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August 22, 2014

Myriam Torres, Vice President
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Sent Via Email to Myriam.Torres@jhsmiami.org and Jeffrey Poppel at jpoppel@miamidade.gov

Dear Ms. Torres:

Thanks you again for the opportunity to meet and for your letter of August 13, 2014. We appreciate all your time and efforts. We also appreciate that JHS is providing a critical community service with limited resources and that you and your staff are working extremely hard to remove barriers to access and services. We hope you understand our desire that the policy improvements agreed to be memorialized in formal and transparent policies, and that the remaining barriers we have identified be addressed without further delay.

This letter: 1) identifies the positive changes your August 13, 2014 letter indicated that JHS is willing to undertake; 2) identifies those issues in which disagreement remains or for which it is unclear whether or not the hospital has agreed to the requested corrective action; and 3) reiterates our request that the operational details implementing the positive changes be shared with FLS and incorporated in the hospital's updated Financial Assistance Program, ("FAP" or JHS charity care program) and described in a press release. In order to clarify our respective positions, his letter follows the format in our July 23 letter. Our original request is in regular type; your response is in italics; and our reply in bold.

(1) Actions to ensure access to timely and accurate classification:

a. Online application (begin by November 15th in time for the next open enrollment period):

JHS goal is to have on-line capability but declined to indicate any potential implementation date.

We understand that this is a resource issue and may not be amendable to agreeing to a date certain for implementation.

i. Real-time written decision provided in person if paper application or online

b. Interim procedures until charity care application is online:

i. Classification the same day as an appointment.

ii. Do not delay appointments while a decision is pending.

JHS will provide every patient with a financial determination the same day as appointment and patients can schedule appointment at any time priors to date of financial classification.

We greatly appreciate confirmation of this policy. As you know from my April 14, 2014 letter to Telisa Lyons, Ms. Lyons told us that this was the new policy at our April 1, 2014 meeting. We had expressed concern that patients were forced to wait for a financial classification before they could schedule a clinic appointment and that the wait could be a matter of several months. As in our April 14, 2014 letter, we again respectfully request that this change be issued as a formal policy and posted online, as some consumers were still being told (even after the end of April 2014) that they must first receive a financial classification. And, as per our July 21 meeting and July 23 letter, this is a positive policy change that should be shared in a press release because many county residents may still believe that they need a financial classification appointment before they can be seen in a clinic appointment.

c. Conform requisite verification to that required in applying for one of the insurance affordability programs, including Medicaid, on healthcare.gov.

JHS "criteria is designed to validate household income, identification and Miami-Dade county residency."

We have expressed the concern that JHS' practice of requiring certain forms of verification unrelated to county residency or determination of federal poverty level (FPL). (The FPL determination only includes verification related to household size and income, which you are already requiring.) For example, we have objected to requiring indigent county residents to produce notarized affidavits from individuals whose income does not count as part of the household's and who may be providing ad hoc support. This additional verification requirement serves as a barrier for some and discriminates against county residents eligible for the charity program. As noted, this verification is not required by the new insurance affordability programs in the Federal Health Care marketplace, including Medicaid.

d. Conform determination of applicant's federal poverty level (FPL) to modified adjusted gross income (MAGI).

i. Provide written clarification both in the financial assistance plan and the brochure describing whose income is included in the applicant's household for the purpose of determining FPL and J classification level and conform to MAGI.

JHS' charity care program will follow Hill Burton definitions of income and family.

JHS has federally funded navigators on site to help county residents apply for insurance through the Marketplace, including Medicaid. All of these programs use MAGI for determining FPL based on household size and income. Thus, for consumers found to be over 100% FPL, navigators or other enrollment or intake personnel can assist the consumer apply for subsidies in purchasing insurance through the marketplace. Similarly, individuals assessed eligible for Medicaid under the same MAGI calculation are referred to DCF for that determination. And, as we discussed, there are well over 150,000 low income county residents who fall into the "coverage gap" (i.e. those adults with income less than 100% FPL and thus not eligible for Marketplace subsidies, and who are not otherwise eligible for Florida's limited adult Medicaid program), and these individuals are all eligible for the JHS charity care program. It would be far more efficient and equitable for JHS to simply enroll these individuals into the JHS program rather than do another FPL determination based on different Hill-Burton criteria.

e. Include what decision was based on:

i. E.g. with an income of X and a HH of X, you qualify for a JOX

ii. Confirmation that same-day classification is in the policy.

JHS will update the application to include qualifications for each J code and every patient will receive a disposition the same day of appointment.

We appreciate this change. We are, however, requesting that the notice state, e.g., based on your household size of xx and an income of xx, you are eligible for a J xx. If you disagree with this determination, you have a right to appeal (and include notice of how to do so). This information is important for consumer and advocate to know in order to determinate whether there was an erroneous classification.

f. Provide scripting and training (subject to FLS input) and consensus agreement regarding JHS classification policy related to persons enrolled in Medically Needy program with share of cost greater than $50/month. The consensus goal is to ensure Medically Needy recipients under 200% FPL are informed that their co-pays will be equivalent to a J02 or J03, depending on income, ad that JHS can count the cost of their care in the Medically Needy bill tracking process.

JHS will instruct patient access to accept the J02 co-payments as a deposit for medically needy cases and bill the remaining balance.

We are troubled by this response, as it is an example of an issue that we thought had been resolved after significant time and effort spent in negotiations in 2012. While we appreciate JHS' agreement to limit the "deposit" to the J02 level, we respectfully disagree that the patient should be" billed the remaining balance" unless the policy clearly states that the "bill" will not be sent to patients or reported to debt collection. Otherwise, as explained during several prior meetings and in correspondence from 2012, enrollment in the medically needy program serves as a discriminatory barrier to indigent patients who should qualify for the charity care program.

We discussed examples such as a single parent with one child and an income of $1000/month. (The child should be on Medicaid and the parent should get a J02 because the poverty level for a family of 2 is $1311.) Her share of cost (SOC) is $613 ($1000 minus $387, the medically needy income level). Accordingly, she must incur bills of $613 before she is on Medicaid for a single month. We understand and appreciate the need for bill tracking and working to ensure that the person's medically needy enrollment can covert to actual coverage if/when the SOC is met. So, in this example, should the parent be hospitalized, even for a single day, JHS could appropriately charge her the $100 deposit for a J02 and bill the remainder to Medicaid as her single day of inpatient hospitalization will meet her share of cost. However, if she goes for a specialist visit and is charged the J02 fee of $40 (and assuming the cost of the visit is approximately $200), this will not satisfy the patient's share of cost. Billing her for the remaining $160 only serves to create an unaffordable medical debt and barrier to future care. Further, the JHS response on this request is an example of where we thought the issue had been resolved after significant time and effort spent in negotiations in 2012. This is an unreasonable and discriminatory result.

g. Ensure that 750 is rewritten pending FLS approval to clarify that immigration documentation is NOT required for a financial classification.

JHS states that "Policy 750 already identifies legal vs illegal residents and documentation required is to protect [JHS] from fraud and possibly qualify the patient for other funding sources."

Although we understand the need to ask for immigration documentation for individuals that are lawfully in the U.S. (in order to qualify them for other potential coverage), there is no purpose in requiring similar documentation from an undocumented individual. Additionally, as we discussed, this issue was the topic of lengthy negotiations between my office other advocates and JHS over 10 years ago. JHS ultimately agreed that requiring documentation from undocumented individuals can be a barrier to accessing care and agreed to corrective actions.

However, as with all policies, the language is critical and the case of L.C. described below suggests that the current policy needs to be further

clarified. L.C., an undocumented indigent county resident, was scheduled for medically necessary surgery. When L.C. attempted to obtain a JHS charity care card prior to his surgery (scheduled for early march 2014), he was told he could not do so unless he provided JHS with a copy of his I-94 which he received over 25 years ago and no longer had. He then sought help and a lawyer went back to JHS with him on March 5, 2014. The lawyer showed the supervisor language from the JHS "Financial Assistance for Medical Care" brochure policy noting that proof of county residence was required and stating that "questions related to immigration status are used only to find an special programs that may help the person pay for [their] care." The supervisor, however, insisted there were other polices requiring documentation.

On March 7, an appeal on behalf of L.C. was sent to the JHS financial classification office. The appeal was captioned "URGENT IMMEDIATE RESPONSE REQUESTED: Appeal of Financial Assessment Decision. . .", and included L.C's name and date of birth. It was not filed on a JHS specific form as the lawyer could not find any financial classification appeal forms on the JHS web site.

The lawyer sent additional urgent emails on March 12, 19 and 21, 2014, urgently requesting renewal of L.C.'s JHS care card and reattaching all relevant documents demonstrating proof of his county residency and stating his willingness to sign an affidavit that he is undocumented. These emails stated that his treating physician said the risks of continued delay, including "severe infections, severe pain, urinary obstruction or even death." L.C.'s lawyer finally received an email from JHS on March 24, 2014, stating that JHS required an attestation from LC (which had previously been offered) and someone else, and that once those were received his charity card would be renewed. LC immediately submitted those documents, and was finally approved for charity care and given his surgery on April 30, 2014, approximately two months after his surgery was initially scheduled. This example illustrates a situation in which we thought there had been an agreed upon policy from extended negotiations in 2000-2001 that would ensure that foreign born county residents not be subject to disparate treatment and which included provisions that undocumented immigrants not be required to produce immigration documentation.

Again, this example underscores the need for posting all policies online and supports our request that consumer advocates be given an opportunity to comment if /when policies are revised.

h. Include written right to appeal and have appeal form online.

JHS states that Policy 750 addresses the written right to appeal and that the appeal form is online.

We have looked for and not found a copy of the appeal form online at http://www.jacksonhealth.org/patients-financial-assistance.asp, the link to JHS Financial Assistance. While the form may be somewhere on the internet, that will not meet the needs of the individuals who may need to request an appeal. Thus, we request that it be included on the logical and appropriate place –on the FAP with other relevant forms. (Note: the attorney assisting LC could not find appeal form online).

i. Implement ombudsmen and emergency appeal procedure.

JHS states that "emergency appeals are escalated in real time."

We are not sure what that means. If there is such a policy and procedure it needs to be documented in the F.A.P , included online and reported in the Miami Herald and other press as a new policy development. As discussed at the July 21 meeting, there should be designated resources and policy, e.g. ombudsman, posters regarding notice of legal services office, for patients in urgent need of care whose classification is being denied or delayed. We understand that an ombudsman would require additional resources that may not be available, but at a minimum, we request that the posted information informing individuals of the opportunity to appeal and advise of a specific person/position that they can speak to regarding the matter.

Otherwise, these patients are at risk of ending up in the emergency room, needing more expensive care, and suffering worsened outcomes. We greatly appreciate your scheduling a new classification for Ms. Jacqueline Samuel within a week after my request for urgent assistance. But the intervention of a lawyer should not be necessary. The recent experience of Mahjela Dilu, described below, illustrates the need.

Ms. Dilu, a 30 year old woman with severe diabetes, resides with her disabled mother and three young children in Miami-Dade County. Ms. Dilu was recently employed as a part-time earning about $800-$1400 per month. Because her income was below 100% FPL, she was ineligible for assistance through the Affordable Care Act's Marketplace, and she made too much money to qualify for Medicaid in Florida (the eligibility limit for a parent with three minor children is $683/month). As a resident of JHS's service area, Ms. Dilu is eligible for a JHS care card with a J02 classification (lowest pay category for county residents with income less than 100% FPL). Ms. Dilu's diabetes requires daily injections of a specific type of insulin that costs $300/month. With the J02 classification, she could get the insulin with a $6.50 copayment.

On or about April 2014, Ms. Dilu was hospitalized for several weeks due to complications from her diabetes. After her discharge, she sought assistance from legal services to get coverage for her insulin. She was in immediate need of assistance and at risk of re-hospitalization if she could not obtain her

medication. At that time, Ms. Dilu was no longer working and, with no income, she should have been eligible for Florida's Medicaid program. Indeed, Ms. Dilu had applied for Medicaid while in the hospital and was told by social workers she was eligible. However, when she went to the pharmacy to get her Rx filled, she was told that she was not on Medicaid.

Given Ms. Dilu's urgent need for medication and her undisputed eligibility for the JHS care card since she was not receiving Medicaid, an attorney in my office advised her to call JHS on May 1, 2014 to request an immediate financial classification appointment. Despite explaining the urgency of her case, JHS informed her that the next available appointment for a financial classification would be over six weeks later. JHS's financial representative advised calling the financial assistance number again but, instead of following the voice mail prompts for requesting an appointment, to instead stay on the line. The representative further suggested that once Ms. Dilu got through, she could explain the urgency of the appointment and would likely get an appointment sooner. Ms. Dilu did so and waited more than 45 minutes on the phone line with no response. At that point I called office of the JHS Corporate Director for Patient Financial Services. After explaining Ms. Dilu's emergency situation, she was given a financial assessment appointment for May 2, 2014.

When Ms. Dilu went to her financial assistance appointment on May 2, however, she was denied access to the charity care program. The JHS intake worker told her that she should be eligible for Florida Medicaid, and that JHS denies the benefits of their charity care program to patients potentially eligible for Medicaid. Although Ms. Dilu explained that while she should be eligible for Medicaid she was nonetheless being denied. She explained that while her legal services attorneys were trying to fix the Medicaid error, she needed the JHS J02 card in order to immediately get her insulin. JHS denied Ms. Dilu the charity classification to which she was entitled as an indigent county resident and did not give her any information regarding her right to appeal the erroneous classification. Without her insulin, Ms. Dilu again became gravely ill and had to be readmitted to the hospital through the emergency room.

In sum, Ms. Dilu's story demonstrates the need to elevate appeals and to have a clear written policy informing applicants and others of how the process should work.

(2) Actions to ensure notice of Jackson's charity care program:

a. Post PDF copies of the completed Policy 750 (and any other policy related to financial assistance or billing, along with classification codes and fee schedule), brochure, and all related forms (including application and appeal forms) on Jackson website

JHS responded that all Jackson polices are public and that JHS will "work to add access via website."

Consumer advocates have complained about lack of availability and transparency of JHS policies on line for several years. The most recent period of protracted negotiations in which we renewed requests for JHS to provide requisite publication and transparency began in earnest again over 7 months ago. At this point in time, JHS is not in compliance with IRS requirements related to publication of the facility's financial assistance policy.

b. Provide notice and opportunity to comment regarding proposed changes to Policy 750 and any other policy related to financial assistance and billing through email alerts to organizations working with indigent county residents, including legal services organizations and medical legal partners.

Policies are approved by Jackson management.

We understand that Jackson management does not wish to complicate the process for approving policies. Please be assured that we do not wish to complicate or "micromanage." However, the lack of transparency, coupled with lack of notice to consumer advocates when polices impacting the low income community are changed, has been a problem. Moreover, despite years of advocacy in this area, there remains significant confusion about what the policies actually are, as well as the process used to formulate them. We believe that our participation in this particular policy revision could help resolve these problems and prevent additional work for JHS and advocates.

For example, at the July 21 meeting was the issue of JHS charging an encounter free for primary care to residents below 100%. JHS's practice has changed several times over the course of the 30 some years I have been representing low income Miami county residents. (Please let me know if you want a copy of old correspondence between legal services and PHT over this issue.) As you know, all policies related to the "determination of the indigent status of patients and health care delivery in the designated facility of the Trust" are annually developed and recommended to the County commission pursuant to County Code Chapter 25A-4(b)(1)(4). Can you please advise as to whether or not that is the current practice and when that process occurs? We understand the need for JHS to amend policies on a more frequent basis, and do those amendments also go the County commission? Again, we are not trying to micromanage but would like to confirm the process for policy development and amendments and have an opportunity to receive notice and provide comment on those actions.

c. Ensure paper copies of completed Policy 750 (with classification codes and fee schedule), the brochure, and application form are available in the hospital facility and by mail.

JHS states that brochures and applications are available at the facility.

Two of my colleagues when to the JHS facility to look for these materials both before and after August 13 and could not see them. The brochure was provided when specifically requested from an employee in the finance office. However, when my colleagues asked for a copy of the fee schedule on August 14, 2014, she was told there was none.

d. Post conspicuous public signs in Jackson's patient facilities notifying patients of the availability of the charity care program.

JHS August 13, 2014 reply states that "we currently have posters in the patient access areas and in the financial assessment areas."

Two of my colleagues went to the JHS facility to look for these materials both before and after August 13 and could not see them posted.

e. Inform the community about the charity care program through methods that will reach members of the community most likely to require charity care, including but not limited to Miami Herald and WLRN.

JHS states that staff have participated in local radio.

We respectfully suggest that that this is far from sufficient. Much of the low income community is either still unaware of the program or has been already subjected to medical debt collection from JHS which they cannot afford or asked to provide verification they do not have. Thus, it is critical to remove barriers and publicize the program, including that known barriers have been removed.

(3) Actions to ensure that people eligible for charity care receive admission and services without discrimination:

a. Adopt written policies ensuring that staff processing requests for appointments not schedule charity care patients *after* patients with other forms of insurance.

JHS states that scheduling is not based on financial class.

We reiterate our request that this be issued as part of formal policy and available on-line as it is not the anecdotal experience reported by some consumers with J cards who appear to wait many months for specialty appointments than patients with other forms of insurance.

(4) Actions to ensure implementation of meaningful Community Health Needs Assessment (CHNA):

a. Follows the CDC's detailed website for implementing the CHNA.

b. Request and consider input from community advocates and other individuals representing the broad interests of Jackson's patient community including individuals with special expertise in public health; legal services attorneys representing low-income residents (i.e. Legal Services of Greater Miami, Florida Legal Services, and Dade Legal Aid); and medical legal partners (FIU and UM).

c. Make the Community Health Needs Assessment widely available and published annually.

JHS responded that they are working on a CHNA and that it is required once every three taxable years.

It is unclear if it is JHS's position that the CHNA is not yet due? Is JHS willing to engage low income consumer advocates in the process? Again, we ask whether JHS is willing to engage low income consumer advocates in this process, as required by law..

(5) Actions to ensure that indigent patients not be charged excessive co-pays which create barriers to care.

a. Conform co-pays to Medicaid for beneficiaries under 100% FPL. *See* Att. A.

JHS states that patients below 100% FPL will not be charged co-payments for primary care.

This does not respond to our request that co-payments for other services, which are required up front as encounter fees, also be limited to the Medicaid standard for adults under the poverty level. We had asked that the copayments, which are required up front as encounter fees, be limited to the Medicaid level. We discussed the overwhelming and uncontroverted evidence establishing that more than nominal copayments for indigent individuals create barriers to care. While there is no charge for primary care for patients below 100% FPL, many chronically ill patients require ongoing treatment from a specialist ($40), including blood tests ($25) routine radiology ($25), plus medications. ($6.50 per drug). Then, if the patient needs any sort of outpatient test or procedure, he or she must pay an additional $100/per day up to $300. For a person below the poverty line this is simply unaffordable and creates a barrier to care.

(6) Actions to ensure a fair and reasonable billing and collections policy:

a. Jackson will undertake "reasonable efforts" to **notify** patients about the charity care program up to 120 days after patients receive their first billing statement. Jackson will not initiate extraordinary collection actions during this 120 day period. Jackson will undertake following reasonable efforts to notify:

i. Provide patients with a charity care brochure and application form for charity care before discharge;

ii. Provide a plain language summary in at least three billing statements as well as all other communications given to the individual;

iii. Inform the individual about the assistance program whenever discussing the bill; and

iv. Provide at least one written notice including information about possible extraordinary collection actions that could be taken if the individual does not apply for the financial assistance policy or pay the bill at least 30 days prior to the deadline specified in the notice.

b. Patients will be afforded the opportunity to apply for charity care up to 240 days after receiving their first billing statement. Jackson will suspend any

extraordinary collection actions during this 240 day period if a patient applies for charity care, even if the application is incomplete.

JHS stated that "all inpatients are screened while in-house for Medicaid and Charity. Patients are provided charity brochures and every effort is made to complete the application for all patients qualifying prior to discharge.

This response only appears to apply to inpatients, and it is unresponsive to all of our specific questions of whether or not JHS will comply with the specific measures defined by the IRS as a necessary part of "reasonable effort." And the definitions of what constitutes the "notification" and "application" period.

c. JHS only contract with physicians who agree to adopt the same billing schedule as JHS. Thus, for patients with a JO2 classification receiving specialty care, the physician would not bill the patient more than $40. For a J03, the physician bill would be limited to $70. (note: this is corrective action requested in our 4/14/14 and 8/6/14 letters).

JHS did not respond to this request. We greatly appreciate that you did agree to contact Jacqueline Samuel's anesthesiologist and asked them to retract her account from collections. But while we greatly appreciate this action on her behalf, the issue needs to be resolved system wide for other indigent county residents relying on the Jackson charity program. As we did not know about the language in the brochure regarding this policy, i.e. "Not all services offered at JHS are covered by the JHS Care Card. For services covered, only JHS facility costs are included and not the physician's bill." We requested that this policy be changed so that charity care card holders receiving services at JHS facilities only be billed for their co-payment based on their J code. We are also requesting that the brochure language be changed so that patients understand their co-payment charge is all that they are responsible for.

In closing, we appreciate all of the positive changes JHS is working on and we also greatly appreciate the individual corrective actions requested and granted for Ms. Samuel. We are aware of JHS' limited resources. However, the above anecdotes demonstrate that the current barriers to access (including lack of transparency which can be remedied at little expense) also end up adding to costs when patients end up sicker due to lack of access. Thus, the barriers need to be addressed systemically, rather than on a case by case basis (as with Ms. Samuel). We welcome the opportunity to continue to work with JHS on further addressing consumer concerns, but at this point we do not believe that the changes indicated in your letter, particularly in the absence of a press release memorializing the changes sufficiently address the concerns we have been raising. That said, we still look forward to continued progress and thank you again for your ongoing time and assistance.

Sincerely,

s/ Miriam Harmatz

Miriam Harmatz