(d)1	Page 10	Billing & collection for services provided as a result of SRE
9-2		613.03(1)(d)2	Page 10	Billing & collection for services that cause or remedy SRE
9-3		613.03(1)(d)3	Page 10	Billing & collection by provider not associated with SRE for SRE-related services
9-4		613.03(1)(d)4	Page 10	Billing & collection for readmission or follow-up on SRE associated with provider
10. Provider Responsibilities - Section 613.08(1)(a)(b)(h)				
10-1		613.08(1)(a)	Page 10	Nondiscrimination
10-2		613.08(1)(b)	Page 10	Board approval for legal execution against patient home or motor vehicle
10-3		613.08(1)(h)	Page 11	Provider responsibility to advise patient on duties and responsibilities
11. Patient Rights and Responsibilities - Section 613.08(1)(2)				
11-1		613.08(2)(a)1	Page 11	Provider responsibility to advise patient on right to apply for MassHealth, Health Connector programs, HSN, Medical Hardship
11-2		613.08(1)(e)2a	Page 11	Provider responsibility to provide individual notice of Eligible Services and programs of public assistance during the Patient's initial registration with the Provider
11-3		613.08(1)(e)2c	Page 11	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 or health insurance coverage
11-4		613.08(2)(a)2	Page 11	Provider responsibility to advise patient of the right to a payment plan
11-5		613.08(2)(b)1	Page 11	Provider responsibility to advise patient on duty to provide all required documentation
11-6		613.08(2)(b)2	Page 11	Provider responsibility to advise patient on duty to inform of change in eligibility status & available Third Party Liability (TPL)
11-7		613.08(2)(b)3	Page 11	Provider responsibility to advise patient on duty to track patient deductible
11-8		613.08(2)(b)4	Page 11	Provider responsibility to advise patient on duty to inform HSN/MassHealth of any TPL claim/lawsuit
11-9		613.08(2)(b)4a	Page 12	Provider responsibility to advise patient on duty to file TPL claim on accident, injury or loss
11-10		613.08(2)(b)4bi	Page 12	Provider responsibility to advise patient on assigning right to recover HSN payments from TPL claim proceeds
11-11		613.08(2)(b)4bii	Page 12	Provider responsibility to advise patient on duty to provide TPL claim or proceeding information
11-12		613.08(2)(b)4biii	Page 12	Provider responsibility to advise patient on duty to notify HSN/MassHealth within ten days of filing TPL claim/lawsuit
11-13		613.08(2)(b)4biv	Page 12	Provider responsibility to advise patient on duty to repay HSN for Eligible Services from TPL proceeds
11-14		613.08(1)(e)1a	Page 12	Provider responsibility to provide individual notice of financial assistance during the Patient's initial registration with the Provider
11-15		613.08(1)(e)1c	Page 12	Provider responsibility to provide individual notice of financial assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
11-16		613.08(2)(c)	Page 12	Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds
12. Distribution of Financial Assistance Program Information - Section 613.08(1)(f)				
12-1		613.08(1)(f)1	Page 12	Location of the signs
12-2		613.08(1)(f)1	Page 12	Size of the signs
12-3		613.08(1)(f)1	Page 13	Multi-lingual signs when applicable
12-4		613.08(1)(f)1	Page 13	Wording in signs
12-5		613.08(1)(f)2	Page 13	Providers must make their Credit and Collection Policy and Provider Affiliate List (if applicable) available on the Provider's website
13. Sample Documents & Notices on Availability of Assistance - Section 613.08(1)(e)(f)				
13-1		613.08(1)(e)1b	Attachment 1	Sample of assistance notice on billing invoice
13-2		613.08(1)(e)2b	Attachment 2	Sample of Eligible Services and programs of assistance notice on billing invoice
13-3		613.08(1)(e)3	Attachment 3	Sample of assistance notice in collection actions (billing invoices)
13-4		613.08(1)(e)4	Attachment 4	Sample of payment plan notice to Low Income or Medical Hardship patients
13-5		613.08(1)(f)	Attachment 5	Sample of posted Signs

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) to patients.. 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% 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

2019 FEDERAL INCOME POVERTY GUIDELINES

	Coverable by Federal Grant Resources *				
		125%	150%	175%	200%
	100%	101-125%	126-150%	151-175%	176-200%
	Slide A	Slide B	Slide C	Slide D	E
SIZE OF FAMILY UNIT	**Maximum Annual Income Level Sliding Fee Discount Program**				
1	$ 12,490	$ 15,613	$ 18,735	$ 21,858	$ 24,980
2	$ 16,910	$ 21,138	$ 25,365	$ 29,593	$ 33,820
3	$ 21,330	$ 26,663	$ 31,995	$ 37,328	$ 42,660
4	$ 25,750	$ 32,188	$ 38,625	$ 45,063	$ 51,500
5	$ 30,170	$ 37,713	$ 45,255	$ 52,798	$ 60,340
6	$ 34,590	$ 43,238	$ 51,885	$ 60,533	$ 69,180
7	$ 39,010	$ 48,763	$ 58,515	$ 68,268	$ 78,020
8	$ 43,430	$ 54,288	$ 65,145	$ 76,003	$ 86,860
For each additional person , add	$ 4,420	$ 5,525	$ 6,630	$ 7,735	$ 8,840
Discount Allowed	100%	80%	60%	40%	20%
Charge to Patient	0%	20%	40%	60%	80%

	Coverable by State Health	
	Full HSN	**Partial HSN**
	up to 200%	up to 300%
SIZE OF FAMILY UNIT	**Maximum Annual Income Level HSN**	
1	$ 24,980	$ 37,470
2	$ 33,820	$ 50,730
3	$ 42,660	$ 63,990
4	$ 51,500	$ 77,250
5	$ 60,340	$ 90,510
6	$ 69,180	$ 103,770
7	$ 78,020	$ 117,030
8	$ 86,860	$ 130,290
For each additional person , add	$ 8,840	$ 13,260

Policy and Procedure:

* "Sliding Fee Scale" (SFS) is used by the federal Section 330 program to allow for discounts to patients with

** 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)

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)*

Attachment 1

PLEASE CALL:
JOHN BERGERON 413-667-2203
To see if you qualify for help with your medica/dental bills.

PLEASE CALL:
JOHN BERGERON 413-667-2203
To see if you qualify for help with your medical/dental bills.

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To see if you qualify for help with your medical/dental bills.

Attachment 2

STATEMENT

This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.

PATIENT NAME		
BILL DATE	ACCOUNT NO.	AMOUNT PAID
03/21/2016	[redacted]	

[redacted]

THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:

Hilltown Community Health Ctrs Inc
58 Old North Road
Worthington, MA 010989753
413-238-5511

DATE OF SERVICE	DESCRIPTION OF SERVICE		AMOUNT
12/03/2015	Claim:162509, Provider: JONATHAN LIEBMAN, NP		
12/03/2015	99213 Office Visit, Est Pt., Level 3	172.00	
03/21/2016	If you are unable to pay this bill please call 413-238-5511 financial assistance is available.		
	Your Balance Due On These Services ...		20.00

DATE	PATIENT NAME	ACCOUNT NO.	PAY THIS AMOUNT	
03/21/2016	[redacted]	[redacted]		20.00

MAKE CHECK PAYABLE TO: **Hilltown Community Health Centers Inc**

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Attachment 3

HILLTOWN COMMUNITY HEALTH CENTERS, INC.
58 Old North Road • Worthington, MA 01098
(413) 238-5511 Clinical Fax: (413) 923-9355

3/29/2016

[redacted]

Dear [redacted],

Our billing department has made a number of attempts to bring your attention to this long overdue account.

The balance of 33.04 has now gone considerably beyond our normal credit limits and you have reached the final stage of our collection process.

Because we are a non-profit Community Health Center, delinquent accounts are especially burdensome for us, as we have no profits to help offset bad debt accounts. We have valued you as a patient in the past and we do not want to jeopardize your credit rating by turning you over to a collection agency. If there is anything we can do to assist you in the payment of this account, please contact our Patient Billing Department at 413-238-5511, option 6.

If for any reason, we do not hear from you within 15 days of the date on this letter, we will be forced to proceed with collection action. Please be aware that our policy is to refuse all non-emergency services to patients whose account status has reached this point, unless payments on this overdue amount are being made. If you do not make an effort to work out a payment settlement, we may also choose to terminate you as a patient.

Thank you,

Karen Rida
HCHC Billing

Attachment 4

HILLTOWN COMMUNITY HEALTH CENTERS, INC.
58 Old North Road • Worthington, MA 01098
(413) 238-5511 Clinical Fax: (413) 923-9355

3/29/2016

[redacted]

Dear [redacted],

Your account has a balance of 33.04. Your payment is now overdue.

In order to avoid further collection action, we request that you pay your outstanding balance in full or that you work out a monthly payment plan that will enable you to pay your account in full within a reasonable amount of time.

If you believe a discrepancy exists in the amount owed, please contact the billing department at 413-238-5511, option 6.

Thank you,

Karen Rida

Karen Rida
Billing Department

Attachment 5

ARE YOU
UNABLE TO PAY OUR BILL?

PLEASE CALL
413-238-5511

FINANCIAL ASSISTANCE
IS AVAILABLE

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) Board of Directors have adopted this policy to make available a sliding fee discount program to ensure that 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.

This policy includes 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 to act as a patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives.

Discounts are offered based on family size and annual income which is documented through the completion of the "Sliding Fee Discount Application".

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 and/or Dental hardware, such as dentures and eye glasses 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.

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: MARCH 2019

Approved by Board of Directors, Date: September 28, 2016

Approved by:
Name: Eliza B. Lake Date: 3/7/2019
Eliza B. Lake

Executive Director, HCHC
Name: John Follet, MD Date: 3/7/2019
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. The SFDP 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.

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

2019 FEDERAL INCOME POVERTY GUIDELINES

	Coverable by Federal Grant Resources *				
		125%	150%	175%	200%
	100% Slide A	101-125% Slide B	126-150% Slide C	151-175% Slide D	176-200% E
SIZE OF FAMILY UNIT	**Maximum Annual Income Level Sliding Fee Discount Program**				
1	$ 12,490	$ 15,613	$ 18,735	$ 21,858	$ 24,980
2	$ 16,910	$ 21,138	$ 25,365	$ 29,593	$ 33,820
3	$ 21,330	$ 26,663	$ 31,995	$ 37,328	$ 42,660
4	$ 25,750	$ 32,188	$ 38,625	$ 45,063	$ 51,500
5	$ 30,170	$ 37,713	$ 45,255	$ 52,798	$ 60,340
6	$ 34,590	$ 43,238	$ 51,885	$ 60,533	$ 69,180
7	$ 39,010	$ 48,763	$ 58,515	$ 68,268	$ 78,020
8	$ 43,430	$ 54,288	$ 65,145	$ 76,003	$ 86,860
For each additional person , add	$ 4,420	$ 5,525	$ 6,630	$ 7,735	$ 8,840
Discount Allowed	100%	80%	60%	40%	20%
Charge to Patient	0%	20%	40%	60%	80%

	Coverable by State Health	
	Full HSN	**Partial HSN**
	up to 200%	up to 300%
SIZE OF FAMILY UNIT	**Maximum Annual Income Level HSN**	
1	$ 24,980	$ 37,470
2	$ 33,820	$ 50,730
3	$ 42,660	$ 63,990
4	$ 51,500	$ 77,250
5	$ 60,340	$ 90,510
6	$ 69,180	$ 103,770
7	$ 78,020	$ 117,030
8	$ 86,860	$ 130,290
For each additional person , add	$ 8,840	$ 13,260

Policy and Procedure:

* "Sliding Fee Scale" (SFS) is used by the federal Section 330 program to allow for discounts to patients with

** 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)

Hilltown Community Health Centers, Inc.

Sliding Fee Discount Application

It is the policy of Hilltown Community Health Centers, Inc. (HCHC), to make available a sliding fee discount program to ensure that 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. Discounts are offered based on family size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

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 and/or Dental hardware, such as dentures and eye glasses 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. This form must be completed every 12 months or if your financial situation changes.

If you have questions or need assistance completing this form please contact an HCHC Navigators at 413-667-2203 or the Billing Manager at 413-238-4114.

HOUSEHOLD/FAMILY INFORMATION

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.

PATIENT NAME :	
RELATIONSHIP TO HEAD OF HOUSEHOLD:	
HOUSEHOLD MAILING ADDRESS:	
PHONE NUMBER:	

Defined Family Living at Household Address:

Name:	Date of Birth:	Relationship

Annual Household Income:

Income Source:	Self	Other Family Member(s)	Total
Gross Wages, salaries, tips, etc.			
Income from business and self-employment.			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, 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.			
Total			

NOTE: Please attach copies of all documents or self-declaration statements being used to verify income.

I certify that the family size and income information shown above is correct.

Name (Print):

Signature: Date:

_

Official Use Only

Patient Name:
Approved Discount:
Approved By:
Date Approved:
List of Documents used to verify Income, please attach copy;

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC., Worthington, MA

Program Name: Health Center 330

Submission Status: Change Requested

Date Requested: 03/05/2019 12:02 PM EST

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Contact Information

Do you self-identify as an NMHC?: No

Title	Name	Phone	Fax	Email
UDS Contact	Frank Mertes	(413) 238 4116	(413) 238 5570	fmertes@HCHCweb.org
Project Director	Eliza Lake	(413) 238 4128	Not Available	elake@hchcweb.org
Clinical Director	Michael Purdy	(413) 667 3009 Ext. 270	(413) 238 5570	mpurdy@hchcweb.org
Chair Person	Not Available	Not Available	Not Available	Not Available
CEO	Not Available	Not Available	Not Available	Not Available

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
Worthington, MA

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Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01379		11		1	**12**
01376	1	3		6	**10**
01375	7	11	1	7	**26**
01373	3	4	3	4	**14**
01370	2	26	13	10	**51**
01360	2	1	3	1	**7**
01346	1	4		1	**6**
01341	2	10	4	5	**21**
01340	2	9	7	2	**20**
01339	3	17	11	3	**34**
01338	1	5	2	4	**12**
01330	7	49	11	29	**96**
01301	5	13	3	2	**23**
01270	6	20	15	30	**71**
01267	0	3	6	1	**10**
01256	3	10	10	10	**33**
01253	1	12	1	9	**23**
01247	1	39	12	8	**60**
01245	3	1	5	0	**9**

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01243	4	20	11	36	71
01238	0	5	1	4	10
01237	0	9	1	2	12
01235	25	84	49	103	261
01226	3	22	11	22	58
01225	3	10	1	4	18
01223	8	62	23	56	149
01220	5	32	9	12	58
01201	10	63	26	27	126
01151	0	6	1	1	8
01129	0	1	6	3	10
01119	1	1	2	4	8
01118	2	3	4	10	19
01109	4	7	3	9	23
01108	3	9	4	7	23
01107	2	6	0	1	9
01106	0	0	2	8	10
01105	0	1	2	3	6
01104	2	5	2	17	26
01098	42	171	142	302	657
01097	4	21	5	12	42
01096	17	82	42	89	230
01095	1	0	1	3	5
01090	0	2	1	1	4
01089	10	24	10	38	82
01088	1	6	0	2	9
01086	3	12	6	13	34
01085	70	337	108	352	867

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01084	4	17	13	25	59
01077	7	34	22	24	87
01075	5	8	2	9	24
01073	6	5	13	18	42
01071	28	87	32	179	326
01070	24	117	72	120	333
01069	0	1	0	3	4
01062	8	45	20	29	102
01061	0	3	1	4	8
01060	23	57	26	23	129
01057	1	3	1	1	6
01056	0	4	3	6	13
01054	0	7	2	1	10
01053	1	10	4	2	17
01050	83	327	159	608	1177
01040	8	25	4	14	51
01039	2	46	13	18	79
01038	1	6	3	1	11
01035	9	21	8	4	42
01034	11	39	9	28	87
01033	3	0	2	3	8
01032	9	18	7	33	67
01030	0	6	1	16	23
01029	4	23	12	11	50
01028	0	3	2	7	12
01027	17	85	31	48	181
01026	31	125	99	188	443
01022	0	0	1	3	4

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01020	3	13	12	13	41
01013	5	11	6	8	30
01012	24	55	39	74	192
01011	27	169	74	308	578
01008	20	87	55	196	358
01007	8	14	5	7	34
01002	84	44	26	31	185
01001	29	82	39	40	190
01367		1	3	1	5
01351	1	2	3		6
					0
01255	0	3	1	0	4
01240	1	5	0	2	8
01227	1	2	0	1	4
01202	0	2	1	1	4
01103	1	3	0	0	4
01101	1	2	0	1	4
01082	1	0	1	2	4
01072	4	3	1	3	11

Other ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	18	50	31	42	141
Unknown Residence					0
Total (Zip Codes + Other Zip Codes)	783	2919	1439	3430	8571

Comments

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC., Worthington, MA

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Table 3A - Patients By Age And By Sex Assigned At Birth

Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	18	15
2.	Age 1	24	18
3.	Age 2	21	21
4.	Age 3	21	21
5.	Age 4	30	41
6.	Age 5	38	39
7.	Age 6	49	44
8.	Age 7	38	41
9.	Age 8	40	48
10.	Age 9	50	53
11.	Age 10	36	26
12.	Age 11	52	39
13.	Age 12	40	39
14.	Age 13	54	46
15.	Age 14	48	42
16.	Age 15	55	45
17.	Age 16	36	44
18.	Age 17	54	37
	Subtotal Patients (Sum lines 1-18)	**704**	**659**
19.	Age 18	36	45
20.	Age 19	31	44

S.No	Age Groups	Male Patients (a)	Female Patients (b)
21.	Age 20	41	36
22.	Age 21	35	37
23.	Age 22	46	54
24.	Age 23	45	44
25.	Age 24	29	52
26.	Ages 25-29	209	309
27.	Ages 30-34	217	294
28.	Ages 35-39	228	290
29.	Ages 40-44	179	254
30.	Ages 45-49	230	314
31.	Ages 50-54	283	348
32.	Ages 55-59	382	496
33.	Ages 60-64	381	492
	Subtotal Patients(Sum lines 19-33)	**2372**	**3109**
34.	Ages 65-69	343	398
35.	Ages 70-74	236	256
36.	Ages 75-79	126	145
37.	Ages 80-84	56	62
38.	Ages 85 and over	33	72
	Subtotal Patients(Sum lines 34-38)	**794**	**933**
39.	**Total Patients(Sum Lines 1-38)**	**3870**	**4701**

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Table 3B - Demographic Characteristics

Universal

S.No	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1.	Asian	1	75		76
2a.	Native Hawaiian	1	6		7
2b.	Other Pacific Islander	0	1		1
2.	**Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)**	**1**	**7**		**8**
3.	Black/African American	8	78		86
4.	American Indian/Alaska Native	2	35		37
5.	White	179	5694		5873
6.	More than one race	0	1		1
7.	Unreported/Refused to report race	79	79	2332	2490
8.	**Total Patients (Sum Lines 1 + 2 + 3 to 7)**	**270**	**5969**	**2332**	**8571**

S.No	Patients by Linguistic Barriers to Care	Number (a)
12.	Patients Best Served in a Language Other Than English	218

S.No	Patients by Sexual Orientation	Number (a)

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	66
14.	Straight (not lesbian or gay)	8115
15.	Bisexual	71
16.	Something else	
17.	Don't know	80
18.	Chose not to disclose	239
19.	**Total Patients (Sum Lines 13 to 18)**	**8571**

S.No	Patients by Gender Identity	Number (a)
20.	Male	3843
21.	Female	4680
22.	Transgender Male/ Female-to-Male	6
23.	Transgender Female/ Male-to-Female	2
24.	Other	0
25.	Chose not to disclose	40
26.	**Total Patients (Sum Lines 20 to 25)**	**8571**

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Table 4 - Selected Patient Characteristics

Universal

Income As Percent Of Poverty Guideline

S.No	Characteristic	Number of Patients (a)
1.	100% and below	759
2.	101 - 150%	1266
3.	151 - 200%	1536
4.	Over 200%	2168
5.	Unknown	2842
6.	**Total (Sum lines 1-5)**	**8571**

S.No	Principal Third Party Medical Insurance	0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	68	715
8a.	Medicaid (Title XIX)	675	2244
8b.	CHIP Medicaid		
8.	**Total Medicaid (Sum lines 8a+8b)**	**675**	**2244**
9a.	Dually eligible (Medicare and Medicaid)		189
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)		1439
10a.	**Other Public Insurance (Non-CHIP) (specify)**		
10b.	Other Public Insurance CHIP		
10.	**Total Public Insurance (Sum lines 10a+10b)**	**0**	**0**
11.	Private Insurance	620	2810
12.	**Total (Sum lines 7+8+9+10+11)**	**1363**	**7208**

Managed Care Utilization

S.No	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months					
13b.	Fee-for-service Member Months	11734			22758	34492
13c.	**Total Member Months (Sum lines 13a+13b)**	**11734**	**0**	**0**	**22758**	**34492**

S.No	Special Populations	Number of Patients (a)
16.	Total Agricultural Workers or Dependents (All health centers report this line)	
23.	Total Homeless (All health centers report this line)	
24.	Total School Based Health Center Patients (All health centers report this line)	669
25.	Total Veterans (All health centers report this line)	486
26.	Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All health centers report this line)	

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Table 5 - Staffing And Utilization

Universal

Medical Care Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1.	Family Physicians	2.83	4776	
2.	General Practitioners			
3.	Internists			
4.	Obstetrician/Gynecologists			
5.	Pediatricians	1	2295	
7.	Other Specialty Physicians			
8.	**Total Physicians (Sum lines 1-7)**	**3.83**	**7071**	
9a.	Nurse Practitioners	5.21	7715	
9b.	Physician Assistants	1	1931	
10.	Certified Nurse Midwives			
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	**6.21**	**9646**	
11.	Nurses	8.36	920	
12.	Other Medical Personnel	13.22		
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**	**31.62**	**17637**	**5392**

Dental Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
16.	Dentist	6.03	10737	
17.	Dental Hygienists	5.57	4763	
17a.	Dental Therapists			
18.	Other Dental Personnel	9.64		
19.	**Total Dental Services (Sum lines 16-18)**	**21.24**	**15500**	**5014**

Mental Health Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
20a.	Psychiatrists			
20a1.	Licensed Clinical Psychologists			
20a2.	Licensed Clinical Social Workers	5.09	4306	
20b.	Other Licensed Mental Health Providers			
20c.	Other Mental Health Staff			
20.	**Total Mental Health (Sum lines 20a-20c)**	**5.09**	**4306**	**472**

Substance Use Disorder Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
21.	**Substance Use Disorder Services**			

Other Professional Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
22.	Other Professional Services Specify			

Vision Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
22a.	Ophthalmologists			
22b.	Optometrists	1.56	2381	
22c.	Other Vision Care Staff			
22d.	**Total Vision Services (Sum lines 22a-22c)**	**1.56**	**2381**	**1485**

Pharmacy Personnel

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
23.	Pharmacy Personnel			

Enabling Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
24.	Case Managers	6.49	2173	
25.	Patient/Community Education Specialists	1.98	1697	
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers	1.06		
27b.	Interpretation Staff			
27c.	Community Health Workers			
28.	**Other Enabling Services Specify**			
29.	**Total Enabling Services (Sum lines 24-28)**	**9.53**	**3870**	**1054**

Other Programs/Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
29a.	**Other Programs/Services Specify:**			
29b.	Quality Improvement Staff	1.91		

Administration And Facility

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
30a.	Management and Support Staff	4.45		
30b.	Fiscal and Billing Staff	6.96		
30c.	IT Staff	1		
31.	Facility Staff	0.81		
32.	Patient Support Staff	16.41		
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**	**29.63**		

Grand Total

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
34.	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)**	**100.58**	**43694**	

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Table 5A - Tenure for Health Center Staff

Universal

S.No	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc Persons (c)	Locum, On-Call, etc Total Months (d)

S.No	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc Persons (c)	Locum, On-Call, etc Total Months (d)
1.	Family Physicians	4	378		
2.	General Practitioners				
3.	Internists				
4.	Obstetrician/Gynecologists				
5.	Pediatricians	1	88		
7.	Other Specialty Physicians				
9a.	Nurse Practitioners	5	215		
9b.	Physician Assistants	1	12		
10.	Certified Nurse Midwives				
11.	Nurses	8	1043		
16.	Dentists	9	739		
17.	Dental Hygienists	9	1178		
17a.	Dental Therapists				
20a.	Psychiatrists				
20a1.	Licensed Clinical Psychologists				
20a2.	Licensed Clinical Social Workers	7	283		
20b.	Other Licensed Mental Health Providers				
22a.	Ophthalmologist				
22b.	Optometrist	2	117		
30a1.	Chief Executive Officer	1	75		
30a2.	Chief Medical Officer	1	52		
30a3.	Chief Financial Officer	1	37		
30a4.	Chief Information Officer				

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC., Worthington, MA

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Table 6A - Selected Diagnoses And Services Rendered

Universal

Selected Infectious And Parasitic Diseases

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	24	7
3.	Tuberculosis	A15- through A19-, O98.01	0	0
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0)	24	19
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	6	5
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	44	21

Selected Diseases Of The Respiratory System

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5.	Asthma	J45-	869	512
6.	Chronic lower respiratory diseases	J40- through J44-, J47-	924	411

Selected Other Medical Conditions

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	138	101
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	34	26
9.	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	1517	518
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	1022	472
11.	Hypertension	I10- through I16-	3369	1427
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	250	205
13.	Dehydration	E86-	10	9
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	5	1
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	1068	744

Selected Childhood Conditions (Limited To Ages 0 Through 17)

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15.	Otitis media and Eustachian tube disorders	H65- through H69-	83	62
16.	Selected perinatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	9	5
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	29	21

Selected Mental Health And Substance Use Disorder Conditions

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18.	Alcohol related disorders	F10-, G62.1	367	142
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	205	75
19a.	Tobacco use disorder	F17-, O99.33	627	344
20a.	Depression and other mood disorders	F30- through F39-	3423	748
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	4336	982
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	496	125
20d.	Other mental disorders excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0-and F43.1-). F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34, R45.1, R45.2, 45.5, R45.6, R45.7, R45.81, R45.82, R48.0	1431	396

Selected Diagnostic Tests/Screening/Preventive Services

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
21.	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	0	0
21a.	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	0	0
21b.	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522	0	0
22.	Mammogram	**CPT-4:** 77052, 77057, 77065, 77066, 77067 OR **ICD-10:** Z12.31	0	0
23.	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	140	137
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal; diphtheria; tetanus; pertussis (DTaP) (DTP) (DT); mumps; measles; rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	560	500
24a.	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90688, 90749, 90756	1459	1451
25.	Contraceptive management	**ICD-10:** Z30-	315	213
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393	354	268
26a.	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	15	15
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, H0050	0	0
26c.	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II:** 4000F, 4001F, 4004F	1	1
26d.	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014	969	969

Selected Dental Services

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27.	Emergency Services	**ADA:** D9110	308	297
28.	Oral Exams	**ADA:** D0120, D0140, DO145, D0150, D0160, D0170, D0171, D0180	5715	3779
29.	Prophylaxis - adult or child	**ADA:** D1110, D1120	5926	3795
30.	Sealants	**ADA:** D1351	435	145
31.	Fluoride treatment - adult or child	**ADA:** D1206, D1208 **CPT-4:**99188	1410	987
32.	Restorative services	**ADA:** D21xx through D29xx	4668	3268
33.	Oral surgery (extractions and other surgical procedures)	**ADA:**D7xxx	837	558
34.	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	278	93

Sources of Codes:

ICD-10-CM (2018). National Center for Health Statistics (NCHS).

CPT (2018). American Medical Association (AMA).

Code on Dental Procedures and Nomenclature CDT Code (2018) - Dental Procedure Codes. American Dental Association (ADA).

Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality Of Care Measures

Universal

[X]: Prenatal Care Provided by Referral Only (Check if Yes)

Section A - Age Categories For Prenatal Care Patients:

Demographic Characteristics Of Prenatal Care Patients

S.No	Age	Number of Patients (a)
1.	Less than 15 years	0
2.	Ages 15-19	1
3.	Ages 20-24	2
4.	Ages 25-44	13
5.	Ages 45 and over	0
6.	**Total Patients (Sum lines 1-5)**	**16**

Section B - Early Entry Into Prenatal Care

S.No	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7.	First Trimester	16	0
8.	Second Trimester	0	0
9.	Third Trimester	0	0

Section C - Childhood Immunization Status

S.No	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	18	18	8

Section D - Cervical Cancer Screening

S.No	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11.	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	1710	1710	632

Section E - Weight Assessment And Counseling For Nutrition And Physical Activity Of Children And Adolescents

S.No	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile and counseling on nutrition and physical activity documented	535	535	120

Section F - Preventive Care And Screening: Body Mass Index (BMI) Screening And Follow-Up Plan

S.No	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	4375	4375	1704

Section G - Preventive Care And Screening: Tobacco Use: Screening And Cessation Intervention

S.No	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User (c)
14a.	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention	3857	3857	1714

Section H - Use Of Appropriate Medications For Asthma

S.No	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	137	137	123

Section I - Coronary Artery Disease (CAD): Lipid Therapy

S.No	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed a Lipid Lowering Therapy (c)
17.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy	100	100	94

Section J - Ischemic Vascular Disease (IVD): Use Of Aspirin Or Another Antiplatelet

S.No	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	229	229	206

Section K - Colorectal Cancer Screening

S.No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	2202	2202	1314

Section L - HIV Linkage To Care

S.No	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	0	0	0

Section M - Preventive Care And Screening: Screening For Depression And Follow-Up Plan

S.No	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive,(2) had a follow-up plan documented	3558	3558	1299

Section N - Dental Sealants For Children Between 6-9 Years

S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)

S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22.	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	54	54	32

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Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

S.No	Prenatal Services	Patients (a)
0	HIV-Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Providers	0

Hispanic/Latino

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a.	Asian	0	0	0	0
1b1.	Native Hawaiian	0	0	0	0
1b2.	Other Pacific Islander	0	0	0	0
1c.	Black/African American	0	0	0	0
1d.	American Indian/Alaska Native	0	0	0	0
1e.	White	0	0	0	0
1f.	More Than One Race	0	0	0	0
1g.	Unreported/Refused to Report Race	0	0	0	0
	Subtotal Hispanic/Latino	**0**	**0**	**0**	**0**

Non-Hispanic/Latino

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a.	Asian	0	0	0	0
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	0	0	0	0
2c.	Black/African American	0	0	0	0
2d.	American Indian/Alaska Native	0	0	0	0
2e.	White	15	0	1	5
2f.	More Than One Race	0	0	0	0
2g.	Unreported/Refused to Report Race	0	0	0	0
	Subtotal Non-Hispanic/Latino	15	0	1	5

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h.	Unreported/Refused to Report Race and Ethnicity	0	0	0	0
i.	**Total**	15	0	1	5

Controlling High Blood Pressure

Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a.	Asian	0	0	0
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	0	0	0
1c.	Black/African American	2	2	1
1d.	American Indian/Alaska Native	0	0	0
1e.	White	15	15	13
1f.	More Than One Race	0	0	0
1g.	Unreported/Refused to Report Race	9	9	7
	Subtotal Hispanic/Latino	**26**	**26**	**21**

Non-Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a.	Asian	7	7	7
2b1.	Native Hawaiian	2	2	1
2b2.	Other Pacific Islander	0	0	0
2c.	Black/African American	13	13	8
2d.	American Indian/Alaska Native	4	4	4
2e.	White	1207	1207	881
2f.	More Than One Race	0	0	0
2g.	Unreported/Refused to Report Race	8	8	6
	Subtotal Non-Hispanic/Latino	**1241**	**1241**	**907**

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	34	34	23
i.	Total	1301	1301	951

Diabetes: Hemoglobin A1c Poor Control

Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a.	Asian	1	1	0
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	0	0	0
1c.	Black/African American	3	3	1
1d.	American Indian/Alaska Native	0	0	0
1e.	White	7	7	2
1f.	More Than One Race	0	0	0
1g.	Unreported/Refused to Report Race	6	6	3
	Subtotal Hispanic/Latino	17	17	6

Non-Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a.	Asian	7	7	3
2b1.	Native Hawaiian	1	1	0
2b2.	Other Pacific Islander	0	0	0
2c.	Black/African American	8	8	4
2d.	American Indian/Alaska Native	4	4	1
2e.	White	411	411	115
2f.	More Than One Race	0	0	0
2g.	Unreported/Refused to Report Race	7	7	0
	Subtotal Non-Hispanic/Latino	**438**	**438**	**123**

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h.	Unreported/Refused to Report Race and Ethnicity	9	9	3
i.	**Total**	**464**	**464**	**132**

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Table 8A - Financial Costs

Universal

* Column c is equal to the sum of column a and column b.

Financial Costs For Medical Care

S.No	Cost Center	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
1.	Medical Staff	2460530	619786	3080316
2.	Lab and X-ray			0
3.	Medical/Other Direct	294534	366336	660870
4.	**Total Medical Care Services (Sum lines 1-3)**	**2755064**	**986122**	**3741186**

Financial Costs For Other Clinical Services

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
5.	Dental	1957089	721952	2679041
6.	Mental Health	319760	159503	479263
7.	Substance Use Disorder			0
8a.	Pharmacy not including pharmaceuticals	3675	926	4601
8b.	Pharmaceuticals	27313		27313
9.	**Other Professional Specify:**			0
9a.	Vision	295078	113807	408885
10.	**Total Other Clinical Services (Sum lines 5-9a)**	**2602915**	**996188**	**3599103**

Financial Costs Of Enabling And Other Services

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
11a.	Case Management	389488		389488
11b.	Transportation	248		248
11c.	Outreach			0
11d.	Patient and Community Education	106921		106921
11e.	Eligibility Assistance	58808		58808
11f.	Interpretation Services			0
11g.	**Other Enabling Services Specify:**			0
11h.	Community Health Workers			0
11.	**Total Enabling Services Cost (Sum lines 11a-11h)**	**555465**	**147812**	**703277**
12.	**Other Related Services Specify:**			0
12a.	Quality Improvement	143640	36182	179822
13.	**Total Enabling and Other Services (Sum Lines 11, 12, and 12a)**	**699105**	**183994**	**883099**

Facility And Non-Clinical Support Services And Totals

S.No	Services	Accrued Cost (a) $	Allocation Of Facility and Non-Clinical Support Services (b) $	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) $
14.	Facility	630712		
15.	Non-Clinical Support Services	1535592		
16.	**Total Facility And Non-Clinical Support Services (Sum Lines 14 And 15)**	**2166304**		
17.	**Total Accrued Costs (Sum lines 4+10+13+16)**	**8223388**		**8223388**
18.	**Value of Donated Facilities, Services and Supplies Specify:** Space donated by Gateway School for school-based services			30000
19.	**Total with Donations (Sum lines 17 and 18)**			**8253388**

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Table 9D - Patient Related Revenue (Scope of Project Only)

Universal

S.No	Payer Category	Full Charges This Period (a) $	Amount Collected This Period (b) $	Collection of Reconciliati / Wrap Around Current Year (c1) $	Collection of Reconciliati / Wrap Around Previous Year (c2) $	Collection of Other Payments: P4P, Risk Pools, etc. (c3) $	Penalty / Payback (c4) $	Allowances (d) $	Sliding Fee Discounts (e) $	Bad Debt Write Off (f) $
1.	Medicaid Non-Managed Care	2328788	1647550					806799		
2a.	Medicaid Managed Care (capitated)									
2b.	Medicaid Managed Care (fee-for-service)	358149	259346					147844		
3.	**Total Medicaid (Sum lines 1+2a+2b)**	**2686937**	**1906896**	**0**	**0**	**0**	**0**	**954643**		
4.	Medicare Non-Managed Care	978568	815040					120723		
5a.	Medicare Managed Care (capitated)									
5b.	Medicare Managed Care (fee-for-service)									
6.	**Total Medicare (Sum lines 4+5a+5b)**	**978568**	**815040**	**0**	**0**	**0**	**0**	**120723**		
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)									
8a.	Other Public including Non-Medicaid CHIP (Managed Care capitated)									

S.No	Payer Category	Full Charges This Period (a) $	Amount Collected This Period (b) $	Collection of Reconciliati / Wrap Around Current Year (c1) $	Collection of Reconciliati / Wrap Around Previous Year (c2) $	Collection of Other Payments: P4P, Risk Pools, etc. (c3) $	Penalty / Payback (c4) $	Allowances (d) $	Sliding Fee Discounts (e) $	Bad Debt Write Off (f) $
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)									
9.	**Total Other Public (Sum lines 7+8a+8b)**	0	0	0	0	0	0	0		
10.	Private Non-Managed Care	1536276	898846					556746		
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)	1033105	657692			37698		399101		
12.	**Total Private (Sum lines 10+11a+11b)**	2569381	1556538			37698	0	955847		
13.	Self-pay	1175913	687128						445195	58489
14.	**Total (Sum lines 3+6+9+12+13)**	**7410799**	**4965602**			**37698**		**2031213**	**445195**	**58489**

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Submission Status: Change Requested

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Table 9E - Other Revenues

Universal

BPHC Grants (Enter Amount Drawn Down - Consistent With PMS-272)

S.No	Source	Amount (a) $
1a.	Migrant Health Center	
1b.	Community Health Center	1719762
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	**Total Health Center (Sum lines 1a through 1e)**	**1719762**
1j.	Capital Improvement Program Grants	367080
1k.	Capital Development Grants, including School Based Health Center Capital Grants	
1.	**Total BPHC Grants (Sum lines 1g+1j+1k)**	**2086842**

Other Federal Grants

S.No	Source	Amount (a) $
2.	Ryan White Part C HIV Early Intervention	
3.	**Other Federal Grants Specify:**	
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	8500
5.	**Total Other Federal Grants (Sum lines 2-3a)**	**8500**

Non-Federal Grants Or Contracts

S.No	Source	Amount (a) $
6.	**State Government Grants and Contracts Specify:** DPH1422, Dept of Early Ed & Care, DSRIP, DPH School Based, Mass Office of Victim Assistance, State Navigator	474006
6a.	**State/Local Indigent Care Programs Specify:** State Free Care	397855
7.	**Local Government Grants and Contracts Specify:** Northern Hilltown Council on Aging, Pioneer Valley Planning Commission, Hilltown Community Dev. Corp, Friends of Hilltown Safety at Home, Safe Passage, Highland Valley Elder Services	187973
8.	**Foundation/Private Grants and Contracts Specify:** Mass Development, BCBS, Cooley Dickinson Hospital, Holyoke YMCA, City of Northampton, Mass League of Comm Hlth Ctrs, Scholastic, UMass, United Way	224393
9.	**Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)**	**1284227**
10.	**Other Revenue (non-patient related revenue not reported elsewhere) Specify:** Dividend Income, Unrealized gain/loss on investments, Mavis Rolland Fund donation, Donations, Pledges, Rental income, Interest income, medical report income	84929
11.	**Total Revenue (Sum lines 1+5+9+10)**	**3464498**

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Submission Status: Change Requested

UDS Report - 2018

Health Center Health Information Technology (HIT) Capabilities

HIT

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?:

[X]: Yes, installed at all sites and used by all providers

[_]: Yes, but only installed at some sites or used by some providers

[_]: No

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?:

[X]: Yes

[_]: No

Vendor: eClinicalWorks, LLC

Other (Please specify):

Product Name: eClinicalWorks version

Version Number: 10

ONC-certified Health IT Product List Number: 07312014-3002-1

Vendor:

Other (Please specify):

Product Name:

Version Number:

1b. Did you switch to your current EHR from a previous system this year?:

[_]: Yes

[X]: No

1c. How many sites have the EHR system in use?:

1d. How many providers use the EHR system?:

1e. When do you plan to install the EHR system?:

[_]: a. 3 months

[_]: b. 6 months

[_]: c. 1 Year or more

[_]: d. Not planned

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing):

[X]: Yes

[_]: No

[_]: Not Sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?:

[X]: Yes

[_]: No

[_]: Not Sure

4. Does your center exchange clinical information electronically with other key providers/health care settings, such as hospitals, emergency rooms, or subspecialty clinicians?:

[X]: Yes

[_]: No

[_]: Not Sure

5. Does your center engage patients through health IT, such as patient portals, kiosks, or secure messaging (i.e., secure email) either through the EHR or through other technologies?:

[X]: Yes

[_]: No

[_]: Not Sure

6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?:

[X]: Yes

[_]: No

[_]: Not Sure

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?:

[_]: We use the EHR to extract automated reports

[_]: We use the EHR but only to access individual patient charts

[X]: We use the EHR in combination with another data analytic system

[_]: We do not use the EHR

8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as Meaningful Use?:

[_]: Yes, all eligible providers at all sites are participating

[_]: Yes, some eligible providers at some sites are participating

[_]: No, our eligible providers are not yet participating

[X]: No, because our providers are not eligible

[_]: Not Sure

8a. If yes (a or b), at what stage of Meaningful Use (MU) are the majority (more than half) of your participating providers attested (i.e., what is the stage for which they most recently received incentive payments)?:

[_]: Received MU for Modified Stage 2

[_]: Received MU for Stage 3

[_]: Not Sure

8b. If no (c only), are your eligible providers planning to participate?:

[_]: Yes, over the next 3 months

[_]: Yes, over the next 6 months

[_]: Yes, over the next 12 months or longer

[_]: No, they are not planning to participate

9. Does your center use health IT to coordinate or to provide enabling services, such as outreach, language translation, transportation, case management, or other similar services?:

[X]: Yes

[_]: No

If yes, specify the type(s) of service: Outreach, case management, language translation requirements

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UDS Report - 2018

Other Data Elements

Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

1a. How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?: 0

1b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?: 0

2. Did your organization use telehealth in order to provide remote clinical care services? (The term 'telehealth' includes 'telemedicine' services, but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.):

[_]: Yes

[X]: No

2a1. Who did you use telehealth to communicate with? (Select all that apply):

[_]: Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

[_]: Specialists outside your organization (e.g., specialists at referral centers)

2a2. What telehealth technologies did you use? (Select all that apply):

[_]: Real-time telehealth (e.g., video conference)

[_]: Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

[_]: Remote patient monitoring

[_]: Mobile Health (mHealth)

2a3. What primary telehealth services were used at your organization? (Select all that apply):

[_]: Primary care

[_]: Oral health

[_]: Behavioral health: Mental health

[_]: Behavioral health: Substance use disorder

[_]: Dermatology

[_]: Chronic conditions

[_]: Disaster management

[_]: Consumer and professional health education

[_]: Other (Please specify)

Other (Please specify):

2b. If you did not have telehealth services, please comment why (Select all that apply):

[_]: Have not considered/unfamiliar with telehealth service options

[_]: Lack of reimbursement for telehealth services

[_]: Inadequate broadband/telecommunication service (Select all that apply)

[_]: Lack of funding for telehealth equipment

[_]: Lack of training for telehealth services

[_]: Not needed

[X]: Other (Please specify)

Other (Please specify): We have received funding to implement telehealth and will do so in 2019.

Inadequate broadband/telecommunication service (Select all that apply):

[_]: Cost of service

[_]: Lack of infrastructure

[_]: Other (Please specify)

Other (Please specify):

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists: 7848

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Date Requested: 03/05/2019 12:06 PM EST

Date of Last Report Refreshed: 03/05/2019 12:06 PM EST

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 03951: Numbers Questioned For Patients Aged 65+ - Patients aged 65 and older is outside the typical range when compared to total patients. Please correct or explain. Persons aged 65 and older: (1727); Total Patients(8571); Ratio of Persons aged 65+ to Total Patients(0.20)

Related Tables: Table 3A(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:22 AM EST: Number of patients aged 65 and older is correct.

Table 3B-Demographic Characteristics

Edit 05142: Unreported Race/Ethnicity in Question - A large proportion of patients (27.21)% are reported as having no race or ethnicity on Line 7 Col c: Unreported/Refused to report race. Please correct or explain.

Related Tables: Table 3B(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:23 AM EST: Confirmed that this data was unreported.

Table 4-Selected Patient Characteristics

Edit 03860: Income as Percent of Poverty Level in Question. - Number of patients reported with income over 200% FPL Line 4 Column (a) (2168) is greater than 25% of the total patients reported (8571). Income must be verified. If income is not verified, please report patients under unknown income. Please correct or explain.

Related Tables: Table 4(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:25 AM EST: Income was verified and the number of patients is accurate.

Table 5-Staffing and Utilization

Edit 00158: PA Productivity Questioned - A significant change in Productivity (visits/FTE) of PAs on Line 9b (1931) is reported from the prior year (950). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:30 AM EST: Confirmed that FTE and visit numbers are accurate.

Edit 04135: Substantial Inter-year variance in Providers - The number of Mid-Level FTEs reported on Line 10a Column a differs from the prior year. Current Year - (6.21). Prior Year - (4.95). Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:35 AM EST: Confirmed that the numbers reported are accurate.

Edit 06349: Mental Health Visit per Patient in Question - On Universal - Mental Health visits per mental health patient varies substantially from national average.CY (9.12); PY National Average (4.82). Please correct and explain.

Related Tables: Table 5(UR)

Frank Mertes (Health Center) on 02/15/2019 12:21 PM EST: Reviewed and we believe this is correct, we have integrated BH into our practice.

Table 6A-Selected Diagnoses and Services Rendered

Edit 02170: Pap Test Patients Questioned - The number of patients who had a pap test reported Line 23 Column (b) (137) on Table 6A, is unreasonably low based on the number of women aged 21-64 reported on Table 3A (2984). Check to be sure that you are using the CPT Code or the ICD Code, not both.

Related Tables: Table 6A(UR), Table 3A(UR)

Eliza Lake (Health Center) on 02/15/2019 9:14 AM EST: We have verified that this number is correct. The explanation is twofold - we serve an older population that clinically only needs a pap test done every five years, which brings down the number completed, and we have had turnover in our providers, which has affected our consistency with completing the test.

Edit 06350: Dental Sealant Visits in Question - You are reporting (3) dental sealant visits per dental patient. This is high compared to the national average. Only count dental sealants on this line if they occurred at a dental visit by a dental provider (dentist or hygenist) in a clinic setting (do not count sealants that were done by a non-dental provider, or as part of a mass screening (for example- health fair). Please correct or explain.

Related Tables: Table 6A(UR)

Eliza Lake (Health Center) on 02/15/2019 9:10 AM EST: We have verified that this number is correct. A large number of patients, some of whose parents had previously refused sealants, had three or four molars treated at once, which increased the number of visits per patient.

Table 6B-Quality of Care Indicators

Edit 05772: Line 10 Universe in Question - You are reporting (68.12)% of total possible medical patients in the universe for the Childhood Immunization measure (line 10 Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Eliza Lake (Health Center) on 02/15/2019 9:28 AM EST: We have verified that this number is correct. We live in a community where many parents choose to only vaccinate their children with some available vaccines, or none at all.

Edit 05894: Missing Clinical Measure - You report no patients newly diagnosed with HIV. Please confirm that this is the case. If not, please complete Line 20.

Related Tables: Table 6B, Table 3A(UR)

Eliza Lake (Health Center) on 02/15/2019 9:25 AM EST: We have verified that this number is correct. There were no newly diagnosed patients with HIV in 2018.

Table 7-Health Outcomes and Disparities

Edit 05088: Deliveries in question - A large difference between deliveries and births is reported. Please correct or explain. Deliveries (15); Births (6).

Related Tables: Table 7

Eliza Lake (Health Center) on 02/15/2019 9:30 AM EST: We have verified that this number is correct, based on the data available. HCHC does not provide prenatal obstetrical care, and refers out all pregnant patients. While every effort is made to receive delivery data for patients, we do not always receive it, particularly if the child is not then enrolled as a patient at HCHC.

Edit 06316: Hypertension Patients by Race or Ethnicity in Question - The total number of Asian patients with hypertension reported on Table 7 (7) is low compared to total Asian patients reported on Table 3B (76). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:36 AM EST: We have verified that this data is correct.

Edit 06324: Hypertension Patients by Race or Ethnicity in Question - The total number of Hispanic/Latino patients with hypertension reported on Table 7 (26) is low compared to total Hispanic/Latino patients reported on Table 3B (270). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:37 AM EST: We have verified that this data is correct.

Edit 06326: Hypertension Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with hypertension reported on Table 7 (34) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (2332). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:38 AM EST: We have verified that this data is correct.

Edit 06332: Diabetes Patients by Race or Ethnicity in Question - The total number of White patients with Diabetes reported on Table 7 (418) is low compared to total White patients reported on Table 3B (5873). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:36 AM EST: We have verified that this data is correct.

Edit 06334: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to report race patients with diabetes reported on Table 7 (13) is low compared to total Unreported/Refused to report race patients reported on Table 3B (158). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:36 AM EST: We have verified that this data is correct.

Edit 06335: Diabetes Patients by Race or Ethnicity in Question - The total number of Hispanic/Latino patients with diabetes reported on Table 7 (17) is low compared to total Hispanic/Latino patients reported on Table 3B (270). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:37 AM EST: We have verified that this data is correct.

Edit 06336: Diabetes Patients by Race or Ethnicity in Question - The total number of Non-Hispanic/Latino patients with diabetes reported on Table 7 (438) is

low compared to total Non-Hispanic/Latino patients reported on Table 3B (5969). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:37 AM EST: We have verified that this data is correct.

Edit 06337: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with diabetes reported on Table 7 (9) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (2332). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:38 AM EST: We have verified that this data is correct.

Table 8A-Financial Costs

Edit 04117: Cost Per Visit Questioned - Total Medical Care Cost Per Visit is substantially different than the prior year. Current Year (223.80); Prior Year (195.44).

Related Tables: Table 8A, Table 5(UR)

Frank Mertes (Health Center) on 02/15/2019 10:54 AM EST: Yes costs are up.

Edit 06306: Costs and FTE Questioned - Quality Improvement is reported on Table 8A, Line 12a (143640) and Table 5, Line 29b (1.91). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Frank Mertes (Health Center) on 02/15/2019 10:59 AM EST: Confirmed that FTE is correctly related to quality costs

Edit 03727: Inter-Year Variance Questioned - Current Year Facility costs vary substantially from last years cost for Line 14 Column a on Table 8A. (Current Year: (630712); Prior Year: (443297)). Please correct or explain.

Related Tables: Table 8A

Frank Mertes (Health Center) on 02/15/2019 10:43 AM EST: Amount correct we added a new site in FY 2018

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column (a) (1535592) varies substantially from cost on the same line last year (1793296). Please correct or explain.

Related Tables: Table 8A

Frank Mertes (Health Center) on 02/15/2019 10:53 AM EST: Amount correct in PY we had significant fundraising costs and related staff. We also had a 50K charge for the membership in the ACO in the PY. We were also short staffed in the billing department for FY 2018.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 03989: Self-pay numbers questioned - more collections and write-offs than charges - More collections and write-offs are reported than charges for self-pay, Line 13. Please review that proper re-allocations of all deductibles and co-payments to the self-pay category is being done. Please correct or explain. Current Year Accounts Receivable (-14899); Prior Year Accounts Receivable (54384);

Related Tables: Table 9D

Frank Mertes (Health Center) on 02/15/2019 12:18 PM EST: Adjusted

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Program Name:Health Center 330
Submission Status: Change Requested

UDS Report - 2018

Comments

Report Comments

HCHC added a new site that provides both medical and dental services. This site opened on June 11, 2018.

Table 7 Comments

HCHC does not provide obstetrical services. but refers all patients out to other providers. The data here is for those patients for whom the data was received back after delivery.

Hilltown CHC
UDS Summary

No. of Patients

	\---FY 2018---/		\---FY 2017---/		\---FY 2016---/		\---FY 2015---/	
HSN/Uninsured	783	9%	651	8%	665	8%	851	10%
Medicaid	2,919	34%	2,777	34%	2,707	34%	2,928	35%
Medicare	1,439	17%	1,248	15%	1,058	13%	1,274	15%
Private	3,430	40%	3,408	42%	3,589	45%	3,233	39%
Total	8,571	100%	8,084	100%	8,019	100%	8,286	100%

FTE's & Visits

	\---FY 2018---/		\---FY 2017---/		\---FY 2016---/		\---FY 2015---/	
	Visits	FTE's	Visits	FTE's	Visits	FTE's	Visits	FTE's
Medical Visits	17,637	31.62	18,716	27.62	18,122	27.00	18,497	28.10
Dental Visits	15,500	21.24	14,882	19.07	14,398	18.25	14,653	17.33
Mental Health Visits	4,306	5.09	3,809	4.65	2,928	3.71	3,806	4.33
Vision Visits	2,381	1.56	2,329	1.91	2,282	1.76	2,078	2.00
Enabling Visits	3,870	9.53	3,898	11.27	2,947	13.16	4,666	9.00
	43,694	69.04	43,634	64.52	40,677	63.88	43,700	60.76
All Other Support Staff		31.54		32.44		29.40		28.67
Total Staff		100.58		96.96		93.28		89.43

Selected Quality of Care Measurements

	\---FY 2018---/	\---FY 2017---/	\---FY 2016---/	\---FY 2015---/
Cervical Cancer Screening				
Total Female Patients Aged 23 through 64	1,710	1,678	1,588	1,691
Number of Patients Tested	632	763	788	578
Percent	37%	45%	50%	34%
Colorectal Cancer Screening				
Total Patients Aged 50 through 75	2,202	2,172	2,056	2,312
Number of Patients with Appropriate Screening for Colorectal Cancer	1,314	1,324	1,211	1,337
Percent	60%	61%	59%	58%
Preventive Care and Screening: Screening for Depression and Follow-Up Plan				
Total Patients Aged 12 and Older	3,558	3,380	3,253	3,297
Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate	1,299	994	940	846
Percent	37%	29%	29%	26%

Hilltown CHC
UDS Summary

Cost per Patient

	\---FY 2018---/	\---FY 2017---/	\---FY 2016---/	\---FY 2015---/	2017 MA Avgerage	2017 Natioanl Avg. (Our size)
Medical Cost	$ 3,741,186	$ 3,412,270	$ 3,170,979	$ 3,331,559		
Patients	5,392	5,200	5,174	4,952		
Cost per visit	$ 693.84	$ 656.21	$ 612.87	$ 672.77	$ 752.82	$ 601.51
Dental Cost	$ 2,679,041	$ 2,492,536	$ 2,285,298	$ 2,319,546		
Patients	5,014	4,610	4,527	4,646		
Cost per visit	$ 534.31	$ 540.68	$ 504.82	$ 499.26	$ 555.45	$ 513.03
Mental Health Cost	$ 479,263	$ 448,285	$ 401,004	$ 423,015		
Patients	472	465	341	345		
Cost per visit	$ 1,015.39	$ 964.05	$ 1,175.96	$ 1,226.13	$ 1,147.11	$ 823.66
Vision Health Cost	$ 408,885	$ 371,338	$ 320,741	$ 344,062		
Patients	1,485	1,808	1,219	1,009		
Cost per visit	$ 275.34	$ 205.39	$ 263.12	$ 340.99	$ 205.93	$ 223.07

Cost per Visit

	\---FY 2018---/	\---FY 2017---/	\---FY 2016---/	\---FY 2015---/	2017 MA Avgerage	2017 Natioanl Avg. (Our size)
Medical Cost	$ 3,741,186	$ 3,412,270	$ 3,170,979	$ 3,331,559		
Visits *	16,717	17,459	17,128	17,109		
Cost per visit	$ 223.80	$ 195.44	$ 185.13	$ 194.73	$ 222.17	$ 192.34
Dental Cost	$ 2,679,041	$ 2,492,536	$ 2,285,298	$ 2,319,546		
Visits	15,500	14,882	14,398	14,653		
Cost per visit	$ 172.84	$ 167.49	$ 158.72	$ 158.30	$ 177.54	$ 200.31
Mental Health Cost	$ 479,263	$ 448,285	$ 401,004	$ 423,015		
Visits	4,306	3,809	2,928	3,806		
Cost per visit	$ 111.30	$ 117.69	$ 136.95	$ 111.14	$ 173.73	$ 170.89
Vision Health Cost	$ 408,885	$ 371,338	$ 320,741	$ 344,062		
Visits	2,381	2,329	2,282	2,078		
Cost per visit	$ 171.73	$ 159.44	$ 140.55	$ 165.57	$ 139.06	$ 168.43

***** Does not iclude RN visits in calcualtion

Hilltown Community Health Center

Administrative Offices
58 Old North Road
Worthington, MA 01098
413-238-5511
www.hchcweb.org

Hilltown Community Health Centers has submitted an application to the Hampshire County United Way's Children and Families fund. We have request $21,000 a year for three years to fund the Hilltown Collaborative for Children and Families to provide the following through HCHC's Community Services Department:

- ***Parenting and Wellness Workshops*** that target the identified needs of participating families. Topics are designed to help parents and caregivers hold realistic expectations of their children's behavior, interact with their children in a safe and nurturing fashion, and learn concrete skills to guide their children's growth and development.

- ***Newborn home visiting*** is offered to parents based on their needs. These visits include:

o Brazleton Newborn Behavioral Observation Home Visits by Family Support staff to help parents better understand their babies' cues and to help families transition to new roles.
o Home Visits from *It Takes a Village* volunteers to help stabilize families by helping with household chores, food preparation, referrals to community resources and social support. The volunteer network also supplies families in need with equipment (e.g., high chairs, strollers, baby carriers) as well as diapers and clothing.

- ***Support Groups*** provided weekly in Huntington and Cummington. Support groups by trained facilitators provide mothers with free, safe, confidential spaces and provide emotional supports to women at a vulnerable time in both their own and their babies' lives.

- ***Individual Counseling and Consultation*** with a Parent Educator for parents who seek help with special concerns including childbirth education and breastfeeding support. Services can include counseling and, as needed, referrals for follow-up to medical, behavioral health, nutrition, and social services.

- ***Playgroups*** at the Hilltown Family Centers and in Worthington, Middlefield and Cummington provide, in a supportive atmosphere and at no cost to families, weekly playgroups for children. A monthly baby group in Huntington and in Cummington serves families with children under a year old.

Vote to Approve: _____