Hilltown Community Health Center

Board of Directors Meeting

March 11, 2021

https://hchcweb-org.zoom.us/j/97600369054?pwd=b2cyeUtmdHNlcGN1R2hINEpWUm90QT09

Meeting ID: 976 0036 9054 Passcode: 627611

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**	**Vote Needed**	Treasurer John Melehov
5:55 PM	**Staff Presentation** • Vaccination Clinics Update	Inform	Jaime Gogol, Vickie Dempesy, and Michael Purdy
6:10 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 Nancy Brenner
6:35 PM	**Senior Management Reports** • Credentialing and Privileging Report • Quality Improvement Report • Risk Management • CEO Report • Employee Recognitions	 **Vote Needed** **Vote Needed** **Vote Needed** Inform/Discussion Inform	 Michael Purdy Vickie Dempesy Michael Purdy Eliza Lake Vickie Dempesy and Michael Purdy
7:00 PM	**New Business** • Annual Disclosure Discussion. • Credit and Collection • Sliding Fee Scale Program • Continuity of Operations Plan (COOP)	 **Vote Needed**	 Eliza Lake John Melehov John Melehov Eliza Lake
7:20 PM	**Old Business** • Uniform Data System (UDS) Submission		 Eliza Lake
7:20 PM	**Executive Session** (if needed)	Discussion	Lee Manchester
7:30 PM	**Adjourn**	**Vote Needed**	Lee Manchester

Upcoming Meetings

- Thursday, April 8, 2021 at 5:30 PM via Zoom
- Thursday, May 13, 2021 at 5:30 PM via Zoom
- Thursday, June 10, 2021 at 5:30 PM via ZOOM

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 2/11/2021 5:30pm
Zoom Meeting

MEMBERS: Lee Manchester, President; John Follet, Vice President and Treasurer; Kathryn Jensen, Clerk; Alan Gaitenby; Nancy Brenner; Matt Bannister; Jennica Gallagher; Seth Gemme; Wendy Long; Deb Leonczyk
STAFF: Eliza Lake, CEO; Michael Purdy, CCCSO; John Melehov, CFO; Vickie Dempsey, COO
GUEST: Kiirsten Cooper, SBHC Manager
ABSENT: Tabitha Griswold, Executive Assistant (reviewed Zoom meeting recording for minutes)

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 1/14/2021	Lee Manchester called the meeting to order at 5:32 pm. Nancy Brenner noted that under the Fundraising Committee report regarding the annual report, the date in which it is set to roll out is in the spring not by the end of the year. Attendance was updated to reflect that Wendy Long was able to attend last month's meeting. **Kathryn Jensen moved to approve the January minutes as amended. Nancy Brenner seconded the motion.**	The Board voted unanimously to approve the January 14, 2021 Board minutes as amended.
Finance Committee	• John Follet reported on the Interim Financial Statement for December and the 2020 year-end results. The financials for the end of the year were primarily highlighted in this report, and included a net gain of $99K, primarily due to the catch up on the draw down of the 330 grant and the PPP grant received in 2020. A total net surplus of $439K on the income sheet is much more robust than normal. The patient revenue for clinical departments was down for the month, but the pharmacy revenue was slightly up from last month. • In the year-end review, salaries and wages were lower than last year due to fewer dental staff working in the last year, and fewer doctors on salary from the year	

	prior. Expenses were consistent month to month, as well as compared to the previous year. • The PPP loan application for 2021 was accepted for $1.17M. Cash on hand is now at 130 days with a good current ratio due to the cash influx. Finances are stabilized, but very dependent on the government and outside sources as opposed to patient revenue. The 340B program is growing and expanding, and the income in the new year looks promising. **Jenicca Gallagher moved to approve the Finance Committee report. Alan Gaitenby seconded the motion.**	The Board voted unanimously to approve the Finance Committee report
Staff Presentation	• Kiirsten Cooper, Manager of School Based Health Center presented on the SBHC's efforts during the COVID-19 pandemic. Kiirsten touched on the immediate delegation of tasks during the Spring 2020 closure of the schools. One important task was calling all student patients to maintain contact and access to services, as needed and possible. SBHC staff worked on helping to identify food insecurities and IT needs and connecting students with services. Staff developed plans for helping children get back to school for Fall of 2020, and planned for service availability. These plans took into consideration managing telehealth and in-persons visits to identify best times for those visits and accountability with the school. Wendy Long praised Kiirsten; in her experience while working with the Gateway Schools, Kiirsten's work with the expansion of dental and optometry services was exemplary. Kiirsten is a great advocate and manager for the school-based health center.	
Executive Committee	• Lee Manchester reported that the Committee met to work on Eliza's performance appraisal, which will be discussed in Executive Session.	
Recruitment, Orientation & Nominating (RON) Committee	• Wendy Long reported that she has been a liaison for the DEI Committee. Last week's topic was the recruitment of new patient Board members from the Amherst area. As noted during the HRSA site visit, the Board is comprised of individuals with extensive professional experience, as compared to other health centers. The Committee discussed ways that it might make an easier transition for new Board members that may not be as experienced in	

	governance of non-profits, finance, etc. The group discussed bringing new members on as a cohort during the Annual Meeting to build affinity and support, or having a seasoned Board member(s) mentor new Board members. The staff have identified several candidates, which will be screened by the DEI Committee before the annual meeting. Deb Leonczyk noted that in her professional experience that it is important to be upfront on the commitments and responsibilities of being on a board to new members. Eliza added that the DEI Committee is also looking at the onboarding agenda for those new board members and assuring that responsibilities are discussed in that process.	
Facilities Committee	• Alan Gaitenby reported that this committee has not met.	
Personnel Committee	• John Follet reported that this committee has not met. A meeting will be scheduled soon to do a staff satisfaction survey.	
Strategic Planning	• Nancy Brenner reported that the committee has not met.	
Fundraising Committee	• Nancy Brenner reported that this committee has not met but reported that Alex, Tabitha and Eliza met to discuss the marketing/ fundraising calendar for the year. This includes the Annual Report and 70th anniversary. Eliza noted that the group is working to update an older marketing/fundraising plan, and Alex will work on that plan to present to the Fundraising Committee once finalized.	
Committee Reports	• **John Follet moved that the Committee reports be approved. Deb Leonczyk seconded the motion.**	The Board voted unanimously to approve the Committee Reports
Credentialing/ Privileging Report	• Michael Purdy reported Tammy Sciartilli, Dental Assistant in Amherst was re-credentialed and privileged last month. **Matt Bannister moved that the re-credentialing and privileging of the above employee be approved. Deb Leonczyk seconded the motion.**	The Board voted unanimously to approve the re-credentialing and Privileging for Tammy Sciartilli,

		Dental Assistant.
Quality Improvement/ Risk Management	• Vickie reported that last month's QI Committee meeting discussed the goals and quarterly dashboards. The Committee will be looking at BH and Eye Care dashboards and UDS review in this month's meeting. Vickie also noted that the Nutritionist, Joanna Martin, suggested collaboration efforts with a peer at another health center on diabetes management. Joanna is also looking at collaborating internally with medical providers to fill her Nutrition Counseling schedule, contacting newly diagnosed diabetes patients to develop a plan for improving their health. • Staff presented an update on the vaccine clinics, and discussed the goal, which currently is to . The vaccine clinic goal is to vaccinate 200 patients a week. Staffing numbers at the clinics still being determined. The traffic control staff has been extremely important to the flow of the clinic. Discussed volunteer opportunities with the full Board. Outreach is being done for patients that are eligible for the vaccine. A postcard went out to all patients as an informative note about eligibility and HCHC's process. Direct patient letters went out to only those patients (in eCW) eligible according to the State eligibility guidelines urging them to call HCHC to schedule. Calls are going out directly to those eligible patients as well from eCW and Dentrix. Social media and website posts are going out at the same time. Peter Whalen of Whalen insurance donated to support the vaccine clinic; a sign for this sponsorship will be posted there. • Telehealth Initiatives discussed with challenges being the focus of the conversation. • Vickie announced that a candidate has been chosen for the Clinical Operations Manager position. She will start on March 1st and this will round out the hiring on the organization chart. **Jenicca Gallagher moved to accept the Quality Improvement report, Matt Bannister seconded that motion.**	The Board voted unanimously to approve the Quality Improvement Report. The Board voted unanimously to approve the Risk Management Report.

	• Michael Purdy reported that there is no incident to be reported. The new providers are set up with senior providers for mentoring to help develop their skills. • Staffing shortage continues to be a challenge especially during the COVID-19 response. • Most employees are through their 2nd dose of the COVID vaccination. Experienced large staffing shortages during these vaccinations due to COVID like symptoms which effect Monday clinic days (as vaccinations are given on Fridays) but that issue is coming to an end with those 2nd doses being completed. • In an effort to maintain an overview of the entire crisis, specific teams were formed around key topics, which include an Infection Control Team, a Vaccination and Testing Team, and the weekly managers' meeting. • Eliza discussed the liability issues that are being brought up during this time especially around the operations of the COVID vaccination clinic. Employees are volunteering to increase their hours to staff the clinic currently, but are all getting paid for the time they provide. **Nancy Brenner moved to accept the Risk Management report, Seth Gemme seconded that motion.**	
CEO Report	• Eliza Lake provided a verbal CEO report this month. Most topics that are generally discussed in this report are now covered by more robust senior management reports, this may affect future CEO report content. • Eliza reported the recent stepping down as CEO of Joanne Marqusee from Cooley Dickinson; David Brown (head of Mass General Emergency Department) will be the Interim CEO as they conduct a search. Eliza is familiar with David, as he is currently on the Cooley Board, and reported that he is a Western Mass native who will better understand the Western Mass needs. • The DEI committee has been working on nailing down a job description for a new DEI Coordinator position. Once developed, Alex Neifer can rally corporate support in funding this position.	

	• Snow days are very different than they have ever been before. There has been two delayed openings and early closings this winter. For patients, the phone is rolled to direct staff working remotely (not switched over to the answering service). Still doing telehealth visits during these closures and having phones managed.	
Staff Recognition	• John Melehov recognized Daniel Worpek, IT Manager. He is the one and only IT staff. He bears the brunt of all IT questions and works tirelessly and is available at all hours. • Michael Purdy recognizes Lori Paquette, Dental Hygienist, who has helped design and implement dental and infection control programs. She is always looking for new processes to improve efficiency and function, and always works to implement necessary safety measures. • A letter will be sent out to those staff recognized from the Board.	
New Business	• John Melehov presented the budget for 2021. He reviewed the methodology and key assumptions, which are challenging given the unknowns due to the pandemic. Revenue highlights include substantial decreases for all clinical departments (based on four months' revenue at the end of 2020), except for behavioral health and pharmacy, where there is an anticipated increase in revenue. This budget already accounts for the PPP grant that was obtained in 2021. Expense highlights are pretty consistent to last year's spending, proportionate to the revenue expected. John discussed the net income, with the PPP loan carrying the agency through until 2023. Payroll will be higher than it was in 2020 by 2% due to wage increases (with primarily lower wage employees) and increased staffing. Donation expectations will be lower than 2020, given that there were two large COVID-related donations. **Alan Gaitenby motioned to approve the 2021 budget and Wendy Long seconded the motion.** • Eliza presented the UDS briefly in a presentation shown. This presentation is included in the meeting material packet for further review. This will be reviewed more thoroughly in next month's meeting with a vote then.	The Board voted unanimously to approve the 2021 Budget. The Board voted unanimously to approve the change in scope as presented by Eliza Lake.

	• The electronic vote on January 26th for the change of scope was included in the meeting material packet. • Eliza presented another change in scope needed for the immunization clinics. In form 5C, adding a new service, Immunizations, under "Other Activities and Locations". Specifically, "HCHC is planning to provide COVID-19 vaccination clinics in the community on a weekly basis for the length of the declared Public Health Emergency. HCHC will be providing COVID-19 immunizations according to Massachusetts' Department of Public Health prioritization guidance. This activity will occur in our clinics as well as in temporary clinics in the community set up for the purposes of increasing access." **Deb Leonczyk motioned to approve the Change in Scope and Nancy Brenner seconded the motion.**	
Old Business	• No old business was discussed.	
Executive Session	**Matt Bannister motioned to move to executive session at 7:25 PM and Deb Leonczyk seconded the motion.** **The Board came out of Executive Session at 8:08 PM.** Lee Manchester reported that in the Executive Session the board discussed amending the CEO contract to reflect language used in other HCHC contracts. The Board discussed replacing the following sentence in Section 5.a. Salary/Bonuses (page 3): *Executive shall be eligible to receive additional compensation in the form of a performance bonus, as may be approved by the Board of Directors in its sole discretion from time to time.* with the following language: *In the sole discretion of the Board of Directors, the Corporation may allocate funds for an increase (no more than once annually) in the Executive's salary based upon the Executive's job performance and market conditions.*	The Board voted unanimously to approve the amendment to the CEO contract, the CEO performance evaluation, and authorized the Executive Committee to negotiate a salary adjustment with the CEO. Deb Leonczyk abstained from this vote as she has not been

	The Board also discussed the Performance Evaluation of the CEO, as presented by the Executive Committee, with the understanding that the Executive Committee would finalize the Development Plan with Eliza at a later date. And finally, the Board discussed a salary adjustment for the CEO, in order to bring the compensation closer to market rates. **Matt Bannister moved that the Board approve:** • **the amendment to the CEO contract** • **the CEO performance evaluation** • **authorizing the Executive Committee to negotiate a salary adjustment with the CEO.** **Nancy Brenner seconded the motion.**	on the board in ten months.
Adjourn	**John Follet moved the meeting be adjourned. Dev Leonczyk seconded the motion.** The meeting was adjourned at 8:12 pm. The next scheduled meeting will be March 11, 2021 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

January 2021 – Presented 3/10/2021

Highlights

- ($40K) Net Income
  - $261K billed to 330, catch-up from PPP coordination
- $1M positive cash flow from PPP-2

Income Statement

	Jan Actual	PY YTD Actual	$ Change	% Change
OPERATING ACTIVITIES				
Revenue				
Patient Services - Medical	$135,440	$194,733	($59,292)	-30%
Patient Services - Dental	$106,182	$145,933	($39,751)	-27%
Patient Services - Beh. Health	$36,624	$39,953	($3,329)	-8%
Patient Services - Optometry	$9,337	$19,191	($9,853)	-51%
Patient Services - Optometry Hardware	$6,162	$10,443	($4,281)	-41%
Patient Services - Pharmacy	$37,224	$7,260	$29,963	413%
Quality & Other Incentives	$3,776	$475	$3,301	695%
HRSA 330 & Other Grant	$261,014	$136,455	$124,559	91%
Other Grants & Contracts	$49,817	$59,052	($9,235)	-16%
Int., Dividends Gain /Loss Investmenst	($465)	($2,424)	$1,959	-81%
Rental & Misc. Income	$2,577	$4,002	($1,425)	-36%
Total Operating Revenue	$647,688	$615,073	$32,616	5%

- Patient revenue severely decreased from pre-covid conditions but consistent with new normal
- 330 Grant payments playing catch-up - $261K

	Jan Actual	PY YTD Actual	$ Change	% Change
Compensation and related expenses				
Salaries and wages	($443,161)	($481,077)	$37,915	8%
Payroll taxes	($33,016)	($36,589)	$3,572	10%
Fringe benefits	($47,695)	($43,725)	($3,969)	-9%
Total Compensation & related exp	($523,873)	($561,390)	$37,518	7%

- 7% or $38K favorable to last year

	Jan Actual	PY YTD Actual	$ Change	% Change
Other Operating Expenses				
Advertising and marketing	($10)	$0	($10)	
Bad debt	($10,871)	($1,307)	($9,564)	-732%
Computer support	($8,840)	($7,088)	($1,753)	-25%
Conference and meetings	($2,087)	($248)	($1,839)	-741%
Continuing education	($1,522)	($2,368)	$846	36%
Contracts and consulting	($13,540)	($2,713)	($10,828)	-399%
Depreciation and amortization	($28,544)	($27,651)	($894)	-3%
Dues and membership	($6,731)	($2,355)	($4,376)	-186%
Equipment leases	($1,535)	($2,580)	$1,045	40%
Insurance	($2,206)	($2,128)	($78)	-4%
Interest	($354)	($1,289)	$935	73%
Legal and accounting	($2,630)	($2,500)	($130)	-5%
Licenses and fees	($5,283)	($4,115)	($1,168)	-28%
Medical & dental lab and supplies	($6,811)	($10,442)	$3,631	35%
Merchant CC Fees	($136)	($1,576)	$1,440	91%
Office supplies and printing	($4,214)	($2,304)	($1,911)	-83%
Postage	($2,189)	($117)	($2,072)	-1776%
Program supplies and materials	($15,674)	($19,372)	$3,698	19%
Pharmacy & Optometry COGS	$426	($7,980)	$8,406	105%
Recruitment	$0	($4,049)	$4,049	100%
Rent	($9,927)	($6,964)	($2,963)	-43%
Repairs and maintenance	($17,864)	($13,597)	($4,267)	-31%
Small equipment purchases	($7,898)	$0	($7,898)	
Telephone	($11,151)	($10,928)	($223)	-2%
Travel	($619)	($1,947)	$1,328	68%
Utilities	($5,193)	($3,234)	($1,959)	-61%
Total Other Operating Expenses	($165,405)	($138,848)	($26,557)	-19%
NET OPERATING SURPLUS	**($41,589)**	**($85,166)**	**$43,576**	**51%**
NON_OPERATING ACTIVITIES				
Donations, Pledges & Contributions	$1,870	$120	$1,750	1458%
NET NON-OPERATING SURPLUS	**$1,870**	**$120**	**$1,750**	**1458%**
NET SURPLUS/(DEFICIT)	**($39,719)**	**($85,046)**	**$45,326**	**-53%**

- Year-over-year, other spending increased 44K
- Net Deficit $45K less negative due to timing of 330 draws

Cash Flow

CASH FLOWS FROM OPERATING ACTIVITIES		
	NET SURPLUS/(DEFICIT) FOR PERIOD	($39,719)
PROVIDED (USED) BY OPERATING ACTIVITIES		
	NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	$1,042,644
CASH FLOWS FROM INVESTING ACTIVITIES		
	NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES	($29,535)
	NET INCREASE/(DECREASE) IN CASH	**$1,013,109**
	CASH AND CASH EQUIVALENTS AS OF 1/1/2021	**$2,127,873**
	CASH AND CASH EQUIVALENTS AS OF 1/31/2021	**$3,140,982**

- Cash on hand increased $1M
- PPP Main increase in *Operating Activities*
- Dental Equipment only decrease in *Investing Activities*

Balance Sheet (as of 12/31/20)

ASSETS		
	Total Current Assets	$3,241,326
	Net Property & Equipment	$4,012,280
	Total Other Assets	$355,300
	TOTAL ASSETS	**$7,608,906**
Liabilities & Fund Balance		
	Total Current Liabilities	$2,325,547
	Total Long Term Liabilities	$130,409
	Total Liabilities	**$2,455,956**
Fund Balance / Equity		
	Fund Balance Prior Years	$5,152,949
	Total Fund Balance / Equity	$5,152,949
	Total Liabilities & Fund Balance	**$7,608,906**

- Current Assets = $3.2 M
- Current Liabilities = $1.15 M (PPP improperly included as current in statement)
- Current Ratio = **2.78**

Credentialing and Privileging Update for HCHC BOD

Month: March

Name	Position/ Credentials	Start date	Date Credentialed	Special Certifications	Privileging Requests	Special Privileging Requests	Any items pending?
Mary Fioravanti	Dental Assistant	3/11/2021	2/24/2021	none	on-the-job trained privileges approved 3/1/2021	none	none
Marianne (Mara) Galus	LICSW	3/1/2021	2/24/2021	none	normal LICSW privileges requested	none	none

UDS 2020 Review

HILLTOWN COMMUNITY HEALTH CENTER

Overview

Uniform Data System (UDS) report is due every year on February 15th.

The UDS is the public report made by all health centers on its financial, clinical, and operational progress during the previous calendar year.

HCHC uses these reports to monitor and analyze utilization patterns, patient demographics, its service area, quality metrics, and much more.

HRSA uses the UDS to determine whether we are meeting our goals for our 330 grant, whether we are cost efficient, how to allocate one-time grants, and what quality awards we are eligible for, among other things. HRSA posts some of the information on its website, along with the data of every other health center in the country.

You can find all of this information at https://bphc.hrsa.gov/datareporting

HCHC UDS Report

The data in the presentation below is not finalized, as the report has been submitted but we have not yet received comments from our HRSA-contracted reviewer.

There may therefore be small changes.

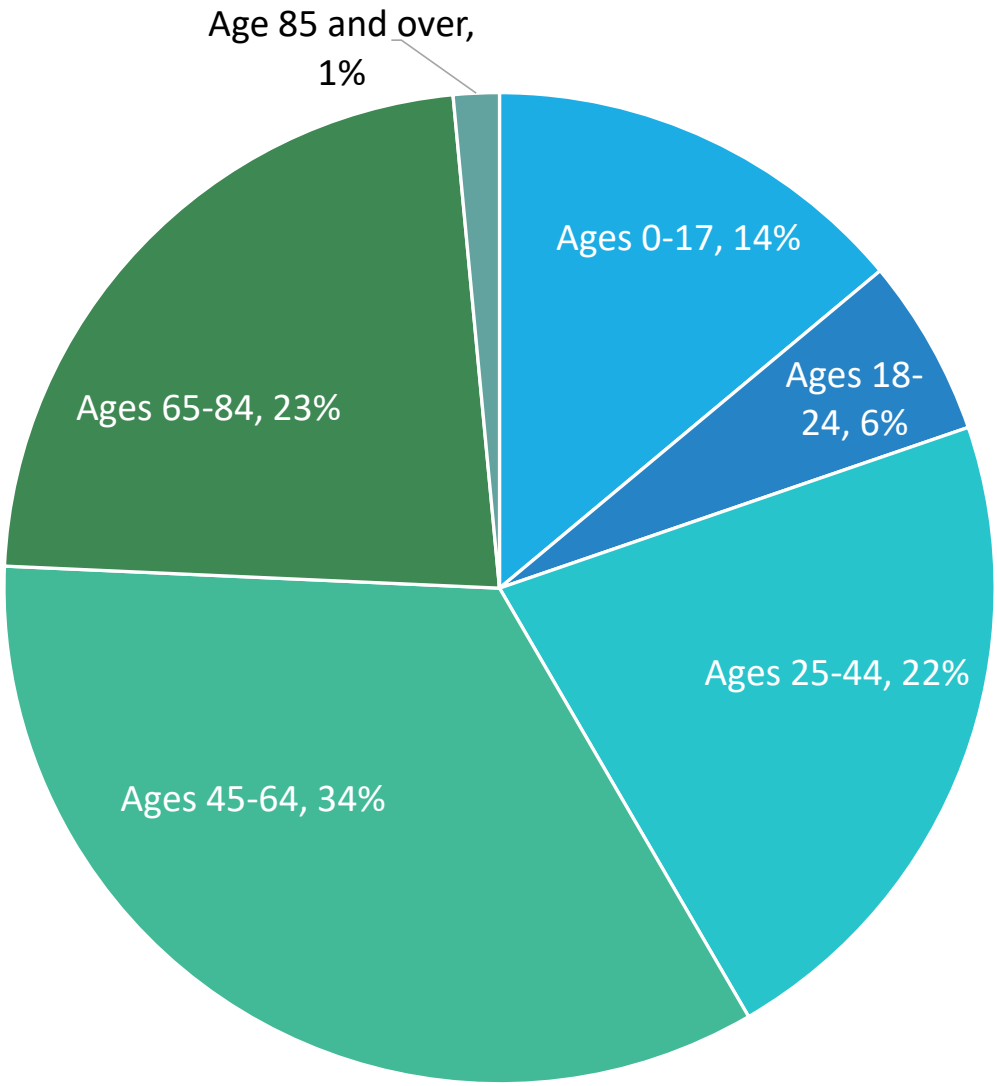
You will receive the final report prior to the next meeting.

Patients by ZIP Code – 135 total

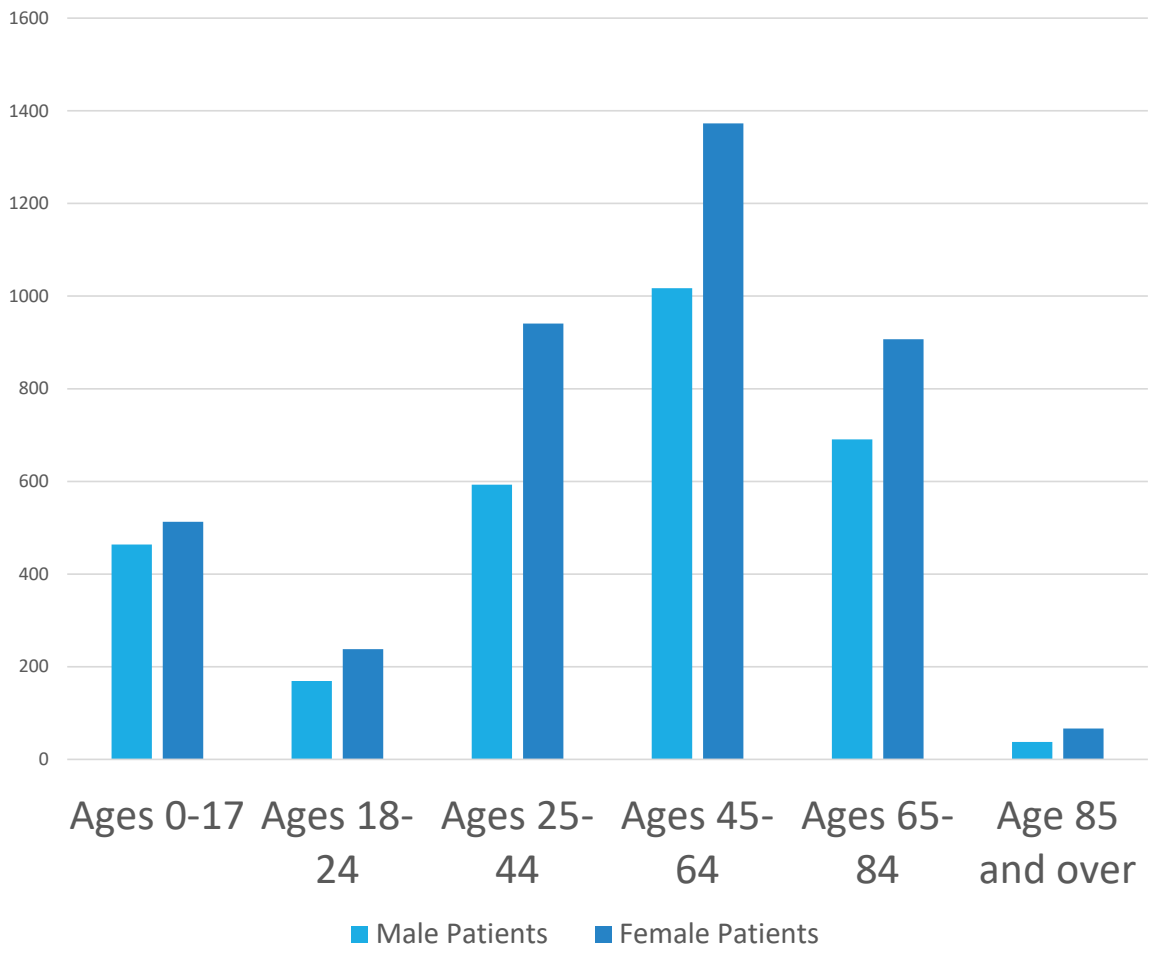
Note: Does not include ZIP codes for sub-municipal ZIP Codes, e.g., Haydenville, West Chesterfield, Leeds, Amherst PO boxes, etc.

	None/ Uninsured	Medicaid	Medicare	Private Insurance	Total Patients
Total	**7.0%**	**31.2%**	**24.9%**	**36.9%**	**7011**
Huntington	1.8%	29.7%	26.0%	42.5%	1225
Chester	5.8%	28.8%	18.3%	47.1%	535
Worthington	9.1%	16.2%	32.5%	42.2%	464
Westfield/ Montgomery	4.5%	17.4%	21.6%	56.6%	334
Amherst	7.2%	43.7%	38.9%	10.2%	332
Blandford	7.9%	21.7%	24.8%	45.6%	318
Cummington	2.9%	45.5%	19.7%	31.8%	314
Russell	5.4%	19.4%	14.0%	61.2%	242
Williamsburg	5.2%	43.8%	27.5%	23.6%	233
Hinsdale	5.8%	35.3%	32.6%	26.3%	224
Easthampton/ Westhampton	2.1%	50.3%	21.2%	26.4%	193
Becket	4.8%	37.0%	32.1%	26.1%	165
Northampton	5.0%	49.2%	39.2%	6.7%	120
Chesterfield	6.0%	23.1%	26.5%	44.4%	117
Plainfield/Hawley	13.0%	15.2%	29.3%	42.4%	92
Tolland/Granville	11.8%	29.4%	21.2%	37.6%	85
Florence	3.6%	52.4%	32.1%	11.9%	84
Middlefield	1.2%	44.0%	20.2%	34.5%	84
West Springfield	6.5%	35.1%	22.1%	36.4%	77
Ashfield	7.8%	72.7%	5.2%	14.3%	77

Patient By Age



Patients by Sex and Age



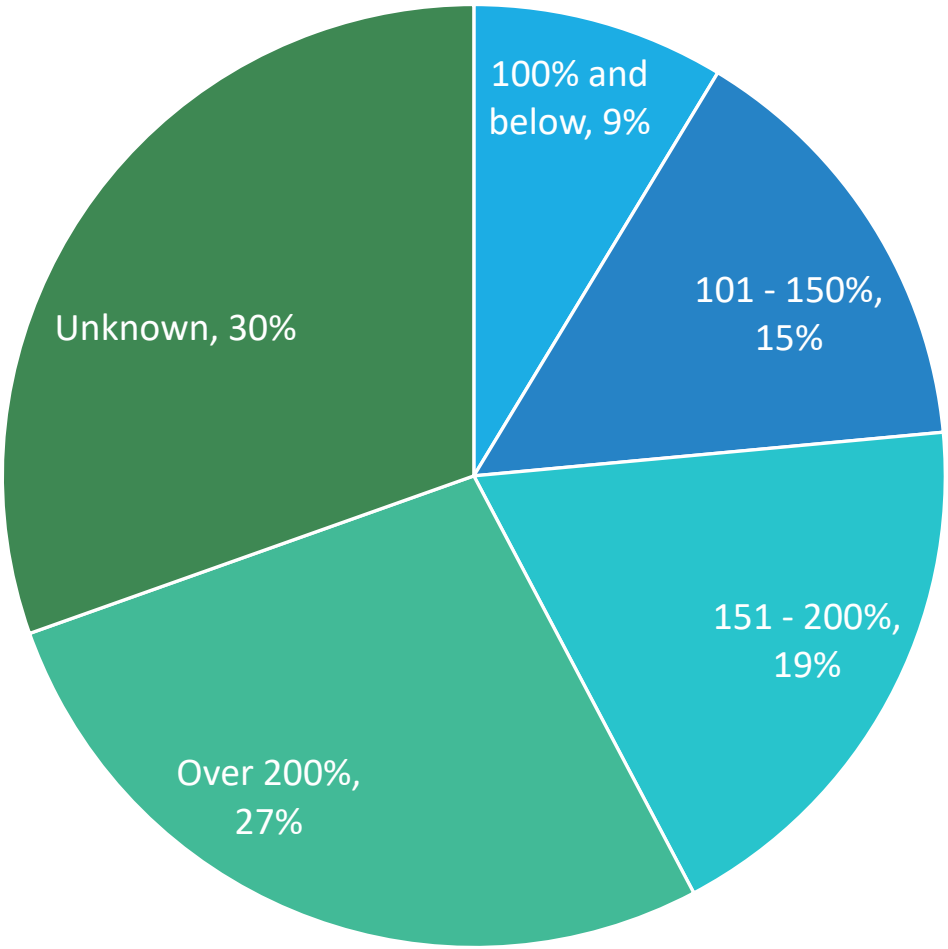
Patients by Race and Ethnicity

Patients by Race	Hispanic or Latino/a	Non-Hispanic or Latino/a	Unreported/ Refused to Report Ethnicity	Total
Asian	3	85	0	88
Total Native Hawaiian/Other Pacific Islander	6	10	0	16
Black/African American	15	99	0	114
American Indian/Alaska Native	2	26	0	28
White	164	6164	0	6328
More than one race	0	0	0	0
Unreported/Refused to report race	139	115	183	437

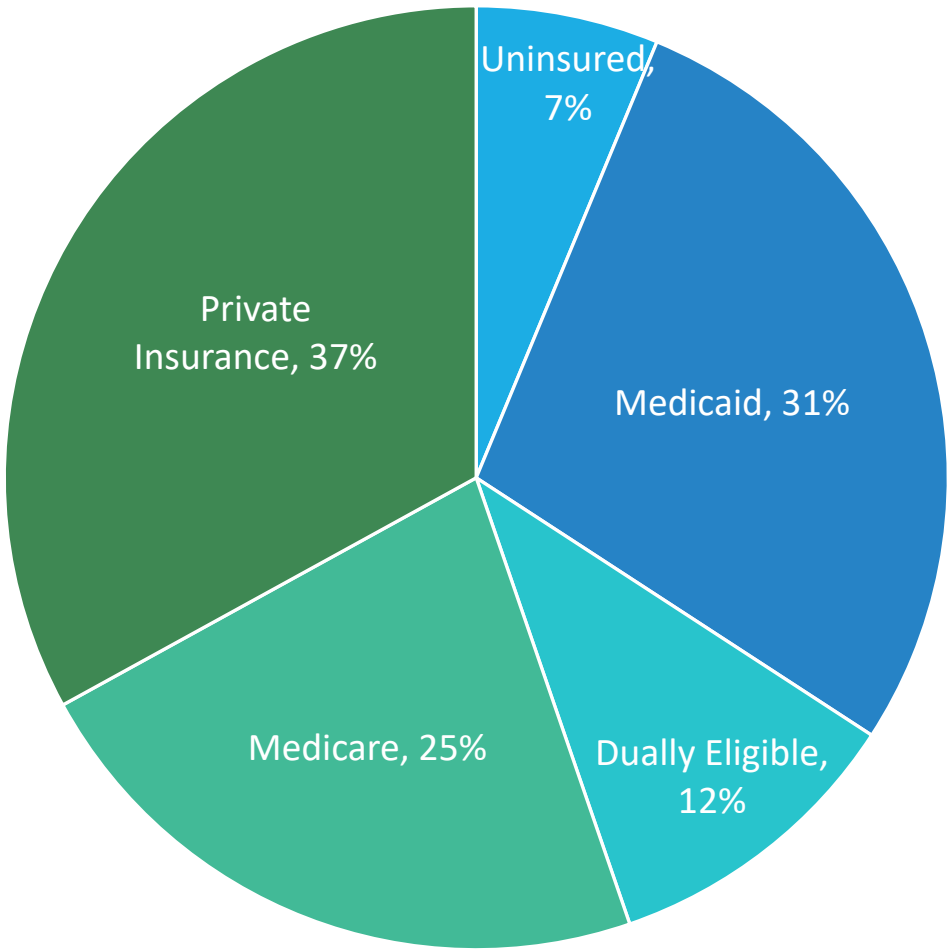
Sexual Orientation and Gender Identity

Patients by Sexual Orientation	Number
Lesbian or Gay	102
Heterosexual (or straight)	6476
Bisexual	86
Something else	0
Don't know	94
Chose not to disclose	253
Unknown	0
Patients by Gender Identity	**Number**
Male	1898
Female	2724
Transgender Man/Transgender Male	5
Transgender Woman/Transgender Female	0
Other	2342
Chose not to disclose	42
Unknown	0

Income Status of Patients



Patients by Payor



Utilization and Staffing – Medical and Dental

Medical Care Services	FTEs	Clinic Visits	Virtual Visits	Patients
Family Physicians	1.4	1,587	1,207	
Nurse Practitioners	5.2	5,853	4,369	
Physician Assistants	0.9	134	142	
Nurses	8.4	932		
Total Medical Care Services		8,506	5,718	5,302
Dental Services				
Dentists	4.5	6,501	493	
Dental Hygienists	5.6	669	-	
Other Dental Personnel	6.4			
Total Dental Services		7,170	493	2,447

Utilization and Staffing – Behavioral Health, Nutrition, and Eye Care

Mental Health Services		FTEs (a)	Clinic Visits	Virtual Visits	Patients
	Licensed Clinical Social Workers	5.67	1007	2944	
	Total Mental Health Services		1007	2944	999
Other Professional Services					
	Nutrition	0.56	134	352	119
Vision Services					
	Optometrists	1.15	1470	29	
	Total Vision Services		1470	29	989

Utilization and Staffing – Enabling Services, QI, and Administration/ Facility

Enabling Services		FTEs	Clinic Visits	Patients
	Case Managers	4.9	635	
	Patient and Community Education Specialists	2.5	1167	
	Eligibility Assistance Workers	2.4		
	Total Enabling Services		1802	507
Other Programs/Services				
	Quality Improvement Staff	1.58		
Administration and Facility				
	Management and Support Staff	7		
	Fiscal and Billing Staff	5.33		
	IT Staff	1.07		
	Facility Staff	0.8		
	Patient Support Staff	12.65		
	Total Facility and Non-Clinical Support Staff	26.85		

Table 6A - Selected Diagnoses and Services										
		2020		2019		% Change		Visits per Patient		
Line	Diagnostic Category	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis/ Number of Patients	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis	Number of Visits	Number of Patients	2019	2020	% change
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	**32**	**8**	28	9	114%	89%	4.0	3.1	78%
3	Tuberculosis	**0**	**0**	0	0	No change	No change			
4	Sexually transmitted infections	**14**	**12**	19	14	74%	86%	1.2	1.4	116%
4a	Hepatitis B	**2**	**2**	6	3	33%	67%	1.0	2.0	200%
4b	Hepatitis C	**19**	**12**	28	15	68%	80%	1.6	1.9	118%
4c	Novel coronavirus (SARS-CoV-2) disease	**137**	**75**					1.8		
5	Asthma	**832**	**422**	704	427	118%	99%	2.0	1.6	84%
6	Chronic lower respiratory diseases	**645**	**274**	831	365	78%	75%	2.4	2.3	97%
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	**6**	**4**					1.5		
7	Abnormal breast findings, female	**53**	**44**	111	79	48%	56%	1.2	1.4	117%

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Line	Diagnostic Category	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis/ Number of Patients	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis	Number of Visits	Number of Patients	2019	2020	% change
8	Abnormal cervical findings	**29**	**18**	30	25	97%	72%	1.6	1.2	74%
9	Diabetes mellitus	**1489**	**481**	1536	512	97%	94%	3.1	3.0	97%
10	Heart disease (selected)	**672**	**340**	919	454	73%	75%	2.0	2.0	102%
11	Hypertension	**2562**	**1149**	3033	1398	84%	82%	2.2	2.2	97%
12	Contact dermatitis and other eczema	**189**	**143**	198	170	95%	84%	1.3	1.2	88%
13	Dehydration	**2**	**2**	7	6	29%	33%	1.0	1.2	117%
14	Exposure to heat or cold	**4**	**4**	3	3	133%	133%	1.0	1.0	100%
14a	Overweight and obesity	**1250**	**683**	1213	867	103%	79%	1.8	1.4	76%
15	Otitis media and Eustachian tube disorders	**32**	**24**	61	45	52%	53%	1.3	1.4	102%
16	Selected perinatal/neonatal medical conditions	**3**	**2**	5	4	60%	50%	1.5	1.3	83%

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Line	Diagnostic Category	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis/ Number of Patients	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis	Number of Visits	Number of Patients	2019	2020	% change
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	**34**	**18**	21	15	162%	120%	1.9	1.4	74%
18	Alcohol-related disorders	**368**	**142**	365	143	101%	99%	2.6	2.6	98%
19	Other substance-related disorders (excluding tobacco use disorders)	**128**	**72**	283	75	45%	96%	1.8	3.8	212%
19a	Tobacco use disorder	**600**	**304**	632	337	95%	90%	2.0	1.9	95%
20a	Depression and other mood disorders	**2172**	**564**	2604	754	83%	75%	3.9	3.5	90%
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	**4194**	**915**	4041	984	104%	93%	4.6	4.1	90%
20c	Attention deficit and disruptive behavior disorders	**514**	**128**	511	130	101%	98%	4.0	3.9	98%
20d	Other mental disorders, excluding drug or alcohol dependence	**1737**	**431**	1581	434	110%	99%	4.0	3.6	90%

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Line	Diagnostic Category	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis/ Number of Patients	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis	Number of Visits	Number of Patients	2019	2020	% change
20e	Human trafficking	**0**	**0**			New	New			
20f	Intimate partner violence	**0**	**0**			New	New			
21	HIV test	**0**	**0**	0	0	No change	No change			
21a	Hepatitis B test	**0**	**0**	0	0	No change	No change			
21b	Hepatitis C test	**0**	**0**	0	0	No change	No change			
21c	Novel coronavirus (SARS-CoV-2) diagnostic test	**0**	**0**			New	New			
21d	Novel coronavirus (SARS-CoV-2) antibody test	**0**	**0**			New	New			
21e	Pre-Exposure Prophylaxis (PrEP)-associated management of all PrEP patients	**1**	**1**			New	New	1.0		

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Line	Diagnostic Category	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis/ Number of Patients	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis	Number of Visits	Number of Patients	2019	2020	% change
22	Mammogram	**46**	**46**	0	0	No change	No change	1.0		
23	Pap test	**95**	**93**	142	139	67%	67%	1.0	1.0	100%
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**536**	**424**	695	631	77%	67%	1.3	1.1	87%
24a	Seasonal flu vaccine	**871**	**835**	1216	1188	72%	70%	1.0	1.0	98%
25	Contraceptive management	**138**	**97**	325	217	42%	45%	1.4	1.5	105%
26	Health supervision of infant or child (ages 0 through 11)	**262**	**195**	358	257	73%	76%	1.3	1.4	104%

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Line	Diagnostic Category	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis/ Number of Patients	Number of Visits by Diagnosis Regardless of Primacy	Number of Patients with Diagnosis	Number of Visits	Number of Patients	2019	2020	% change
26a	Childhood lead test screening (9 to 72 months)	**4**	**4**	19	16	21%	25%	1.0	1.2	119%
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**0**	**0**	0	0	No change	No change			
26c	Smoke and tobacco use cessation counseling	**0**	**0**	0	0	No change	No change			
26d	Comprehensive and intermediate eye exams	**498**	**488**	600	600	83%	81%	1.0	1.0	98%
27	Emergency services	**1113**	**868**	1170	972	95%	89%	1.3	1.2	94%
28	Oral exams	**2707**	**2409**	6295	4404	43%	55%	1.1	1.4	127%
29	Prophylaxis-adult or child	**2830**	**2447**	6329	4103	45%	60%	1.2	1.5	133%
30	Sealants	**47**	**43**	169	127	28%	34%	1.1	1.3	122%
31	Fluoride treatment-adult or child	**482**	**404**	1369	861	35%	47%	1.2	1.6	133%
32	Restorative services	**1665**	**1122**	3335	1952	50%	57%	1.5	1.7	115%
33	Oral surgery (extractions and other surgical procedures)	**488**	**295**	562	452	87%	65%	1.7	1.2	75%
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**176**	**128**	372	243	47%	53%	1.4	1.5	111%

Table 6B: Quality of Care Measures - 2020

Demo of Prenatal Care Patients

	Age	Number of Patients	Percentage
1	Less than 15 Years	0	0.0%
2	Ages 15 - 19	2	18.2%
3	Ages 20 - 24	2	18.2%
4	Ages 25 - 44	7	63.6%
5	Ages 45 and Over	0	0.0%
	Total Patients	11	

Entry into Care

	Early Entry into Prenatal Care	Women Having First Visit with Health Center	Women Having First Visit with Another Provider
7	First Trimester	11	0
8	Second Trimester	0	0
9	Third Trimester	0	0
	Unknown/Unrecorded	0	0

Other Quality of Care Measures

	Childhood Immunization Status	Total Patients with 2nd Birthday	Number of Patients Immunized	2020	2019	2018	2017	2016	NOTES
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	15	5	33.33%	27.27%	44.44%	35.29%	40.00%	
	Cervical Cancer Screening	Total Female Patients Aged 23 through 64	Number of Patients Tested	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	1127	314	27.86%	32.97%	36.96%	45.47%		
	Breast Cancer Screening	Total Female Patients Aged 51 through 73	Number of Patients with Mammogram	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
11a	MEASURE: Percentage of women 51-73 years of age who had a mammogram to screen for breast cancer	793	408	51.45%					New Measure 2020
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 16	Number of Patients with Counseling and BMI Documented	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES

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12	MEASURE: Percentage of patients 3-16 years of age with a BMI percentile and counseling on nutrition and physical activity documented	352	102	28.98%	22.22%	22.43%	21.39%	0.66%	Age range changed in 2020 - was 3-17
	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	2817	1390	49.34%	38.05%	38.95%	42.23%	32.57%	
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention	2359	2063	87.45%	82.49%	44.44%	43.59%	30.83%	
	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma	Number of Patients with Acceptable Plan	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	
16	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication				92.90%	89.78%	96.04%	98.55%	Removed in 2020
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events	Number of Patients Prescribed or On Statin Therapy	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	694	469	67.58%	71.43%	94.00%	86.05%	89.71%	

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	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	167	167	100.00%	90.91%	89.96%	88.89%		
	Colorectal Cancer Screening	Total Patients Aged 50 through 74	Number of Patients with Appropriate Screening for Colorectal Cancer	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
19	MEASURE: Percentage of patients 50 through 74 years of age who had appropriate screening for colorectal cancer	1464	853	58.27%	57.42%	59.67%	60.96%	58.90%	Age range changed in 2020 - was 50-75
	HIV Linkage to Care	Total Patients First Diagnosed with HIV	Number of Patients Seen Within 30 Days of First Diagnosis of HIV	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center staff between December 1 of the prior year and November 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis	1	1	100.00%	0.00%	0.00%	0.00%	0.00%	Date range was changed in 2020 - was 10/1 to 9/30 and within 90 days
	HIV Screening	Total Patients Aged 15 through 65	Number of Patients Tested for HIV	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range	2240	260	11.61%					New Measure 2020
	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older with Major Depression or Dysthymia	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES

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21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented	2230	722	32.38%	29.86%	36.51%	29.41%	28.90%	Denominator changed in 2020 - was Total Patients Aged 12 or Older only
	Depression Remission at Twelve Months	Total Patients Aged 12 and Older with Major Depression or Dysthymia	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event	27	1	3.70%					New Measure 2020
	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries	Number of Patients with Sealants to First Molars	% in 2020	% in 2019	% in 2018	% in 2017	% in 2016	NOTES
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	9	24	266.67%	58.96%	59.26%	54.76%	66.96%	

Health Outcomes and Disparities - 2020

Table 7, Section A: Deliveries and Birth Weight

Deliveries and Birthweight

	Description	Patients
0	HIV-Positive Pregnant	0
2	Deliveries Performed by Health Center's Providers	0

Hispanic/Latino

	Race and Ethnicity	Prenatal Care Patients Who	Live Births: < 1500 grams	Live Births: 1500 - 2499 grams	Live Births: > = 2500 grams
1a	Asian	0	0	0	0
1b1	Native Hawaiian	0	0	0	0
1b2	Other Pacific Islander	0	0	0	0
1c	Black/African American	0	0	0	0
1d	American Indian/Alaska	0	0	0	0
1e	White	0	0	0	0
1f	More than One Race	0	0	0	0
1g	Unreported/Refused to Report Race	0	0	0	0
	Subtotal Hispanic/Latino	0	0	0	0

Non-Hispanic/Latino

	Race and Ethnicity	Prenatal Care Patients Who	Live Births: < 1500 grams	Live Births: 1500 - 2499 grams	Live Births: > = 2500 grams
2a	Asian	0	0	0	0
2b1	Native Hawaiian	0	0	0	0
2b2	Other Pacific Islander	1	0	1	0
2c	Black/African American	0	0	0	0
2d	American Indian/Alaska	0	0	0	0
2e	White	2	0	0	2
2f	More than One Race	0	0	0	0
2g	Unreported/Refused to Report Race	0	0	0	0
	Subtotal Non-	3	0	1	2

Unreported/Refused to Report Race/Ethnicity

	Race and Ethnicity	Prenatal Care Patients Who	Live Births: < 1500 grams	Live Births: 1500 - 2499 grams	Live Births: > = 2500 grams
h	Unreported/Refused to Report Race and Ethnicity	0	0	0	0
	Total	3	0	1	2

Table 7: Health Outcomes and Disparities - 2020

Notes

Age Range has changed in 2020 - was 18-85 yo

Section B: Controlling High Blood Pressure

Hispanic/Latino			
	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension	Patients with Hypertension Controlled
1a	Asian	1	1
1b1	Native Hawaiian	0	0
1b2	Other Pacific Islander	1	1
1c	Black/African American	1	0
1d	American Indian/Alaska Native	0	0
1e	White	21	8
1f	More than One Race	0	0
1g	Unreported/Refused to Report Race	12	8
	Subtotal Hispanic/Latino	36	18
Non-Hispanic/Latino			
	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension	Patients with Hypertension Controlled
2a	Asian	11	6
2b1	Native Hawaiian	1	0
2b2	Other Pacific Islander	0	0
2c	Black/African American	20	13
2d	American Indian/Alaska Native	6	4
2e	White	985	586
2f	More than One Race	0	0
2g	Unreported/Refused to Report Race	10	7
	Subtotal Non-Hispanic/Latino	1033	616
Unreported/Refused to Report Race/Ethnicity			
	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension	Patients with Hypertension Controlled
h	Unreported/Refused to Report Race and Ethnicity	22	14
		Total Patients 18 through 84 Years of Age with Hypertension	Patients with Hypertension Controlled
Total		1091	648

% of Patients with Hypertension Controlled	% in 2019	% in 2018	% in 2017	% in 2016
59.40%	69.07%	73.10%	70.54%	69.30%

Table 7: Health Outcomes and Disparities - 2020

Notes

Age Range changed in 2020 - was 18-75 yo

Section C: Hemoglobin A1C Poor Control

Hispanic/Latino			
	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes	Patients with HbA1c >9% or No Test During Year
1a	Asian	1	0
1b1	Native Hawaiian	0	0
1b2	Other Pacific Islander	1	1
1c	Black/African American	0	0
1d	American Indian/Alaska Native	0	0
1e	White	4	2
1f	More than One Race	0	0
1g	Unreported/Refused to Report Race	7	3
	Subtotal Hispanic/Latino	13	6
Non-Hispanic/Latino			
	Race and Ethnicity	Total Patients 18 through 85 Years	Patients with Hypertension
2a	Asian	11	3
2b1	Native Hawaiian	0	0
2b2	Other Pacific Islander	0	0
2c	Black/African American	7	0
2d	American Indian/Alaska Native	3	2
2e	White	309	95
2f	More than One Race	0	0
2g	Unreported/Refused to Report Race	2	0
	Subtotal Non-Hispanic/Latino	332	100
Unreported/Refused to Report Race/Ethnicity			
	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes	Patients with HbA1c >9% or No Test During Year
h	Unreported/Refused to Report Race and Ethnicity	7	3
		Total Patients 18 through 74 Years of Age with Diabetes	Patients with HbA1c >9% or No Test During Year
Total		352	109

% of Patients with A1c Poor Control	% in 2019	% in 2018	% in 2017	% in 2016
30.97%	27.51%	28.45%	30.68%	28.84%

Policy Title: Continuity of Operation Plan (COOP)	**Policy Number:** ADM-18
Department: All Departments	**Policy status:** Active
Regulatory Reference: HRSA PIN 2007-15 Health Center Emergency Management Program Expectations; CMS Final Rule for Emergency Preparedness 491.12(a)(3); internal policies	
Date Published: March 2006	
Dates Reviewed: 2014, 2015, 2017, 2018, 2019, 2020	
Dates Revised: March ~~2020~~2021	

PURPOSE:

In the event that the health center is affected by an epidemic infectious agent or other unanticipated hazards such as weather related closure, regional power failures, subsequent damage to infrastructure or systems causing significant multi-day and extended disruption to our mission, Hilltown Community Health Center will make every effort to continue operations subject to limitations on resources including human resources, materials and equipment and capital.

This plan outlines a comprehensive approach to ensure the continuity of essential services during such an event while ensuring the safety and well-being of employees, the emergency delegation of authority, the safekeeping of records vital to the agency and its clients, emergency acquisition of resources necessary for business resumption, and the capabilities to work remotely or at alternative work sites until normal operations can be resumed.

POLICY:

1. HCHC will follow the procedures outlined in this policy in the event of a significant reduction in staffing, either in a specific department or across the organization.
2. Business interruptions will be handled in coordination with local (town, state, hospital) emergency preparedness plans.
3. The Incident Commander will be the CEO, and in their absence, the Incident Commander will be the first individual present and available following the list of succession in Appendix A.

4. Issues that would arise were there a physical impact on the health center infrastructure such as a prolonged loss of energy, disruption in water supply, fire, earthquake, or other natural or intentional disaster are addressed in the Emergency Management Plan (EMP).
5. This policy will be used in conjunction, as appropriate, with the Health Center Closure Policy, the Illness at Work procedure, the Telecommuting Policy, and the EMP. This includes in the case of a physical impact on the health center infrastructure such as a prolonged loss of energy, disruption in water supply, fire, earthquake, or other natural or intentional disaster.

Questions regarding this policy or any related procedure should be directed to the Chief Executive Officer at 413-238-4128.

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

Section 1: COOP Assumptions

Plans to continue operations will need to be flexible to address the effects of the serious disruption of normal operations.

An infectious agent associated with a viral or bacterial epidemic, bio-terror attack, and outbreak of food-borne illness, severe weather incident or similar event may cause serious reductions in the availability of staff available for work and/or limit the stamina and work capacity of individuals. In such cases, a staff contingency plan must be developed to address critical functions throughout the health center.

The following list of assumptions outlines the potential impact on the health center's capacity to continue operations.

- Staff levels may be significantly reduced due to high levels of illness and hospitalization
- Staff may be lost due to significant mortality associated with disease
- Remaining workers may be psychologically affected by disease, family concerns, concerns about economic loss, or fear.
- Staffing may be reduced by the need for some workers to attend to family illness or to children remaining at home due to school closures.
- Human resource reductions may be temporary or may be long-term depending on the severity of the epidemic or similar event.
- There may be suspended function of building infrastructure due to power failure or damage as a result of inclement weather, including breach of the physical structure.

Section 2: General Information

2.A. Purpose: This Continuity of Operations Plan (COOP) provides policy and guidance to ensure the execution of essential functions in the event that core health center functions are threatened by an epidemic or similar event.

2.B. Applicability and Scope: This document applies to all personnel and associates of Hilltown Community Health Centers, Inc. (HCHC) including each of its sites in Worthington, Huntington, Amherst, School-Based programs, and Hilltown Community Center.

2.C. Responsibilities

The Chief Executive Officer (CEO) is responsible for the development of viable and executable contingency plans for the health center. The contingency plans will identify essential functions and the individuals to support them.

If the COOP is activated the Incident Commander~~,~~ will be the CEO or, in their absence or unavailability, the Chief Operating Officer, Chief Financial Officer, Chief Clinical and Community Services Officer or other designated Incident Commander. The Incident

Commander will use the Emergency Management Plan (EMP) for full Incident Command activation and procedures.

Section 3: Operational Concept

3.A. Objective: Staff Resources

The objective of this plan for human resources is to ensure the execution of HCHC's essential functions during any crisis and to provide for the safety and wellbeing of the employees during any emergency when a sudden or ongoing and severe reduction in staff/human resources critical to the safe and effective operation of the organization threatened occurs. Specific objectives of this plan include:

1. Ensuring the continuous performance of essential functions during an emergency;
2. Protecting the safety and productivity of working staff;
3. Reducing or mitigating disruptions to operations;
4. Addressing behavioral health issues that may affect the organization;
5. Pre-planning for potentially critical losses of staff through scheduling, identification of alternate resources, use of telecommuting, and temporary business reduction efforts;
6. Reducing loss of life and minimizing damage and losses;
7. Achieving a timely and orderly recovery from an emergency and resumption of full service to customers.

3.B. Concept of Execution

Emergencies, or threatened emergencies, may adversely affect the ability of HCHC to continue to carry out core functions and operations (as defined in Section 3.D). Infectious diseases, terrorist agents, and natural disasters may contribute to high morbidity and mortality among staff or reduced or complete cessation of services due to a compromise of the internal systems. An epidemic, for example, could affect 40% of the workforce, which would decrease existing staff levels to critically low levels and threaten the capacity of the organization to continue operations. Likewise, reduced capacity to provide care may result if essential systems are damaged or rendered inoperable for a period of time.

The following levels of emergencies are defined for planning purposes for this section of the COOP:

> ***Level 1 Emergency***: Less than 15% of the workforce necessary to carry out one or more core functions is unavailable due to illness, quarantine, caring for family members, impassable roadways, etc. Capacity reductions may be in place due to power failure or Internet Service Provider (ISP) interruptions. May require mandatory overtime for available staff and/or minor/temporary reductions in non-essential services. Temporary but more time-consuming systems may be enacted to allow essential care delivery.
>
> ***Level 2 Emergency*:** Between 15% and 40% of the workforce necessary to carry out one or more core functions is unavailable due to illness, quarantine, caring for family members, impassable roadways, etc. May require mandatory overtime for available staff and/or significant reduction in non-essential services and hours of operation. Multiple

days of service interruption due to adverse weather conditions may result in decreases of workforce availability due to impassable roadways or failures of the power infrastructure or ISP.

***Level 3 Emergency*:** 40% or more of the workforce necessary to carry out one or more core functions is unavailable due to illness, quarantine, caring for family members, impassable roadways, etc. May require cessation of essential services and redeployment of available personnel to resource pools managed by local, state, or federal emergency agencies. These may include but are not limited to, mass immunization sites, overflow treatment centers, and distribution sites for antivirals and other medications. Other incidents include cessation of essential services due to adverse weather events resulting in systems and/or utilities interruption.

There are numerous scenarios in which the COOP will need to be activated, including:

Infectious Disease Epidemic: Epidemic is defined as an event with widespread morbidity and mortality due to a highly contagious and dangerous virus resulting in an epidemic disease event. Staff reduction levels may reach 40% or more over a period of many months depending on incidence of disease within area of worksite/facility. Staff reductions may occur due to staff illness due to disease or family responsibilities, closure of schools, lack of caregiver support, or similar instances that prevent employees from coming to work.

HCHC may direct full or partial activation of the COOP. Activation of the plan may involve the transfer of essential functions or the deployment of pre-identified personnel and equipment/supplies. Activation of the plan may also involve significant alteration of work plans and assignments of staff to critical work areas; use of contractors; extension of overtime for well workers, and similar alternatives to offset staff reduction.

While an epidemic will most likely be preceded by up to a period time before the disease affects staff levels, staff reductions may be sudden and severe, and would likely occur across organizations. HCHC will maintain routine awareness of the threat environment through communications from the federal and state governments, local media, the Mass League of Community Health Centers (MLCHC), the Hampshire Public Health Preparedness Coalition (HPHPC), the regional Health and Medical Coordinating Council (HMCC), and other Emergency Preparedness partners. Developing situations should be closely followed, with emphasis on worsening situations that could develop into crisis conditions.

It is expected that HCHC will receive a warning from the Massachusetts Department of Public Health (MDPH) prior to declaration of an epidemic; however, an epidemic may last several months. Under this circumstance, the process of activation would normally enable the partial or full activation of the COOP with a complete and orderly alert, notification, and deployment of pre-designated personnel, equipment/supplies, and/or temporary transfer of selected core functions.

Weather Related Disaster: Extreme weather conditions preventing staff from reaching the facility may result in partial or complete reduction of capacity to provide care for indeterminate amounts of time. Accompanying this may be cessation of power, both situations may result in a full or partial activation of the COOP, as well as the Health Center Closure policy. It is expected that HCHC will be notified through the National Weather Service (NWS), Massachusetts Health and Homeland Alert Network (HHAN), the MDPH, and the HMCC of an impending weather event that is anticipated to carry enough force requiring activation of the COOP.

In any of the situations outlined above, without a warning the process ~~becomes~~can become less routine and potentially more serious and difficult to address. The clinical and leadership teams will identify key individuals who can realistically commit to reporting for work (either on-site or remote) under any anticipated conditions related to the above circumstances.

If the epidemic, weather related disaster or other incident results in loss of life, a major consideration becomes reconstitution of key leadership positions with personnel drawn from surviving departmental locations and elements, in accordance with the Order of Succession outlined in Appendix B.

3.C. Staff Resource Contingency Plan

Each Department Head, in consultation with Practice Management and their Senior Manager, will assess staffing needs for each site and develop a contingency plan to provide for alternative staffing in the event of an epidemic or any other event with major staff reduction. This includes:

1. Identification of functions necessary for continuity of operations (e.g., clinical providers, receptionists, management staff, finance staff, etc.) that are necessary for business to continue.
2. Plans for service reduction based on need, critical nature of function as a support for organization or local population, and other factors.
3. Reassignment of staff to critical areas of health center functioning or other sites from their current role or place of work. Evaluation of potential health and safety issues that might arise through diversion of staff to new job roles and loss of critical staff in various operational positions.
4. Identification of work options available through “telecommuting” or other off-site possibilities.
5. Assessment of flexible leave options that would allow employees to address family needs while continuing to support the employing organization through a flexible work plan where feasible.
6. Training of workers on an annual basis about contingency planning and the need for personal back up plans for transportation, family needs, etc.
7. Possibility of hiring temporary staff as required and possible from temporary staffing agencies.

3.D. Essential Functions

HCHC shall ensure essential function continuity or resumption as rapidly and efficiently as possible in the event of a staff reduction.

HCHC core functions have been prioritized as follows:

1. Medical Primary Care, including:
    a. Provision of urgent medical care and management of chronic diseases, including medication management; and
    b. 24-hour provider coverage of the practice's primary care patients
2. Dental primary and restorative care, with a focus on emergency care
    a. Dental hygiene patients can continue being seen as long as one hygienist is available. If one dentist and one dental assistant are available, dental patients will continue to be seen, consolidated into fewer sites as necessary.
3. Behavioral health services, with a focus on crisis management
    a. Behavioral health requires only one provider to deliver some service. They will continue to see urgent patients only.
4. Community services that support the provision of primary care and patient access.
    a. CHWs will focus on facilitating patient and community communication.
5. Optometry, with a focus on emergency care
    a. The eye care department will remain open as long as there is one optometrist available and the exam lanes are not needed for urgent medical visits

Administrative staffing, including billing, HR, and IT, will be prioritized as appropriate and required to support core functions. Any task in any department not deemed essential will be deferred until additional personnel and resources are available.

3.E. Direction and Control Succession

The following is an order of succession for Chief Executive Officer if they are no longer able to carry out their functions according to Appendix B. Delegation of authority will be to one of the leadership team members who are listed in Appendix B in the order in which they are listed. The delegation will last in auto-renewing 30-day periods or until revoked by the CEO or the Chair of the Board of Directors, and if unavailable, another Board officer (see Appendix C for Board Executive Committee members' contact information).

3.F. Operating Hours

During a COOP activation period, new hours of operation and/or changed hours of work for personnel may be necessary. However, to the extent possible, working hours of most staff will be similar to those during normal non-emergency periods. Hours of operation may be reduced at the discretion of the Chief Executive Officer or designee during periods of COOP activation.

3.G. Employee Hours

In the event that HCHC's COOP is activated due to a contagious medical outbreak, a negative balance in sick time may be allowed. ~~The negative balance cannot exceed one week's worth of time, per the employee's most recent PAF.~~HCHC will determine the amount of time allowed in the negative balance for each activation period, taking into account possible state and/or federal programs and regulations.

Section 4: COOP Activation/Termination

4.A. COOP Activation

The COOP may be activated under several situations if adequate staff are not available for work in order to keep critical business interests operational. It should be kept in mind that the COOP is NOT an evacuation plan; rather it is a deliberate and planned deployment of pre-identified and trained personnel and/or the transfer of essential functions.

Should a full or partial activation of the plan be necessary, the Chief Executive Officer will disseminate notification of the COOP activation with appropriate information and instructions, by email and text, as possible. If public notification is necessary, HCHC will use available means including social media, radio, television, telephone or e-mail. Pre-identified personnel should follow the instructions given and or in accordance with the instructions contained in this policy.

The COOP will be activated upon notification of the CEO or any one of the leadership team listed in Appendix B in the order that they are listed if the CEO is unavailable. Upon activation the CEO or designee will convene a leadership team to implement the COOP plan and assign responsibilities, using the Incident Command System as outlined in the EMP.

4.B. Initial Actions

Following COOP activation, the Incident Command Team will complete:

- Review of mission critical functions for the organization
- Evaluation of current staffing levels and resource deployment
- Evaluation of immediate and ongoing staff needs based on existing and predicted levels of human resources available.
- Notification of human resources, managers, and other key personnel as to status and plan implementation
- Notification of employees as to plan activation and process
- Implementation of alternative staff resource options
- Inventory of epidemic supplies, including special infection control masks. If supply chains are disrupted, Incident Commander or designated staff person will maintain communication with HMCC, Mass League, DPH, HPHPC, etc. to ensure that adequate supplied are secured.

- Consideration as to whether as many services as possible might need to be relocated to another of our facilities (e.g., Worthington to Huntington, Huntington to Amherst, etc.)
- Notification of emergency and community partners, including the Mass League, HMCC, local Board of Health and town government, local EMS, HPHPC, etc.
- Public notification and dissemination of infectious disease or other relevant safety information by means of mail, social media, press releases, etc. based on the most current information available from the Massachusetts Department of Public Health and the CDC.

4.C. Transition of Responsibilities to Redeployed staff

Transition of responsibilities according to job function analysis will occur throughout the course of an epidemic, infectious agent emergency or other identified hazard. Redeployment of personnel should be evaluated on a regular basis to ensure continuity of critical operations. This evaluation will be carried out by the senior management team convened by the organization's Incident Commander.

4.D. Deactivation/Termination of the COOP

Following the incident, the primary effort will be the resumption of services at HCHC's sites with adequate personnel to restore complete business operations. When sufficient functions have been restored at the original work site and/or other occupied space or a reconstituted facility(s) and notification that an imminent threat of disease or disaster no longer exists, the Chief Executive Officer or their designated successor can order the termination of COOP operations.

Section 5: COOP Responsibilities

5-1 Responsibilities of Senior Management

The responsibilities of senior management personnel in the event of staff loss to an epidemic or other such event will be to implement the COOP and EMP to support loss of management capabilities across the organization.

5.B. Responsibilities of Clinical Personnel

The responsibilities of clinical personnel will be to support critical operations at maximum feasible capacity as identified by Senior Management. Clinical personnel may be redeployed to programs requiring assistance outside of their standard functional job definition.

5.C. Responsibilities of Non-Clinical Supervisors

Administrative personnel will be responsible for providing support across the organization for key operations such as payroll, vital records maintenance, phone and internet service, customer support, database management, and similar functions, and may be redeployed to other programs requiring additional assistance.

5.D. Responsibilities of Support Personnel

Support personnel will be responsible for providing services across the organization as necessary and may be re-deployed to other programs requiring additional assistance.

6: Coordinating Instructions

6.A. Vital Records and Databases

Personnel will be deployed during an emergency to ensure the protection and ready availability of electronic and hardcopy documents, references, records, and information systems needed to support essential functions under the full spectrum of emergencies. All Health Center personnel with an identified role in the activation of the COOP must be identified before an emergency in order to have full access to use records and systems to conduct their essential functions. Categories of such records may include:

- ***Emergency Operating Records***: These are defined as vital records essential to the continued functioning or reconstitution of an agency during and after an emergency regardless of medium (paper, electronic, etc.). Included are emergency plans and directives; orders of succession; job action sheets; delegations of authority; staffing assignments; and related records of a policy or procedural nature that provide staff with guidance and information resources necessary for conducting operations during an emergency and for resuming formal operations at its conclusion.
- ***Legal and financial records***: These are defined as vital records, regardless of medium, critical to carrying out an organization's essential legal and financial functions and activities and protecting the legal and financial rights of individuals directly affected by its activities. Included are records having such value that their loss would significantly impair the conduct of essential agency functions, to the detriment of the legal or financial rights or entitlements of the organization or of the affected individuals.

6.B. IT and Billing Activities

As a backup to our critical IT infrastructure, HCHC has an informal arrangement with Cooley Dickinson Health Care, which hosts the EHR on its servers, to provide critical IT support during the activation period. HCHC also has a backup to its dental server located at its site in Worthington. Email systems are provided through Office 365, which is a cloud-based system, and all network drives are backed up on servers also located in Worthington. Financial systems are all cloud-based.

Financial and billing records will either be posted as normally done, if possible, or will be batched and processed as staff becomes available to perform that function.

6.C. Tests, Training and Exercises

Tests, training and exercises should be carried out regularly or at least annually to evaluate the COOP and improve the ability of HCHC to activate the COOP effectively. Testing will include team training of agency COOP staff and emergency personnel to ensure current knowledge and integration of skills necessary for plan execution; agency testing of COOP plans and procedures to ensure the ability of the agency to perform essential and mission critical functions; and testing of alert and notification procedures and systems.

6.D. Communications

Every member of the leadership team will have at least two different and independent ways of being contacted. In addition, staff will be notified as necessary by their direct supervisor, according to the Emergency Contact list maintained by HCHC Human Resources.

6.E. Security

Security of agency facilities, records, materials and other resources will be continuously evaluated to determine the effect of staff losses on security levels. All facilities are under security badge access to designated areas, restricted to authorized personnel.

Personnel will wear HCHC-issued badges at all times while on health center properties and while representing HCHC externally and shall continue to wear their identification during COOP operations. Temporary staff shall be issued badges as well, so that the leader of each work area can ensure that only health center personnel are in restricted areas and having patient contact.

APPENDIX A

Leadership Contact List

CRITICAL TEAM MEMBERS

Title	Name	Primary Phone	Secondary Phone
CEO	Eliza Lake	617-413-8604 (cell)	413-238-8001 (home)
CFO	John Melehov	978-815-8457 (cell)	978-668-5127 (home)
CCCSO	Michael Purdy	937-243-3148 (cell)	
COO	Vickie Dempesy	413-575-8113 (cell)	
Medical	Marisela Fermin-Schon	917-748-7132 (cell)	
Dental	Mary Lou Stuart	413-584-0202 (home)	
Behavioral Health	Franny Huberman	413-854-8662 (cell)	
Optometry	Michael Purdy	937-243-3148 (cell)	
Community	Kim Savery	413-329-8129 (cell)	413-623-5432 (home)
Dental Operations	Cynthia Magrath	973-953-3717 (cell)	413-238-0461 (home)
Reception	Patti Igel	413-977-6615 (cell)	
Facilities	Russ Jordan	413-992-7021 (cell)	413-634-2038 (home)
IT	Daniel Worpek	413-563-7150 (cell)	
EHR	Briana Blanchard	774-276-6929 (cell)	

APPENDIX B

Order of Succession

Title	Next in Line	Name	Primary Phone	Secondary Phone
CEO	CCCSO	Michael Purdy	937-243-3148 (cell)	
	COO	Vickie Dempesy	413-575-8113 (cell)	
	CFO	John Melehov	978-815-8457 (cell)	978-668-5127 (home)
CFO	Finance Director	Pat Kirouac	413-212-3319	
CCCSO	Medical Director	Marisela Fermin-Schon		
COO	Clinical Operations Manager	TBD		
	Dental Operations Manager	Cynthia Magrath	973-953-3717 (cell)	413-238-0461 (home)
Medical Director		Jon Liebman		
Dental Director		Warren Graham		
Behavioral Health Director	Assistant BH Director	David Bjorklund		
Optometry Director		Kim Krusell	860-371-7011 (cell)	
Community Programs Director		Susan Labarron		
Dental Operations Manager		Kate Mauter		
Reception Manager	Lead Receptionist	Camille Wead		
Facilities		John Melehov		
IT		John Melehov		
EHR		Cooley eCW Support		

APPENDIX C

Board Executive Committee Members

• Chair	M. Lee Manchester	413-296-4323 (home) 413-667-7112 (cell)
• Vice-Chair/Treasurer	John Follet	413-634-0221 (home) 413-441-6961 (cell)
• Clerk	Kathryn Jensen	413-464-5628 (home)

Policy Title: Credit and Collection Policy	**Policy Number:** FIN-01
Department: Administrative	**Policy status:** Active
Regulatory Reference: MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES 101 CMR 613.00: M.G.L. c. 118E	
Date Published: MAR 2016	
Dates Reviewed: MAR 2019, 2021	
Dates Revised: MAR 2021	

POLICY:

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.

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

Approved by:
Name: Eliza B. Lake Date: 3/11/2021
Eliza B. Lake
Chief Executive Officer, HCHC

Name: M. Lee Manchester Date: 3/11/2021
Lee Manchester
President, HCHC Board of Directors

Procedure:

CREDIT & COLLECTION POLICY

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

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

2. General Definitions *613.02*

2.1 Emergency Services – N/A

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

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

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

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

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

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

(1) an initial bill is sent to the party responsible for the patient's financial obligations;

(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;

(3) efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and

(4) a final notice is sent by certified mail for balances over $1000, where notices have

not been returned as an incorrect address or as undeliverable.
(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments in accordance with 101 CMR 613.04 (6) (b) and deductibles in accordance with 101 CMR 613.04(6) (c), that they will be responsible for these co-payments.
(d) Low Income Patient Co-Payment Requirements. The health center requests co-payments of $1 for antihyperglycemic, antihypertensive, and antihyperlipidemic generic prescription and $3.65 for generic and brand-name drugs from all patients over the age of 18, with the exception of pregnant or postpartum women, up to a maximum pharmacy co-payment of $250 per year.
(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Health Safety Net - Partial Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, the health center determines their deductible (40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL). If any member of the PBFG has an FPL below 150.1 % there is no deductible for any member of the PBFG. The Patient is responsible for 20% of the HSN payment for all services, with the exception of pharmacy services, provided up to this Deductible amount. Once the Patient has incurred the Deductible, the patient is no longer required to pay 20% of the payment. Only one Deductible is allowed per PBFG approval period.

3.2 Policies & Procedures for Collection Financial Information from patients

613.08(1)(c)2b

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth/Connector Care Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 515.000.
(a) Determination Notice. The Office of Medicaid or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.
(b) The Division's Electronic Free Care Application issued under 101 CMR 613.04(2)(b)(3) may be used for the following special application types:
a. Minors receiving Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. *613.04(3)a*
b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address. *613.04(3)b*

Presumptive Determination. An individual may be determined to be a Low Income Patient for a limited period of time, if on the basis of attested information submitted to the health center on the form specified by the Health Safety Net Office, the Provider determines the individual is presumptively a Low Income Patient, The health center will submit claims for Reimbursable Health Services provided to individuals with time-limited presumptive Low Income Patient determinations for dates of service beginning on the date on which the Provider makes the presumptive determination and continuing until the earlier of: a. The end of the month following the month in which the Provider made the presumptive determination if the individual has not submitted a

complete Application, or b. The date of the determination notice described in 101 CMR 613.04(2)(a) related to the individual's Application. *613.04 (4)*

3.3 Emergency Care Classification - NA

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

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

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

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

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

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

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

The health center offers a Sliding Fee Discount Program (SFDP) to patients.. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 200% of the FPIG. The Sliding Fee Discount Schedule applies to standard charges and to amounts left unpaid by insurances in compliance with the Federal Health and Resources and Services Administration (HRSA) PIN 2014-02.

Sliding Fee Discount Schedule

2021 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	$12,880	$16,100	$19,320	$22,540	$25,760
2	$17,420	$21,775	$26,130	$30,485	$34,840
3	$21,960	$27,450	$32,940	$38,430	$43,920
4	$26,500	$33,125	$39,750	$46,375	$53,000
5	$31,040	$38,800	$46,560	$54,320	$62,080
6	$35,580	$44,475	$53,370	$62,265	$71,160
7	$40,120	$50,150	$60,180	$70,210	$80,240
8	$44,660	$55,825	$66,990	$78,155	$89,320
For each additional person , add	$4,540	$5,675	$6,810	$7,945	$9,080
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	$19,320	$38,640
2	$26,130	$52,260
3	$32,940	$65,880
4	$39,750	$79,500
5	$46,560	$93,120
6	$53,370	$106,740
7	$60,180	$120,360
8	$66,990	$133,980
For each additional person , add	$6,810	$13,620

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)*

Policy Title: Sliding Fee Discount Program	**Policy Number:** FIN-03
Department: Administrative	**Policy status:** Active
Regulatory Reference: HRSA/BPHC [Public Health Service Act 330(k)(3)(G) of the PHS Act; and 42 CFR 51c 303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR56.303(g) and 42 CFR 56.303(u)	
Date Published: JAN 2013	
Dates Reviewed: MAR 2021	
Dates Revised: MAR 2021	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) Board of Directors have adopted this policy to make available a sliding fee discount program to ensure that no patient will be denied health care services provided by HCHC due to an inability to pay or on the basis of race, color, religion, creed, sex, gender, gender identity or gender expression, age, marital status, national origin, mental or physical disability, political belief or affiliation, veteran status, sexual orientation, genetic information, and any other class of individuals protected from discrimination under state or federal law with respect to the provision of services.

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

Discounts are offered based on family size and annual household income which is documented through the completion of the "Sliding Fee Discount Application". 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). The professional services component of procedures performed by HHC staff that involve lab charges or other 3rd party fees are subject to all sliding fee discount conditions and will be charged in accordance with the SFDP. Payment options and lab or separate eligible service costs will be discussed up front prior to services being provided and referenced in written documentation (eg, treatment plans).

The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

POLICY:

To make available discount services to those in need.

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

Originally Drafted: JANUARY 2013 Reviewed or Revised: MARCH 2021

Approved by:
Name: Eliza B. Lake Date: 3/11/2021
Eliza B. Lake
Chief Executive Officer, HCHC

Name: M. Lee Manchester Date: 3/11/2021
Lee Manchester
President, HCHC Board of Directors

Procedure:

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

1. **Notification:** HCHC will notify patients of the Sliding Fee Discount Program by:

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

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

3. **Request for discount:** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. Information and forms can be obtained from the Front Desk, Billing Department and from Navigators.

4. **Administration:** The Sliding Fee Discount Program procedure will be administered through the Finance Department / Billing Manager or their designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application with Navigators and /or the Billing Manager. Dignity will be respected and

confidentiality maintained for all who seek and/or are provided charitable services.

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

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

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

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

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

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

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

10. **Waiving or Reducing Charges:** In certain situations, patients may not be able to pay the discount fee, regardless of the patient income levels. Waiving of charges may only be used in special circumstances and must be approved by HCHC's CEO, CFO, or their designee. Examples of such special circumstances may include, but are not limited to, displacement of current housing due to catastrophic events such as fires or water damage, auto/personal injuries, or as a victim of serious crimes. Any waiving or reduction of charges should be documented in the patient's file along with an explanation.

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

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

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

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

15. **Referral contracts:** All HCHC referral contracts must include a clause detailing that HCHC patients receive services on a discounted fee equal to or better than the SFDS criteria of the Health Center Program. If the referral provider offers the services discounted on a SFDS with income at or below 250% FPG, as long as health center patients at or below 200% of the FPG

receive a greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule, and patients at or below 100% of the FPG receive no charge or only a nominal charge for the services, the referral arrangement is in compliance.

16. **Budget:** During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a deduction from revenue. Board approval of Sliding Fee Discount Program will be sought as an integral part of the annual budget.

HILLTOWN COMMUNITY HEALTH CENTER SLIDING FEE DISCOUNT SCHEDULE

2021 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	$12,880	$16,100	$19,320	$22,540	$25,760
2	$17,420	$21,775	$26,130	$30,485	$34,840
3	$21,960	$27,450	$32,940	$38,430	$43,920
4	$26,500	$33,125	$39,750	$46,375	$53,000
5	$31,040	$38,800	$46,560	$54,320	$62,080
6	$35,580	$44,475	$53,370	$62,265	$71,160
7	$40,120	$50,150	$60,180	$70,210	$80,240
8	$44,660	$55,825	$66,990	$78,155	$89,320
For each additional person , add	$4,540	$5,675	$6,810	$7,945	$9,080
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	$19,320	$38,640
2	$26,130	$52,260
3	$32,940	$65,880
4	$39,750	$79,500
5	$46,560	$93,120
6	$53,370	$106,740
7	$60,180	$120,360
8	$66,990	$133,980
For each additional person , add	$6,810	$13,620

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)]