Hilltown Community Health Center

Board of Directors Meeting

December 10, 2020

https://hchcweb-org.zoom.us/j/95708963346?pwd=L0dSODJjZWpUbVgvT2o4Z2dMa2xZdz09

Meeting ID: 957 0896 3346

Passcode: 339946

5:30 p.m. – 7:30 p.m.

AGENDA

Time	Topic	Purpose	Presenter
5:30 PM	**Call to Order and Approval of Minutes**	**Vote Needed**	Lee Manchester
5:35 PM	**Finance Committee Report** • Closure of Credit Card Account	**Vote Needed**	Treasurer John Melehov
5:55 PM	**Staff Presentation** • Community Programs	Inform	Kim Savery, Director of Community Programs
6:15 PM	**Committee Reports** • Executive Committee • Fundraising Committee • Personnel • Facilities • Recruitment Orientation and Nomination • Strategic Planning	**Vote Needed**	 Lee Manchester Nancy Brenner John Follet Alan Gaitenby Wendy Long Alan Gaitenby
6:20 PM	**Senior Management Reports** • Credentialing and Privileging Report • Quality Improvement Report • Risk Management • CEO Report	 **Vote Needed** **Vote Needed** **Vote Needed** Inform/Discussion	 Michael Purdy Vickie Dempesy Michael Purdy Eliza Lake
6:55 PM	**New Business** • Financial Policies • Staff Recognition o Monthly o January All Staff event	 **Vote** Discuss	 John Melehov Senior Management
7:25 PM	**Executive Session** (if needed)	Discussion	Lee Manchester
7:30 PM	**Adjourn**	**Vote Needed**	Lee Manchester

Upcoming Meetings

- Thursday, January 14, 2021 at 5:30 PM via Zoom
- Thursday, February 11, 2021 at 5:30 PM via Zoom
- Thursday, March 11, 2021 at 5:30 PM via Zoom

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 11/12/2020 5:30pm
Zoom Meeting

MEMBERS: Lee Manchester, President; John Follet, Vice President and Treasurer; Kathryn Jensen, Clerk; Alan Gaitenby; Nancy Brenner; Seth Gemme; Matt Bannister; Kate Albright-Hanna; Jennica Gallagher; Wendy Long
STAFF: Eliza Lake, CEO; Michael Purdy, CCCSO; John Melehov, CFO; Vickie Dempsey, COO; Tabitha Griswold, Executive Assistant
ABSENT: NONE

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 10/8/2020	Lee Manchester called the meeting to order at 5:32 pm. Wendy Long noted a grammatical error in New Business and some language changes to the QI/ RM report describing the structure changes in reporting. **Nancy Brenner moved to approve the October minutes as amended. Wendy Long seconded the motion, which was approved by those present.**	The Board voted unanimously to approve the October 8, 2020 Board minutes as amended.
Finance Committee	• John Follet reported on the September financials. The September finances saw a $220K loss which is higher than it has been, with a net loss of $500K for the year. This shows the continuing negative cash flow. The PPP loan was forgiven in full and will not need to be repaid, which will be reflected in the finances for October. The income from patient revenue for the month is about $40K less than last month. Some large routine expenses for the month contributed to the larger than normal loss, and many of them were due to timing, which are all normal fluctuations. The revenue for clinical departments has been staying the same with a slight increase noted in dental. Employee compensations are about the same, but still down from last year as we have rehired NP's instead of MDs, and we still have some staff out. It was noted that that staff are out by choice (due to	The Board voted unanimously to approve the Finance Committee report

	COVID related issues) not due to furloughs at this time. Future finances are predicted to see an increase in revenues with the new providers hired in September and October. • John Melehov presented information on the 403B retirement plan audit. The agency is demonstrating good faith in correcting the issue as soon as possible and fortunately has enough funds to cover the amount due at this time, which is still estimated at $100k total for the ten years covered. The 403B Plan document has been reviewed and changed to include language that the contribution will not be based on a yearly contribution but per pay period. **John Follet moved to approve the amendment to the OneAmerica 403B plan document that all retirement contributions will change from an annualized contribution to a per period basis. Kathryn Jensen seconded the motion.** • The Board discussed an update on potential new revenue source(s) through the creation of a pharmacy, and the beginning of the budget for 2021. John Melehov has been researching the potential of an in-house or off-site pharmacy, and is looking in particular at a mail order service. The revenues could be quite substantial and offset the startup expenses. Finally, with the budget being developed for 2021 the rough math shows about a forecasted $1MIL loss in FY2021, which is accounted for in the cash on hand projections. **Wendy Long moved to approve the Finance Committee report. Nancy Brenner seconded the motion.**	The Board voted unanimously to approve the amendment of the OneAmerica 403B retirement plan.
CEO Report	• Eliza Lake provided a presentation on the implication of current political environment after the presidential election of 2020. She discussed some possible developments from the health centers' point of view. This presentation will be distributed to employees.	

Executive Committee	• Lee Manchester reported that the committee did not meet.	
Recruitment, Orientation & Nominating (RON) Committee	• Wendy Long reported that the committee has not met. However, Wendy has been able to attend the first few DEI committee meetings.	
Facilities Committee	• Alan Gaitenby reported that this committee has not met but Alan has toured the Huntington site to see some of the COVID related facility changes.	
Personnel Committee	• John Follet reported that this committee has met and reviewed personnel policies. There is a recommended policy to be discussed in New Business.	
Strategic Planning	• Nancy Brenner reported that the committee has not met but the staff have been doing work on collecting data. Nancy will work with Eliza about the logistics of a shorter plan due to current uncertainties.	
Fundraising Committee	• Nancy Brenner reported that this committee has not met. However, there has been some talk about a Giving Tuesday campaign.	
Committee Reports	• **Kathryn Jensen moved that the committee reports be approved. John Follet seconded the motion.**	The Board voted unanimously to approve the Committee Reports
Quality Improvement/ Risk Management	• Vickie reported that the annual UDS submission is due in February, and HCHC's PCMH recertification is due in June 2021. HCHC will develop a multi-site application for PCMH, which will be more work in the short term, as we will need to report out for all three sites individually in the application, as opposed to just attesting to items already approved for only Worthington and Huntington. • Vickie discussed the current effects of the COVID-19 pandemic and the restoration of services. There has been new requirements and restrictions put into place to reflect those changes. The three new providers are working very well in their first month.	The Board voted unanimously to approve the Quality Improvement Report. The Board voted unanimously to approve the Risk

	• There have been new Telehealth initiatives, including the designation of a Medical Assistant that works remotely and schedules only telehealth visits. • Peer review procedures in Dental and Behavioral Health are being reviewed as discussed in last month's committee meeting, as well as the development of a more effective tool for reporting incidents. **Alan Gaitenby moved to accept the Quality Improvement report, Kathryn Jensen seconded that motion.** • Michael Purdy reported on Risk Management. He echoed Vickie's conversation on the pandemic and potential for a surge in infection for both employees and patients. Michael noted that the Infection Control Group is currently looking at expanding employee safety processes. • Michael reported that the staffing shortage continues to be an issue especially with support staff in both medical and dental departments. He did note that hiring managers are working with DEI committee to aid in recruitment. There has been recent success in hiring through some new recruitment sites. There is also potential for an incentive program offered to bilingual employees through fluency tests. • Michael reported that hours of operations in all sites are being looked at for opportunities to maximize staffing and allow for proper social distancing of staff as colder weather is imminent. • John Melehov also noted for risk management that there has been a recent call on health care providers to assess ransomware threat, as there have been several recent IT threats in the field. HCHC's IT Manager is currently working on a list of enhanced security features suggested by C3's IT Consultant to ensure adequate and appropriate protection for the agency. **Kathryn Jensen moved to accept the Risk Management report, Jenicca Gallagher seconded that motion.**	Management Report.

Credentialing/ Privileging Report	• Michael Purdy informed the Board that the following employee is being presented for initial credentialing: o Jose Velazquea, Medical Assistant o Sarah Pais, Dental Assistant Intern o Tina Andros, Medical Assistant **Nancy Brenner moved to approve the initial credentialing of the employees as presented, Alan Gaitenby seconded the motion.**	The Board voted unanimously to approve the initial credentialing of Jose Velazquea, Medical Assistant; Sarah Pais, Dental Assistant Intern; Tina Andros, Medical Assistant. Bridget Rida to notify employee of the granted credentials.
New Business	• Eliza Lake presented the School Based Health Center Policies. An amendment was noted to change the language in some places from "policies" to "procedures," to reflect current practice. • Lee Manchester presented the clinical policies. An amendment was noted the Hospital follow up policy to reflect Emergency Department as the current term in use, not Emergency Room. There was no further changes to the policies listed below: o Dismissal of Patient Policy o Hospital ED Follow Up Policy o Peer Review Policy o Tracking Patient Referrals Policy **Kathryn Jensen moved to approve the slate of policies as amended, and John Follet seconded the motion.**	The Board voted unanimously to approve the slate of clinical policies. The Board voted unanimously to approve the Policy of Personnel Policies.

	• John Follet presented the new policy on personnel policies. This is an omnibus policy, as there were several policies that were repeated in the Employee Handbook and were more procedural. Those procedures listed in the policy would be included only in the Handbook and approved when the Handbook is approved as needed. The language was amended in the policy to state that the Handbook may not necessarily be reviewed annually but only as needed. **John Follet moved to approve the Policy on Personnel Policies as amended, and Wendy Long seconded the motion.**	
Old Business	• No old business was discussed	
Executive Session	• No executive session called for by those present.	
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 7:25 pm. The next scheduled meeting, which will be December 10, 2020 via Zoom.	The Board voted unanimously to approve adjournment.

Respectfully submitted,
Tabitha Griswold, Executive Assistant
Approved by Board of Directors:

_____ _____
Chair, HCHC Board of Directors Date

Hilltown Community Health Center

Interim Financial Statement Presentation

October 2020 – Presented 12/10/2020

Highlights

- $80K Net Income in October
  - 330 Grant accounts for $350K of revenue – was being held due to PPP coordination
- YTD Net $491K loss
- $59K negative cash flow
- PPP/330 coordination in progress
  - Cash improves in November and December due to suspended draw-downs being executed

Income Statement

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	Oct Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
OPERATING ACTIVITIES														
Revenue														
Patient Services - Medical	$194,733	$157,776	$162,144	$127,027	$132,581	$147,308	$105,190	$147,451	$147,640	$160,430	$1,482,281	$2,165,681	($683,400)	-32%
Patient Services - Dental	$145,933	$123,425	$70,156	$17,187	$11,337	$26,937	$32,119	$57,754	$87,135	$111,240	$683,222	$1,610,865	($927,643)	-58%
Patient Services - Beh. Health	$39,953	$37,463	$29,811	$29,864	$25,700	$30,858	$46,280	$22,958	$31,480	$36,598	$330,964	$313,286	$17,678	6%
Patient Services - Optometry	$19,191	$13,103	$12,268	$4,184	$3,632	$3,162	$9,814	$16,594	$15,561	$19,168	$116,676	$175,033	($58,357)	-33%
Patient Services - Optometry Hard	$10,443	$4,945	$2,446	$998	$996	$3,574	$3,894	$5,390	$6,201	$5,579	$44,466	$77,560	($33,095)	-43%
Patient Services - Pharmacy	$7,260	$6,065	$11,596	$18,350	$24,126	$27,724	$13,829	$79,287	$41,854	$34,076	$264,166	$110,852	$153,315	138%
Quality & Other Incentives	$475	$324	$24,149	$277	$25	$7,684	$279	$238	$337	$20,137	$53,925	$44,910	$9,015	20%
HRSA 330 & Other Grant	$136,455	$138,372	$139,990	$225,857	$131,598	$155,075	$24,098	$88,619	$33,534	$348,885	$1,422,484	$1,489,072	($66,588)	-4%
Other Grants & Contracts	$59,052	$60,987	$64,025	$289,624	$187,345	$245,236	$200,559	$66,665	$102,503	$176,324	$1,452,322	$727,045	$725,277	100%
Int., Dividends Gain /Loss Investme	($2,424)	($22,104)	($40,933)	$27,765	$13,531	$7,243	$15,548	$16,824	($6,562)	($4,693)	$4,194	$46,918	($42,724)	-91%
Rental & Misc. Income	$4,002	$3,700	$1,132	$2,333	$2,567	$2,567	$4,002	$2,159	$2,567	$4,387	$29,416	$26,187	$3,229	12%
Total Operating Revenue	$615,073	$524,057	$476,784	$743,467	$533,437	$657,368	$455,612	$503,939	$462,251	$912,129	$5,884,116	$6,787,410	($903,293)	-13%

- Patient billings continue to improve slowly…
- 330 Grant payments playing catch-up - $349K
- $20K in quality payments

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	Oct Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
Compensation and related expenses														
Salaries and wages	($481,077)	($448,425)	($386,453)	($256,747)	($481,227)	($349,402)	($380,723)	($343,543)	($432,333)	($453,285)	($4,013,215)	($4,578,569)	$565,354	12%
Payroll taxes	($36,589)	($33,543)	($29,040)	($19,068)	($35,581)	($24,476)	($24,710)	($21,815)	($29,232)	($118,688)	($372,742)	($355,502)	($17,240)	-5%
Fringe benefits	($43,725)	($28,748)	($25,023)	($37,384)	($35,876)	($36,396)	($35,287)	($33,702)	($30,528)	($34,591)	($341,259)	($385,925)	$44,666	12%
Total Compensation & related exp	($561,390)	($510,716)	($440,516)	($313,198)	($552,684)	($410,274)	($440,720)	($399,060)	($492,093)	($606,563)	($4,727,215)	($5,319,996)	$592,780	11%

- Salaries increased due to additional providers
- Still 11% or $593K favorable to last year

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	Oct Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
Other Operating Expenses														
Advertising and marketing	$0	$0	($99)	$0	$0	($240)	($341)	($255)	($561)	$0	($1,496)	($8,006)	$6,509	81%
Bad debt	($1,307)	$6,292	($9,288)	($8,831)	($4,411)	($8,382)	$8,168	$988	$5,524	$4,486	($6,761)	($117,005)	$110,243	94%
Computer support	($7,088)	($6,199)	($21,428)	($9,589)	($12,655)	($8,388)	($8,388)	($1,948)	($8,027)	($14,818)	($98,528)	($67,350)	($31,178)	-46%
Conference and meetings	($248)	($1,350)	$0	$1,475	($1,882)	($480)	($30)	($2,636)	($358)	($85)	($5,595)	($7,783)	$2,189	28%
Continuing education	($2,368)	($1,092)	$0	$0	($308)	($1,733)	($275)	($496)	($218)	($530)	($7,021)	($26,226)	$19,205	73%
Contracts and consulting	($2,713)	($17,931)	($28,137)	($20,701)	($38,786)	($22,638)	($19,439)	($18,699)	($36,352)	($39,509)	($244,904)	($64,200)	($180,703)	-281%
Depreciation and amortization	($27,651)	($29,438)	($28,544)	($28,544)	($28,544)	($28,544)	($28,544)	($28,544)	($28,544)	($28,544)	($285,443)	($276,506)	($8,938)	-3%
Dues and membership	($2,355)	($3,243)	($2,355)	($2,530)	($2,405)	($7,955)	($3,247)	($6,692)	($1,850)	($5,894)	($38,524)	($28,061)	($10,463)	-37%
Equipment leases	($2,580)	($1,877)	($2,273)	($1,735)	($2,911)	($2,487)	($945)	($1,413)	($2,529)	($3,018)	($21,768)	($22,922)	$1,154	5%
Insurance	($2,128)	($2,202)	($2,202)	($2,192)	($2,192)	($2,192)	($2,192)	($2,192)	($2,192)	($2,192)	($21,874)	($21,095)	($779)	-4%
Interest	($1,289)	($1,279)	($1,187)	($1,258)	($1,209)	($1,238)	($1,187)	($1,723)	($156)	($355)	($10,881)	($13,383)	$2,502	19%
Legal and accounting	($2,500)	($2,500)	($2,626)	($2,500)	($2,895)	($2,668)	($2,500)	($2,500)	($2,500)	($2,584)	($25,773)	($25,058)	($715)	-3%
Licenses and fees	($4,115)	($6,952)	($4,006)	($2,898)	($2,959)	($3,504)	($3,794)	($3,775)	($4,525)	($5,418)	($41,944)	($39,716)	($2,228)	-6%
Medical & dental lab and supplies	($10,442)	($9,416)	($6,226)	($897)	($283)	($1,630)	($3,256)	($8,571)	($7,997)	($7,624)	($56,343)	($101,023)	$44,680	44%
Merchant CC Fees	($1,576)	($1,690)	($2,037)	($1,492)	($633)	($564)	($571)	($1,067)	($1,368)	($1,185)	($12,181)	($15,881)	$3,700	23%
Office supplies and printing	($2,304)	($3,052)	($1,899)	($7,188)	($1,530)	($7,637)	($7,234)	($13,799)	($7,334)	($7,595)	($59,572)	($33,928)	($25,643)	-76%
Postage	($117)	($2,051)	($2,240)	($151)	($2,233)	($2,040)	($511)	($28)	($2,066)	($650)	($12,087)	($13,334)	$1,247	9%
Program supplies and materials	($19,372)	($17,012)	($14,163)	($2,688)	($15,733)	($17,073)	($13,480)	($18,625)	($30,784)	($37,531)	($186,461)	($194,376)	$7,915	4%
Pharmacy & Optometry COGS	($7,980)	($10,963)	($4,699)	($3,785)	($3,420)	($9,287)	($6,308)	($19,791)	($30,040)	($26,752)	($123,024)	($109,501)	($13,524)	-12%
Recruitment	($4,049)	($527)	($90)	$0	$0	$0	$0	$0	$0	($75)	($4,741)	($15,960)	$11,219	70%
Rent	($6,964)	($8,584)	($10,064)	($6,964)	($15,758)	($13,843)	($16,052)	($11,738)	($20,683)	($7,741)	($118,393)	($78,440)	($39,953)	-51%
Repairs and maintenance	($13,597)	($18,942)	($15,221)	($11,565)	($12,108)	($21,849)	($15,799)	($10,838)	($15,690)	($16,930)	($152,539)	($135,852)	($16,686)	-12%
Small equipment purchases	$0	($1,669)	$0	($1,299)	($4,240)	($12,046)	($7,050)	$0	($1,704)	($3,213)	($31,221)	($20,165)	($11,056)	-55%
Telephone	($10,928)	($13,895)	($14,263)	($15,336)	($14,707)	($14,343)	($13,859)	($14,701)	($14,258)	($14,503)	($140,793)	($130,750)	($10,043)	-8%
Travel	($1,947)	($1,348)	($940)	($639)	($327)	($1,076)	($1,171)	($1,050)	($1,184)	($935)	($10,617)	($20,329)	$9,713	48%
Utilities	($3,234)	($5,499)	($3,312)	($4,481)	($4,838)	($2,955)	($3,467)	($3,102)	($3,643)	($2,757)	($37,287)	($40,407)	$3,119	8%
Total Other Operating Expenses	($138,848)	($162,418)	($177,298)	($135,788)	($176,969)	($194,792)	($151,474)	($173,195)	($219,038)	($225,951)	($1,755,772)	($1,627,259)	($128,513)	-8%
NET OPERATING SURPLUS	**($85,166)**	**($149,077)**	**($141,031)**	**$294,481**	**($196,216)**	**$52,302**	**($136,583)**	**($68,317)**	**($248,881)**	**$79,615**	**($598,871)**	**($159,845)**	**($439,026)**	**-275%**

- Year over Year increases ($128K)

Net Deficit (Income)

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	Oct Actual	YTD Total Actual	PY YTD Actual	$ Change	% Change
NON_OPERATING ACTIVITIES														
Donations, Pledges & Contribution	$120	$9,800	$20,725	$40,211	$4,657	$1,476	$7,740	$2,000	$20,432	$400	$107,562	$165,419	($57,858)	-35%
Capital Grants	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,274	($84,274)	-100%
NET NON-OPERATING SURPLU	**$120**	**$9,800**	**$20,725**	**$40,211**	**$4,657**	**$1,476**	**$7,740**	**$2,000**	**$20,432**	**$400**	**$107,562**	**$249,693**	**($142,132)**	**-57%**
NET SURPLUS/(DEFICIT)	**($85,046)**	**($139,277)**	**($120,306)**	**$334,692**	**($191,559)**	**$53,778**	**($128,843)**	**($66,317)**	**($228,449)**	**$80,015**	**($491,309)**	**$89,848**	**($581,158)**	**-647%**

- $491K YTD deficit
  - 2020 will be net positive once $1,171,200 PPP is applied as grant revenue
- Cash should hold out for around 17 months at current levels
  - This number has not gone down in several months
  - Current cash forecast has funds lasting until May 2022
- 70 days cash on hand (how long the cash will last if income dried up)

Cash Flow

CASH FLOWS FROM OPERATING ACTIVITIES		
	NET SURPLUS/(DEFICIT) FOR PERIOD	$80,015
ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH		
	NET CASH PROVIDED (USED) BY OPERATING ACTIV	($91,795)
CASH FLOWS FROM INVESTING ACTIVITIES		
	NET CASH PROVIDED (USED) BY INVESTING ACTIVI	$33,237
	NET INCREASE/(DECREASE) IN CASH	**($58,558)**
	CASH AND CASH EQUIVALENTS AS OF 8/1/2020	**$1,990,818**
	CASH AND CASH EQUIVALENTS AS OF 8/31/2020	**$1,932,260**

- Cash on hand decreased $58K
- Cash on hand decreased $94K in September

Balance Sheet (as of 8/31/20)

ASSETS		
	Total Current Assets	$1,920,681
	Net Property & Equipment	$4,064,997
	Total Other Assets	$344,045
	TOTAL ASSETS	**$6,329,723**
Liabilities & Fund Balance		
	Total Current Liabilities	$2,317,039
	Total Long Term Liabilities	$135,034
	Total Liabilities	**$2,452,072**
	Total Fund Balance / Equity	3,877,650
	Total Liabilities & Fund Balance	**6,329,723**

- Current Assets = $1.92 M
- Current Liabilities = $2.32 M
- Current Ratio = **0.83** up from **0.79** in September
  - Current Ratio as of 11/10/20 with PPP forgiveness = 1.45
  - Current Ratio as of 12/10/20 with PPP forgiveness = 1.68 (330 grant draws improve asset side)

Other Items

- Work on retirement plan correction continues
  - Estimates were around $70K
  - Actual costs were around $100K
  - All negative effects have been absorbed and created minimal long-term impact
- In-house pharmacy being put on back burner due to cost and complexity
  - Plenty of low hanging fruit in contract pharmacy area
  - Recently signed up Walmart in Westfield, another Walgreens site, and several new CVS stores
  - Engaged a service to get money from scripts written through specialists (closing the referral loop)
- Budget in progress, still expecting to have a significant deficit
  - No additional providers on the horizon
  - Fee For Service volume expected to be hampered by Covid

CEO Progress Report to the Board of Directors
Strategic and Programmatic Goals
December 2020

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

1) ***Accountable Care Organization (ACO) Engagement***: Yesterday, we had our semi-annual review with the C3 leadership, to discuss the next year and briefly review our performance over the last year. Some highlights:
    - The Telehealth Consortium Initiative has finished its Phase I fundraising, having successfully raised $5 million for health centers in the state. They are now working to raise $12 more, with $1 million secured and another application for a $1.5 million FCC grant. These funds are being used to support health centers in many ways, including technology (for both health centers and patients), staffing, and more. Impressively, C3 was able to get a $500k earmark for this project in the FY21 state budget, unless the Governor vetoes it, which is unusual in a year with very few earmarks allowed.
    - As the state begins its process of developing an 1115 Waiver application to the Centers for Medicare and Medicaid Services (CMS), both the League and C3 are very focused on the possible transition from fee-for-service (FFS) primary care (where you get paid by the visit) to a value-based payment system (where you're paid for quality), including a system that pays a capitated rate. In the current ACO, we have a budget for each patient, and while we are paid FFS, we are evaluated by C3 and ultimately the state on whether we are providing care within that budget. In a capitated system, we would be paid the amount of the budget up front, and would have to control the cost of care for that patient, if we wanted to make any money. There is a lot of risk or benefit with such a system, but there are concerns about health equity as well – research has shown that people who are low-income or people of color that have higher rates of chronic disease or have behavioral health needs are deemed "high cost," and are denied care. Obviously, community health centers would not knowingly engage in this behavior, but it is an issue that Michael in particular is raising consistently to express our concern about this move. This is likely to be a topic of conversation over the next few years, as the state and country continue to explore ways to control health care costs.
    - HCHC's performance for 2019 is still in flux, but it currently appears that we did ok, and will potentially neither have to pay nor will receive payment for our performance. Of course, there were times when this seemed likely for 2018, and we ended up having to pay a considerable amount, so I am not yet celebrating. The numbers for 2020 will not be finalized for over a year, and there is so much uncertainty about how MassHealth will address the challenges posed by the pandemic, that it seems odd that C3 still reports them to us.
    - As you may remember, C3 hired a nurse to provide case management to some of our patients, and she worked on-site and yet was not our employee. She left her job this spring, and C3 has not been able to refill her position, and is reconfiguring how they are implementing the model of care, such that it is not clear that they will do so. This means that some of the many quality measures for 2020 do not look good, which is not surprising.

2) ***Hospital Engagement***: Over the next six to nine months, and possibly longer, it seems likely that most of our interactions with hospitals will be centered on the COVID-19 vaccination effort. At least at the moment, hospitals will be the first recipients of the vaccine, both because they have the ability to transport and store the doses (which require very specific refrigeration and monitoring) and because their staff is the first priority for vaccination. Health center staff will be part of the second phase of the first wave of vaccination – our providers are also considered A1 priority, but not in the very first phase. We are waiting to learn (but currently assume) if this means that, when the second phase begins, our clinical staff will be vaccinated by the hospital. There is still a lot of uncertainty about how the vaccinations will be rolled out, but community health centers are mentioned repeatedly in the state's plan as critical to ensuring that communities of color and other vulnerable populations are targeted. We are received, over the last week, a number of opportunities to learn more about how to successfully talk with patients and staff about the importance of this vaccination, and will be able to access materials and videos from the League for distribution and education.

3) ***Electronic Health Record (EHR)***: No update..
4) ***Patient Centered Medical Home (PCMH)/National Council on Quality Assurance Certification (NCQA)***: COO Vickie Dempesy and Alex Niefer and I are developing a workplan to ensure that this project is completed on time. A setback occurred this month when we learned that the staff person at C3 who was meeting with Vickie and Alex regularly will be leaving her position at the end of the year. I am confident that, building on the work that Marie Burkart did in 2017, we will be able to develop a strong application for certification of all three of our sites. The application process must be completed in June.

Goal 2: HCHC Expansion

1) ***Expanded Services:***
   a) Office-Based Opioid Treatment (OBOT): No change at this time.
   b) Telehealth: Vickie has identified dedicated staff members who are setting up video visits for specific providers, and once they have developed a strong system, we plan to have all providers' schedules using video visits as much as possible when a telehealth visit is appropriate. This capability is increasingly important not just because of the greater reimbursement rate for some payers, but due to the rising infection rates, we need to move as many visits from in-person to telehealth as possible.
   c) Specialty Care: Our extensive efforts to hire a psychiatric Nurse Practitioner, who would have been funded for a few hours a week by our Integrated BH Services grant from HRSA, fell apart when the candidate determined that she could not take the position at this time. We are now planning to hire an additional BH provider with the funds, but this plan will not address the need for both provider consultation and patient access to medication management. We will continue to explore our options in providing this critically important service.
   d) Portable services: As the plans for vaccination roll out, we may be looking at setting up clinics in the community, or supporting clinics that other organizations are establishing. The most likely of these will be working with the Gateway Regional School District to support them as an Emergency Dispensing Site (EDS). We have a meeting on the 23rd to discuss our collaboration on this issue. I have also reached out to the Hampshire Regional School District, which is not an EDS, to see if there is any collaboration we can do as well, and I hope to have a meeting with their Health department, as well.
   e) Pharmacy: John Melehov has spent a great deal of time assessing our 340B program, and has engaged HCHC in a few new contracts and relationships that should increase our 340B revenue significantly. We are waiting to see if the new Pharmacy Program at C3 will be able to help us identify other possible expansions in this area. There are no new developments on the federal level around 340B.

2) ***Expanded Sites/Service Areas:***
   a) Amherst/John P. Musante Health Center: As you may have heard, UMass Amherst has been chosen as the site of Hampshire County's only Stop the Spread testing site, and based on conversations with people at UMass, we had hoped that we would have been able to develop a referral relationship with the testing program. The state, however, decided that it did not want the site to do anything but provide testing by appointment. Providers are concerned that this will not guarantee communication of test results to PCPs (as has been the case with the other Stop the Spread sites), making it difficult for us to coordinate care for our patients diagnosed with COVID. We have also been having conversations with the Town and local homelessness organizations about how we can support their efforts to serve this very vulnerable population. This collaboration is complicated by our and the healthcare for the homeless program's FTCA malpractice coverage, and we are trying to do what we can to help in a tricky and political situation.
   b) Westfield, Northampton, Ware, or other sites: No changes at this time.
3) ***Patient Populations*:** The new Diversity, Equity, and Inclusion (DEI) Committee is not moving quickly, but has been having almost weekly meetings with very thoughtful and deliberate conversations about a workplan for the next few years. Recently, they agreed that they will present their staff education plan at the All Staff meeting being held in January, with a range of educational opportunities for staff available over the course of many months. The focus will be on health equity, and will start with a presentation from a local expert explaining some of the most important concepts, including the difference between equity and equality, and how we need to engage with these concepts. They will also be sending out information to all staff about the diversity of holiday experiences around this time of year, encouraging staff to support each other in their own, different practices (or lack thereof).
4) ***Community Collaborations*:** We submitted a grant application last week to the Baystate system asking for support for food security efforts in the Southern Hilltowns. The funding is being provided through the health system's Determination of Need process, which is a requirement of the state whenever a hospital plans a major construction project. I have and will recuse myself from the grant review process, as it will be part of the responsibility of the CBAC I chair. Our application is to support an expansion of the current Mobile Market program, in collaboration with the Hilltown CDC.

Goal 3: Improved Organizational Infrastructure

1) ***Financial Stability:*** Our financial situation has not changed over the last few months – we continue to lose money on a weekly basis, but we have enough cash to hold us over for over a year. It is a strange contradiction that we are in better cash position than perhaps in the organization's entire history, and yet it is completely unsustainable. According to NACHC talking points released today, health centers across the country are still seeing a 20% reduction in their revenue due to COVID, and the most recent "skinny" stimulus bill does not contain any funds for CHCs. If a bill passes, and includes a new round of Paycheck Protection Program funding, John is already in communication with our contact at PeoplesBank to ensure that we apply immediately. We hope that there will be another vehicle that will both reauthorize the on-going funding for health centers (the Continuing Resolution passed this week only funds us, and the government, for an additional week) and provide us with over $7 billion in relief funding. There is no talk about the state providing any additional relief at this point.
2) ***Staff Development and Support:*** As has been true for much too long, the lack of adequate staffing is starting to take a real toll. We are seeing more issues with processes and procedures being followed, due to their simply not being enough people to get the work done. The fact that all of our colleagues across the state, and in other non-profits, are having the same problem doesn't make things easier. We have just heard that hospitals are now advertising for Medical Assistants in anticipation of the COVID vaccination efforts, and offering exorbitant pay rates to attract candidates. The situation therefore may not improve for filling those positions for quite a while.

We are making some progress with hiring for the front desk, as I believe there are four new hires starting in the next few weeks, and perhaps some additional dental staff as well. We are also reorganizing the two most challenging positions and their job descriptions, in an effort to improve recruitment and retention. We have created three tiers of positions for medical assistants and for front desk staff, who will be renamed as Patient Services Representatives (PSRs). This is a common term at other health centers, and better reflects the complexity of their job duties than the term "receptionist." New pay scales are being implemented, which will also position us to be compliant with the new minimum wage rules in Massachusetts. These changes will all be in place for January 1st. We are also in the final stages of implementing a stipend for any non-salaried staff members who can prove that they are bilingual through successful completion of a fluency test administered by our interpretation service. The stipend will be prorated for FTE status, but not for position or pay rate, which will make it a significant pay increase for our lower paid staff. HCHC will also pay up to a certain amount for any staff member to enroll in an educational program to learn another language, with a focus on fluency in a medical setting. We hope that this will increase access for patients, support our current bilingual staff, help with recruitment, and signal to all our existing staff our commitment to diversity and inclusion.

In recognition of the holiday season, we are closing all sites early on both Christmas and New Year's Eves, and providing lunch for all staff on-site on December 22nd. We are also announcing tomorrow that we will be buying fleece jackets or vests for all staff members with the HCHC logo on it. We will be holding an All Staff meeting on January 13th that will be an opportunity to recognize our staff Service Awards (recognizing 5, 10, 15, etc years of service), look back at 2020 and recognize the pain and the gratitude we experienced, and then look forward to 2021. We plan to make it as interactive an experience as possible, given it will be on Zoom, and hope that it will be a reset for everyone.

Finally, the increasing rates of infection in the community are taxing the organization in multiple ways. Our Respiratory Triage Team and COVID teams are seeing dramatic increases in calls, and are having to move staff from other responsibilities to handle the volume. The Employee Health team, which tracks every employee showing any symptoms or with any possible exposures, must make difficult decisions every day about whether an employee can come to work, and, if not, how long they must be out on quarantine/self-isolation. The guidelines may seem clear, but every situation is unique, and all of them can have a dramatic impact on HCHC operations. We have already had to close a department at one site or another multiple times in the last month, due to lack of staff because of COVID. And the Infection Control Team is doing a remarkable job balancing the changes criteria and requirements of the CDC and the state DPH, ensuring that all staff and patients are kept as safe as possible, and maintain firm but gentle education efforts to counteract the fatigue and frustration that we all feel. It is a difficult time, as we knew it would be, but we have months to go.

3) ***Facilities Improvement and Expansion:*** No change at this time.
4) ***Information Technology (IT) Improvement and Expansion:*** There are upgrades to our internet connectivity equipment occurring over the next few weeks, and we hope that this will enable the upgrade to our bandwidth to occur soon – it is badly needed, particularly in Worthington.

Other reports:

HRSA Update: For the next two months, we will be spending a great deal of time preparing:

1) our Non-Compete Continuation/Budget Period Report (NCC/BPR) for HRSA, which is how we can ensure another year of our 330 grant. We were scheduled to complete a Service Area Competition application this winter, which is much more work and a total re-application for funding, but HRSA gave all health centers a year's extension due to COVID. This is due 1/8/2020, so we will present it at the next Board meeting for your approval, if we cannot send it to you prior to submission.

2) Our annual UDS report is due 2/15/2020, and it will be even more difficult than usual this year, given that all of our utilization and quality data will be heavily affected by the pandemic. This report is what HRSA uses to assess our compliance across a wide range of issues, and determines funding decisions like our Quality Improvement Awards, the distribution of emergency relief funds, etc. We cannot truly start to work on it until the calendar year is over, but it will occupy a great deal of time over the first six months of the year. We will plan to present it at your February meeting.

Risk Management Report: 12/10/2020

1) Area of greatest risk:
    a. COVID:
        i. Ensuring employee and patient safety
            1. Infection control team meets weekly
            2. Michael, Ellen and Jon continue to participate in biweekly DPH calls
            3. Increased capacity for employee health
            4. Established PPE monitoring systems and dispensing protocol
        ii. Increase demand on staff:
            1. Increase in RTT (Respiratory Triage Team) calls have spiked
            2. CDC guidelines for employees returning to work are stringent
    b. Staffing:
        i. Shortages exist in referrals, reception, and eye care
2) Incident reports:
    a. Three incidents resulted in delay of care
    b. One incident involving inappropriate appointment scheduling by RTT
    c. One incident involving a delay in a 51A report being filed by staff member (a timely report was filed by an outside party)

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: DECEMBER 2020

Approved by the Board of Directors, Date: December 10, 2020

Approved by:

Name: Eliza B Lake
Eliza B. Lake
Executive Director, HCHC
Date: 12/10/2020

Name: Lee Manchester
President, HCHC Board of Directors
Date: 12/10/2020

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: John Melehov	**Title: CHIEF FINANCIAL OFFICER**
Contact #: 413-238-4116	**Contact Email: JMELEHOV@HCHCWEB.ORG**
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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.

2020 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% Slide E
SIZE OF FAMILY UNIT	**Maximum Annual Income Level Sliding Fee Discount Program**				
1	$ 12,760	$ 15,950	$ 19,140	$ 22,330	$ 25,520
2	$ 17,240	$ 21,550	$ 25,860	$ 30,170	$ 34,480
3	$ 21,720	$ 27,150	$ 32,580	$ 38,010	$ 43,440
4	$ 26,200	$ 32,750	$ 39,300	$ 45,850	$ 52,400
5	$ 30,680	$ 38,350	$ 46,020	$ 53,690	$ 61,360
6	$ 35,160	$ 43,950	$ 52,740	$ 61,530	$ 70,320
7	$ 39,640	$ 49,550	$ 59,460	$ 69,370	$ 79,280
8	$ 44,120	$ 55,150	$ 66,180	$ 77,210	$ 88,240
For each additional person , add	$ 4,480	$ 5,600	$ 6,720	$ 7,840	$ 8,960
Discount Allowed	100%	80%	60%	40%	20%
Charge to Patient	$0.00	20%	40%	60%	80%

Coverable by State Health Safety Net (HSN)**

	HSN Primary & Secondary	**HSN Primary & Secondary Partial**
	up to 150%	150.1% to 300%
SIZE OF FAMILY UNIT	**Maximum Annual Income Level HSN**	
1	$ 19,140	$ 38,280
2	$ 25,860	$ 51,720
3	$ 32,580	$ 65,160
4	$ 39,300	$ 78,600
5	$ 46,020	$ 92,040
6	$ 52,740	$ 105,480
7	$ 59,460	$ 118,920
8	$ 66,180	$ 132,360
For each additional person , add	$ 6,720	$ 13,440

Policy and Procedure:

* "Sliding Fee Scale" (SFS) is used by the federal Section 330 program to allow for discounts to patients with incomes below or at 200% of the Federal Poverty Level(FPL). The Sliding Fee Discount Program applies to all required and additional health services within the HRSA approved scope of project delivered at HCHC facilities. Costs for items done outside the health centers (eg. 3rd party dental and optometry lab charges) are exempt from the sliding fee discounts and the actual cost will be charged to the patient (even patients at/below 100% FPG).

** MA Health Safety Net Office (HSN) for discounts to eligible patients with incomes below or at 300% of the FPL. [per 101 CMR 613.00 (formerly 114.6 CMR 13.00) and 101 CMR 614.00 (formerly 114.6 CMR 14.00)]

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.

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

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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		
[redacted]		
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.

Finance Department

SUBJECT: NAME OF POLICY – FINANCIAL POLICY
REGULATORY REFERENCE: Code of Federal Regulations 45 (CFR) Part 75 and PIN 2013-01

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

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

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

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

Originally Drafted: MARCH 2004

Reviewed or Revised: DEC. 2020 and retroactive to JAN.1, 2020

Approved by Board of Directors,

Date: December 10, 2020

Approved by:

Eliza Lake _ Date: December 6, 2018
Eliza B. Lake
Chief Executive Officer, HCHC

LeeManchester Date: December 6, 2018
LeeManchester
President, HCHC Board of Directors

Hilltown Community Health Centers, Inc.
(HCHC)

FINANCIAL PROCEDURES MANUAL

December 2020

TABLE OF CONTENTS

December 2020

HILLTOWN COMMUNITY HEALTH CENTERS, INC.

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

Mission

Creating access to high quality integrated health care and promoting well-being for individuals, families and our communities.

Vision

Communities Engaged for Health

Values

We listen, consider and care. We respect the individual strengths and diverse experiences of the people we serve and all of our employees.

We commit to working together. We provide integrated care through teamwork and collaboration.

We hold ourselves accountable. We work to the best of our abilities and commit to open communication.

We encourage curiosity and growth. We strive to continually improve through innovation and the use of best practices.

We focus on our future. We ensure financial sustainability through efficient practices and management.

Purpose of the Corporation

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

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

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

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

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

Financial Management

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

HCHC must;

a) Establish and maintain effective internal control over the Federal and state award that provides reasonable assurance that HCHC is managing the Federal and state award in compliance with Federal and state statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government," issued by the Comptroller General of the United States or the "Internal Control Integrated Framework," issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).
b) Comply with Federal and State statutes, regulations, and the terms and conditions of the awards.
c) Evaluate and monitor the compliance with statutes, regulations and the terms and conditions of awards.
d) Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

e) Take reasonable measures to safeguard protected personally identifiable information and other information the awarding agency or pass-through entity designates as sensitive or what HCHC considers sensitive consistent with applicable Federal and state laws regarding privacy and obligations of confidentiality.

Chart of Accounts

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

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

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

Each account code is subdivided into four separate segments.

Consisting of:

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

1. Fund - 01 Used for all transactions

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

    a. Assets = 1XXXX
    b. Liabilities = 2
    c. Net Assets = 3
    d. Revenue / Income = 3
    e. Salaries and Benefits = 5
    f. Expenses = 6

3. Location – XX Used to identify location.

4. Department – XX Used to identify each department.

Subaccount Segment

1. Alphanumeric codes that identify grants
2. UFR codes that correspond with UFR coding – if required
3. Raiser's Edge code – if required

Description of Accounts

Assets

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

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

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

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

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

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

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

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

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

Liabilities

Accounts Payable

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

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

Loans/Mortgages payable

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

Capital Leases

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

Deferred Revenue Accounts

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

Net Assets

YTD Net Income

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

Net Assets

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

Net Assets without and with Donor Restrictions

Beginning in 2018, *net assets without donor restrictions* is one of two classifications of net assets reported on the financial statements of a not-for-profit organization's financial statements. This classification replaces the previous classification unrestricted net assets.

Beginning in 2018, *net assets with donor restrictions* is second of two classifications of net assets reported on the financial statements of a not-for-profit organization's financial statements. This classification is to be used instead of the following two classifications: *temporarily restricted net assets* and *permanently restricted net assets*.

Revenues

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

Contra-Revenues

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

Expenses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maintenance of Accounting Records

The health center maintains the following accounting records:

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

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

Accounts Payable Register

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

Cash Receipts Journal

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

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

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

By the end of each month all entries are posted to the general ledger. The cash account is debited for the total of the monthly receipts.

Payroll Register

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

General Ledger and General Journal Entries

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

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

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

Record Retention

Computerized/Electronic Records:

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

Non-computerized Records:

Accounting Records

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

- External Audit reports = Permanent

Corporate Records:

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

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

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

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

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

Cash Disbursements

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

<u>Disbursement Procedures</u>

All checks drawn by the health center must be reviewed and signed by the Chief Financial Officer or the Executive Director. In his/her absence, a signature stamp may

be used for essential disbursements provided a list of the checks so stamped is submitted for review. The signature stamp is kept in a locked cabinet at all times. Checks in the amount of $10,000 or more require two signatures.

Pre-approval limits and requirements are detailed on page 28 under Purchasing Procedures.

A multipart check is prepared for disbursements paid from the general operating account. The bottom two-thirds of the check is sent as payment to vendors. The top portion of the check is stapled to the invoice to provide the health center with adequate documentation for payment of the expenditure. The detailed procedures related to the preparation, distribution, and retention of the disbursement vouchers are prescribed in the accounts payable section.

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

Petty Cash

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

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

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

Cash Receipts

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

Draw downs on Federal awards must minimize the time elapsing between the transfer of funds from the United States Treasury or the pass-through entity and the

disbursement by HCHC. All advance payments on Federal awards must be deposited and maintained in insured accounts whenever possible and in interest-bearing accounts unless the following applies;

a) HCHC receives less than $120,000 in Federal awards per year.
b) The best reasonably available interest-bearing account would not be expected to earn interest in excess of $500 per year on Federal cash balances.
c) The depository would require an average or minimum balance so high that it would not be feasible within the expected Federal and non-Federal cash resources.
d) A foreign government or banking system prohibits or precludes interest bearing accounts.

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

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

Cash Receipts – Mail or Billing

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

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

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

Cash Receipts – Front Desk

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

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

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

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

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

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

Cash Receipts – Miscellaneous

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

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

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

General Operating Account

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

from this money market account are transferred back to the general operating account as needed.

Other Non-Operating Revenue

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

Grant and Contracts Revenue and Receivable Procedures

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

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

Standard Journal Entries

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

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

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

COST PRINCIPLES

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

COST ALLOCATION PLAN

Direct Cost Allocation:

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

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

Cost Allocation for Internal Management:

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

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

a) Facilities costs are recorded in separate cost pools for each site. Any expenses related to overall building operation are considered shared services and recorded to these pools. Costs are then allocated monthly to each program based on the square footage occupied by each program in that building. This pool can contain non-facility costs that need to be distributed by square feet.
b) Administration/Front Desk services are located at each main site and the services currently benefit two Departments/Programs at each site. These

departments are Medical & Behavioral Health. Originally the Dental Department was part of the allocation, currently dental has its' own front desk, so no costs are allocated to dental. Administrative or Front Desk costs are allocated to the programs based on the annual visits in each program during the previous fiscal year.

c) The billing office is one service that is shared by all sites, but not by all programs. The billing office services only benefit the programs that bill for patient services. For this reason the costs that are associated with the billing office are pooled and allocated based on visits or units of service provided for the month.
d) Indirect/Overhead costs are costs that benefit the whole Center. These are costs such as salaries and associated costs of the Executive Office, Finance Department or Human Resources. These expenses are pooled and allocated based on the modified direct costs (excludes cost of subcontracts over $25,000 in the base) of each program, sub-program or grant. Every program gets an even share allocated to it based on their direct expenses (with all other allocated expenses already included). This method allows each program to be allocated the same percentage of Indirect/Overhead costs as every other department in the Center.

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

Regulatory Cost Allocation Methods:

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

Procurement

HCHC general procurement standards;

a) Procurement procedures reflect applicable federal and state regulations.

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

No employee, officer, or agent may participate in the selection, award, or

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

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

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

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

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

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

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

i) HCHC may use a time and materials type contract only after a determination that no other contract is suitable and if the contract includes a ceiling price that the contractor exceeds at its own risk.

1) Time and materials type contract means a contract whose cost to a non-Federal entity is the sum of:
    i. The actual cost of materials; and
    ii. Direct labor hours charged at fixed hourly rates that reflect wages, general and administrative expenses, and profit.
2) Since this formula generates an open-ended contract price, a time-and-materials contract provides no positive profit incentive to the contractor for cost control or labor efficiency. Therefore, each contract must set a ceiling price that the contractor exceeds at its own risk. Further, HCHC must assert a high degree of oversight in order to obtain reasonable assurance that the contractor is using efficient methods and effective cost controls.

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

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

Competition;

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

7) Any arbitrary action in the procurement process.

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

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

Procurement Procedures;

HCHC must use one of the following methods of procurement;

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

price is considered to be reasonable.

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

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

d) Procurement by competitive proposals. The technique of competitive proposals is normally conducted with more than one source submitting an offer, and either a fixed price or cost-reimbursement type contract is awarded. It is generally used when conditions are not appropriate for the use of sealed bids. If this method is used, the following requirements apply:
    1. Requests for proposals must be publicized and identify all evaluation factors and their relative importance. Any response to publicized requests for proposals must be considered to the maximum extent practical;
    2. Proposals must be solicited from an adequate number of qualified sources;
    3. HCHC must have a written method for conducting technical evaluations of the proposals received and for selecting recipients;
    4. Contracts must be awarded to the responsible firm whose proposal is most advantageous to the program, with price and other factors considered; and
    5. HCHC may use competitive proposal procedures for qualifications-based procurement of architectural/engineering (A/E) professional services whereby competitors' qualifications are evaluated and the most qualified competitor is selected, subject to negotiation of fair and reasonable compensation. The method, where price is not used as a selection factor, can only be used in procurement of A/E professional services. It cannot be used to purchase other types of services though A/E firms are a potential source to perform the proposed effort.

e) Procurement by noncompetitive proposals. Procurement by noncompetitive proposals is procurement through solicitation of a proposal from only one source and may be used only when one or more of the following circumstances apply:
    1. The item is available only from a single source;
    2. The public exigency or emergency for the requirement will not permit a delay resulting from competitive solicitation;
    3. The HHS awarding agency or pass-through entity expressly authorizes noncompetitive proposals in response to a written request from the non-Federal entity; or
    4. After solicitation of a number of sources, competition is determined inadequate.
f) Contracting with small and minority businesses, women’s business enterprises, and labor surplus area firms
    1. HCHC must take all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.
    2. Affirmative steps must include:
        i. Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
        ii. Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

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

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

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

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

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

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

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

Additional Procurement Procedures;

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

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

Payment arrangements need to be made in advance, as the health center cannot accept C.O.D. shipments.

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

PURCHASE	REQUIRED SIGNATURES/APPROVALS
Up to $500	Dept. Head **or** Designee signature only

$501 to $5,000	Dept. Head **and** CEO **or** CFO
$5,001 to $10,000	Dept. Head **and** CEO **and** CFO.
$10,001 & over	CEO, CFO **and** Finance Committee **or** Chair of BOD

Travel Reimbursement Procedures

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

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

For local travel, an employee who uses his or her own vehicle will be reimbursed upon completion of a Mileage Reimbursement Request. *(Refer to Appendix E)* The employee's immediate supervisor must approve the request. Reimbursement will be at the current mileage rate established by the Finance Committee. Receipts must be presented for reimbursement of other related travel expenses, such as tolls and parking.

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

Continuing Education Reimbursement Procedures

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

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

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

Accounts Payable Procedures

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

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

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

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

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

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

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

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

Check Preparation

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

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

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

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

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

Payment Procedures

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

Check not cleared

If a check is not cleared after 120 days, the payee will be notified in writing with suggested options for resolving the final distribution of funds.

Lost Checks

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

Monthly Management Reports

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

Payroll Procedures

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

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

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

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

Employees may voluntarily contribute to United Way through payroll deductions.

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

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

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

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

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

Payroll Reports Maintained

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

Accounting for Fixed Assets

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

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

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

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

Patient Revenue and Receivable Process

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

Liquidity Management

HCHC will review and quantify the available resources on hand to meet cash needs for expenditures within one year and communicate qualitative and quantitative information regarding liquidity. The result of the review process, i.e. the Liquidity Plan will determine how liquid assets are managed to meet cash needs for general expenditures within one year following the balance sheet date.

HCHC's Liquidity Management Plan will consider the following items;

1. Determining the amount of cash and short-term investments to keep on hand to meet 60 days of operating expense (how is the organization going to structure its financial assets to ensure they are available).
2. Identifying the average monthly operating expenses.
3. Consider investing any excess daily cash balances not needed to meet current general operating expenses.
4. Appropriate use of the line of credit to cover cash short-falls.
5. Ensuring the timely collection of receivables.
6. Consideration of contractual obligations, covenants, or donor restrictions that would limit the availability of resources to meet operating expenses in the next year.

In compliance with FASB ASU 2016-14 HCHC will consider and if required implement and disclose the following:

1. Present on the face of the statement of financial position amounts for two classes of net assets at the end of the period, That is, HCHC will report amounts for net assets with donor restrictions and net assets without donor restrictions, as well as the currently required amount for total net assets.
2. Present on the face of the statement of activities the amount of the change in each of the two classes of net assets. HCHC will continue to report the currently required amount of the change in total net assets for the period.
3. Continue to present on the face of the statement of cash flows the net amount for operating cash flows using either the direct or indirect method of reporting but no

longer require the presentation or disclosure of the indirect method (reconciliation) if HCHC were to use the direct method.

4. Provide the following enhanced disclosures about:
    a. Amounts and purposes of governing board designations, appropriations, and similar actions that result in self-imposed limits on the use of resources without donor-imposed restrictions as of the end of the period.
    b. Composition of net assets with donor restrictions at the end of the period and how the restrictions affect the use of resources.
    c. Qualitative information that communicates how HCHC manages its liquid resources available to meet cash needs for general expenditures within one year of the balance sheet date.
    d. Quantitative information, either on the face of the balance sheet or in the notes, and additional qualitative information in the notes as necessary, that communicates the availability HCHC's financial assets at the balance sheet date to meet cash needs for general expenditures within one year of the balance sheet date. Availability of a financial asset may be affected by (1) its nature, (2) external limits imposed by donors, grantors, laws, and contracts with others, and (3) internal limits imposed by governing board decisions.
    e. Amounts of expenses by both their natural classification and their functional classification. That analysis of expenses is to be provided in one location, which could be on the face of the statement of activities, as a separate statement, or in notes to financial statements.
    f. Method(s) used to allocate costs among program and support functions.
    g. Underwater endowment funds, which include required disclosures of (1) HCHC's policy, and any actions taken during the period, concerning appropriation from underwater endowment funds, (2) the aggregate fair value of such funds, (3) the aggregate of the original gift amounts (or level required by donor or law) to be maintained, and (4) the aggregate amount by which funds are underwater (deficiencies), which are to be classified as part of net assets with donor restrictions.

5. Report investment return net of external and direct internal investment expenses and no longer require disclosure of those netted expenses.

6. Use, in the absence of explicit donor stipulations, the placed-in-service approach for reporting expirations of restrictions on gifts of cash or other assets to be used to acquire or construct a long-lived asset and reclassify any amounts from net assets with donor restrictions to net assets without donor restrictions for such long-lived assets that have been placed in service as of the beginning of the period of adoption (thus eliminating the current option to release the donor-imposed restriction over the estimated useful life of the acquired asset).

Regulatory Reporting

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

a) Identification, in its accounts, of all Federal awards received and expended and the Federal programs under which they were received. Federal program and Federal award identification must include, as applicable, the CFDA title and number, Federal award identification number and year, name of the HHS awarding agency, and name of the pass-through entity, if any.
b) Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements set forth in §§75.341 and 75.342. If an HHS awarding agency requires reporting on an accrual basis from a recipient that maintains its records on other than an accrual basis, the recipient must not be required to establish an accrual accounting system. This recipient may develop accrual data for its reports on the basis of an analysis of the documentation on hand. Similarly, a pass-through entity must not require a subrecipient to establish an accrual accounting system and must allow the subrecipient to develop accrual data for its reports on the basis of an analysis of the documentation on hand.
c) Records that identify adequately the source and application of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income and interest and be supported by source documentation.
d) Effective control over, and accountability for, all funds, property, and other assets. The non-Federal entity must adequately safeguard all assets and assure that they are used solely for authorized purposes.
e) Comparison of expenditures with budget amounts for each Federal award.
f) Written procedures to implement the requirements of §75.305.
g) Written procedures for determining the allowability of costs in accordance with subpart E of this part and the terms and conditions of the Federal award.

The major reports which are required include:

Annual, Federal Uniform Data System (UDS) Report
Annual audit in accordance with Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards
45 (CFR) Part 75
Annual grant year Federal Financial Status Report (FSR)
State annual Uniform Financial Report (UFR)
IRS Tax Form 990

State tax Form PC
Federal cash draw down quarterly report PSC-272
Medicare annual cost report
Medicaid annual cost report
The system also allows for grant reporting, salary surveys and other numerous reports which may be required from time to time. These include the annual Federal 330 grant budget renewal, DPH annual contract budget adjustments and various local and private grants.

Annual Fiscal Audit Requirements

a)
HCHC must provide for and submit an independent annual financial audit that is conducted in accordance with Generally Accepted Accounting Principles (GAAP) and the applicable requirements prescribed in 45 CFR Part 75 Subpart F. HCHC must promptly follow up and take corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan in accordance with 45 CFR 75.511Auditor procurement;
In procuring audit services, the procurement standards prescribed under this policy must be adhered to, as applicable. When procuring audit services, the objective is to obtain high-quality audits. In requesting proposals for audit services, the objectives and scope of the audit must be made clear and HCHC must request a copy of the audit organization's peer review report which the auditor is required to provide under GAGAS. Factors to be considered in evaluating each proposal for audit services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of peer and external quality control reviews, and price. Whenever possible, HCHC must make positive efforts to utilize small businesses, minority-owned firms, and women's business enterprises, in procuring audit services, as applicable.

b) *Restriction on auditor preparing indirect cost proposals.*
An auditor who prepares the indirect cost proposal or cost allocation plan may not also be selected to perform the audit required by this part when the indirect costs recovered by the auditee during the prior year exceeded $1 million. This restriction applies to the base year used in the preparation of the indirect cost proposal or cost allocation plan and any subsequent years in which the resulting indirect cost agreement or cost allocation plan is used to recover costs.

c) HCHC Board of Director involvement in selection of auditor;
Annually the HCHC Board of Directors will review and appoint the Auditor based upon the procurement standards.

APPENDIX A

ORGANIZATIONAL CHART

APPENDIX B1 & B2

CHART OF ACCOUNTS
AND
SUB ACCOUNT SEGMENTS

December 2020

APPENDIX C

PURCHASE REQUISITION FORM

APPENDIX D

CHECK REQUEST FORM

APPENDIX E

MILEAGE REIMBURSEMENT REQUEST

APPENDIX F

Copy of Conflict of Interest Policy

The pulse of the community during the COVID-19 pandemic

COMMUNITY PROGRAMS UPDATE

DECEMBER 2020

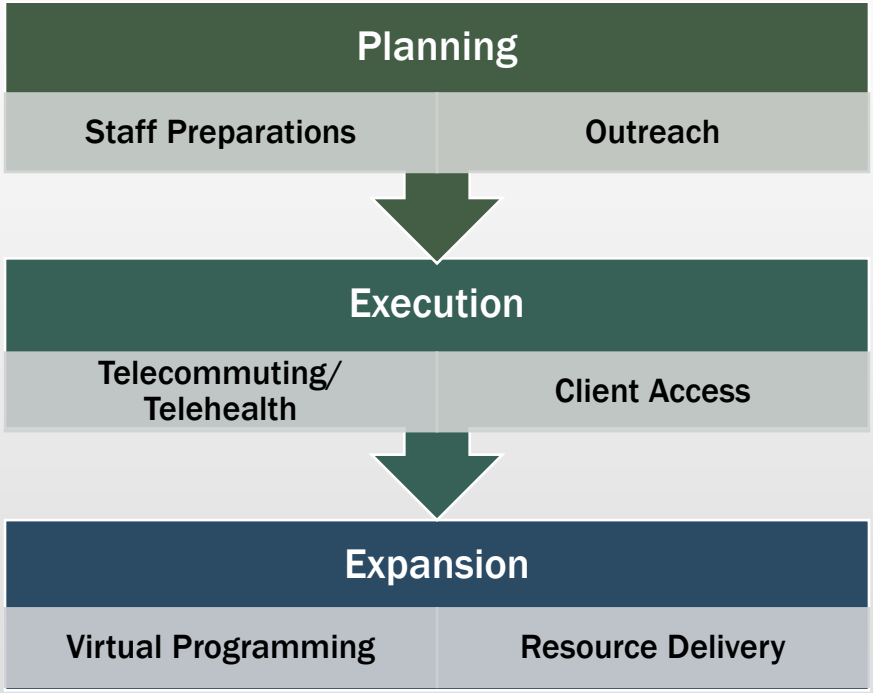
Hilltown Community Health Center

Community Programs Response to the pandemic

Something that I consider remarkable since the pandemic began is how well we have adapted our roles to a new reality. The creativity and flexibility that the Community Department has shown I believe should be an example for the rest of HCHC. Proof of this is the fluid and constant communication that we have maintained as a work team, in addition to the support that our clients have not stopped receiving despite all the existing limitations, both technological and operational, which prevent us from doing our job as usual, but which we have improved like never before.

It is also extraordinary to see how each of us has put all our resources at home to continue with our work without regard: the space for improvised offices, mobile phones and the internet, among others. The level of collaboration that we have all shown is admirable and exposes in the midst of adversity, the added value that we represent within this organization.

Thank you, Biani Salas-Morales, Community Health Worker



Shift to remote services

- **What I find extraordinarily good is the speed and flexibility in which our clients have adapted to working remotely with the Navigator team.**

Buliah Mae Thomas, Lead Navigator

- **I feel like we are able to be more flexible as I am able to accommodate everyone's schedule since I am remote. I also feel like how much the dogs barking is annoying people on the phone love it and also feel like clients like knowing we are human with lives!**

Karen Lampson, Health Access Outreach Worker

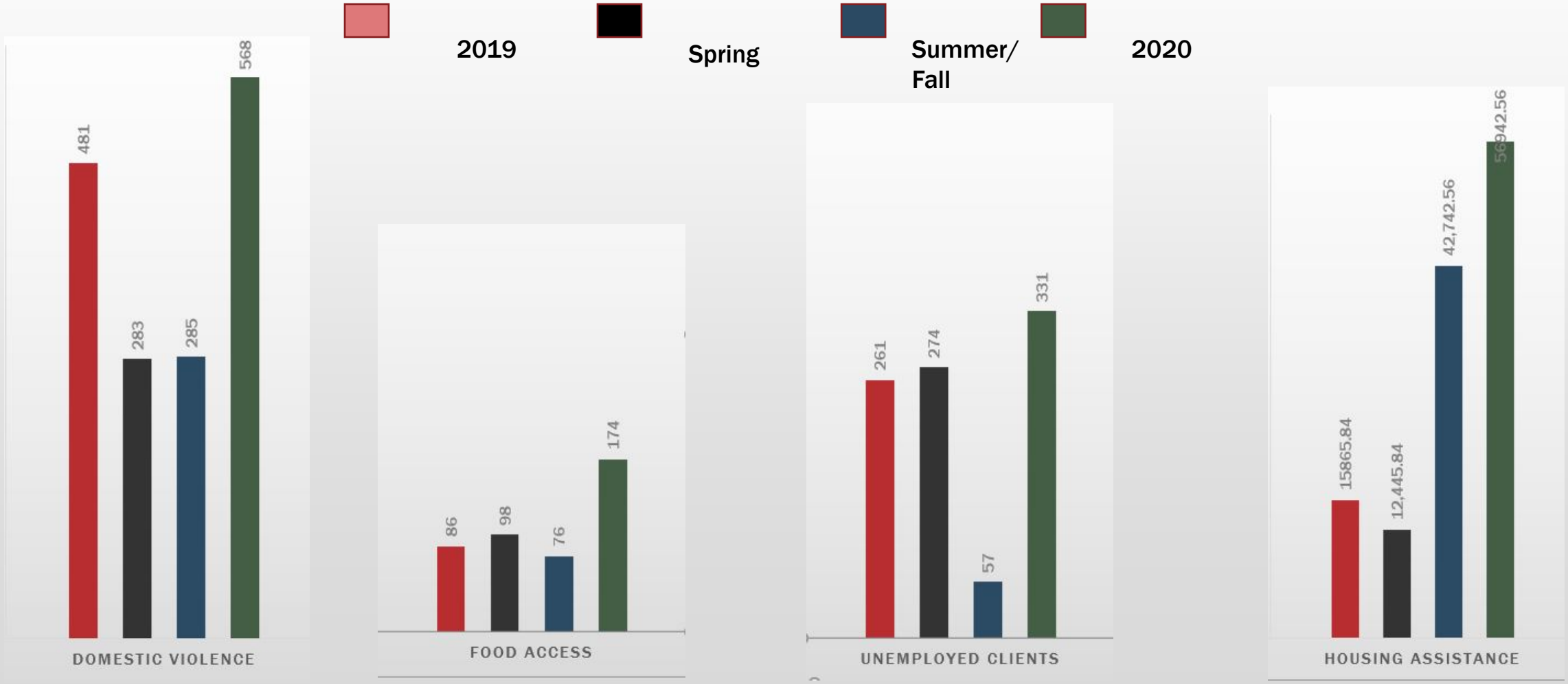
What have we seen in the community?
$42,742.56

Bad- housing crisis that was already a horrible issue is worsened by the pandemic. Shelters being less accessible, Working with elders and those with disabilities that really need that face to face interaction has been a struggle. General depression and fear throughout clients and staff.

Good- Our team has stayed cohesive and has problem solved ways to serve our clients even when we cannot see them, Many people are willing to help (thinking about volunteers for food boxes and holiday help), We did have some additional funds to lessen the housing burden on some folks.

Emily Magnifico, CHW and Clinical BH Intern

Some of the picture



Being Nimble and Flexible

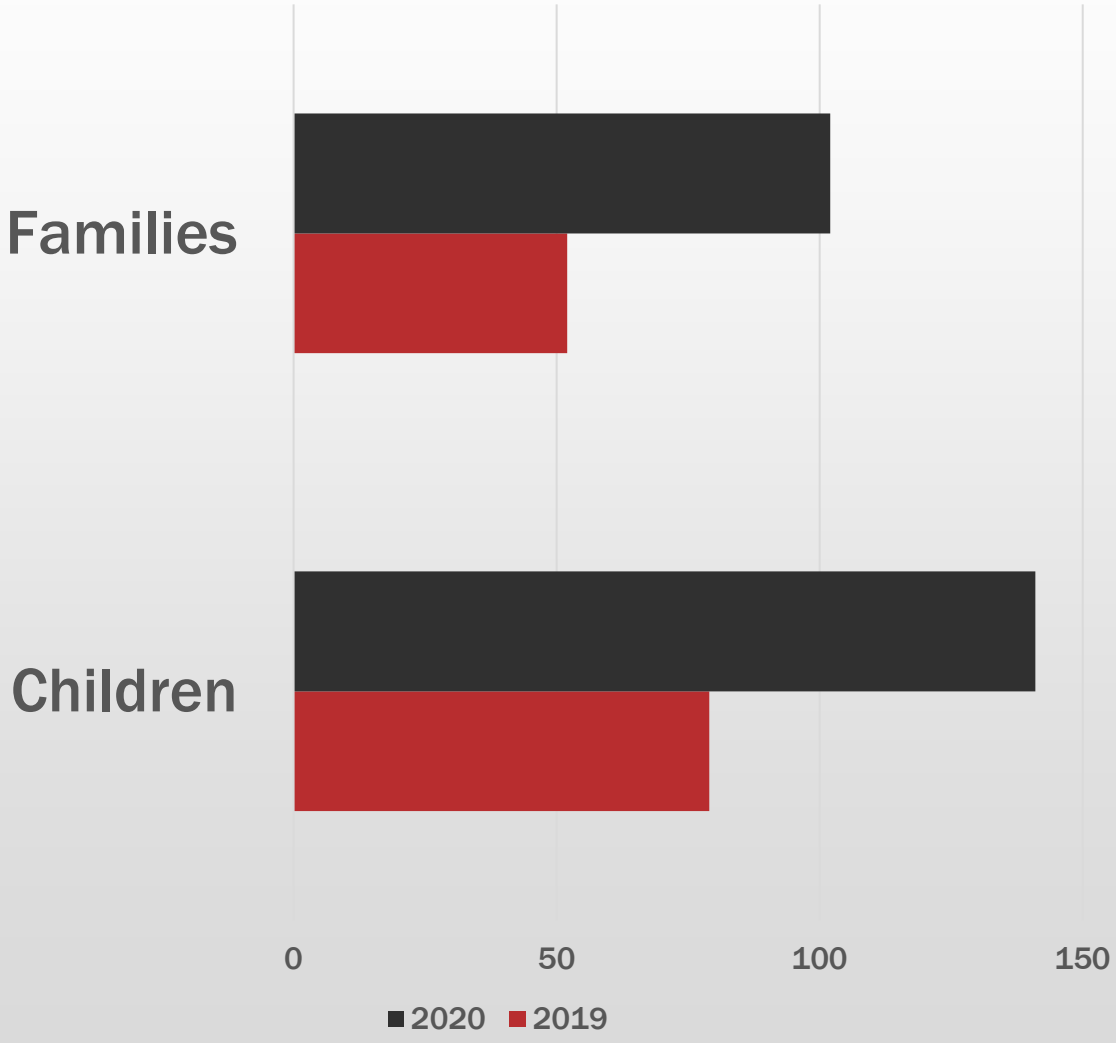
Programs

- I found it extraordinary how quickly things can change for a family. Seeing young families deal with serious medical issues and domestic violence I realized how quickly their life is turned upside down. Who will take care of the children? How does this impact their jobs? How will they then pay the bills? What kind of anxiety are they feeling dealing with a new diagnosis and going into a doctor's appointment or hospital during a pandemic? What kind of anxiety does a survivor of domestic violence have when they worry about their children and their self and temporarily lose their way of life in deciding to protect their family. These families have multiple challenges all at the same time. They need them to make decisions about many different issues. That is when the CP staff is ready to jump in and provide the supports. We can help explain what supports are available and help them make decisions and get to the next step. Also was just thinking.... it is extraordinary that these families trust us and come to us to tell us these intimate events that are impacting their lives. That is an incredibly hard thing for most people to do.
- Susan LeBarron, Family Center Coordinator.

Community Response

More from Susan:
For a community that faces so many issues with isolation, low incomes, limited job opportunities, and lack of transportation, it was very refreshing to see the community come together to support the Holiday Help program. While our families were contacting us to ask to have their children added to the list, community members were also offering to help. There are so many small churches and they asked their members to help buy gifts for a family or two and to provide turkey dinners to families. Individuals contacted us asking how they could help. They offered to deliver, to give us new toys, to sponsor a family, to donate to the Gofundme account or send a check or gift certificates.

Hilltown Holiday Help



How does the landscape look in this moment?

Where do we stand?

Virtual Offerings: Playgroups and School Readiness, Exercise, Diabetes Prevention Program, Health Access Education, Ready parent texting platform for child development, Domestic Violence trainings for staff, Chronic Disease Self Management Diabetes Module, virtual art therapy with the Child Witness Advocate and more.