ACCRETIVE HEALTH
RESPONSE TO INQUIRY BY SENATOR AL FRANKEN

May 11, 2012

Accretive Health strives every day to be a constructive and positive contributor to the American healthcare system. We take seriously the allegations by the Minnesota Attorney General, and Accretive Health appreciates this opportunity to set the record straight.

BACKGROUND

Accretive Health has two service offerings at issue: Revenue Cycle Management and Quality and Total Cost of Care. Both are fundamentally designed to improve outcomes, primarily by eliminating errors, for healthcare providers and patients. An October 2011 Kauffman Foundation interview of our CEO, Mary Tolan, shows the commitment Accretive Health has to its healthcare provider partners and the admiration and respect we have for our customers' work.

Here is a link to the interview:

http://www.accretivehealth.com/AboutAccretiveHealth/OurPassionForOurClients/tabid/395/Default.aspx.

Revenue Cycle Management

In our Revenue Cycle Management offering, Accretive Health works with its healthcare provider clients and assists them in improving the quality of their revenue processes, consistent with the providers' individual policies and procedures. This means, among other things, making sure insurance claim forms and payor reimbursements are accurate. It also means finding appropriate solutions for the uninsured or, if coverage cannot be identified, charity programs that can assist those who qualify. And it means educating patients about their financial obligations for their healthcare costs and helping to ensure that they fulfill them.

Specifically, Revenue Cycle Management covers patient registration, insurance and benefit verification, medical treatment documentation and coding, third-party collections, and patient collections. Through this offering, Accretive Health works with healthcare providers to strengthen their financial stability so that they can, in turn, focus on their mission of providing better care to their local communities. Accretive Health collaborates with its clients to help

them recover the significant amounts of money contractually owed to them by insurance companies and other third-party payors, and to collect the proper amounts owed by those who have an obligation (subject to any assistance or charity qualification) to pay for their share of the cost of medical services they receive. Accretive Health's Revenue Cycle Management offering is consistent with Congressional directives aimed at lowering hospital bad debt.[1]

In collaboration with its provider partners, Accretive Health has developed leading-edge technology unlike any other offering in the industry. While other technological solutions provide insight into one specific segment of the Revenue Cycle (insurance payment, government billing, patient payment), Accretive Health's software tools provide an integrated picture of the entire financial life cycle of an episode of care. Accretive Health's software tools add significant value for its customers by, for example, helping providers identify accounts that are at highest risk of not receiving payment from third-party payors, as opposed to other solutions that treat all accounts the same. Thus, the Accretive Health tools help the hospital focus its scarce revenue cycle resources.

Accretive Health uses its technology and software tools to review, and where appropriate, challenge payment denials by insurance companies (such as denials for pre-existing conditions and coordination-of-benefit denials), check the accuracy of payors' reimbursements, ensure that bills are accurate and codes are properly entered to get full and compliant reimbursement, and, for the uninsured, identify available alternative funding sources so that providers can be compensated for care. Accretive Health brings focus and experience to these goals so that healthcare providers have the resources they need to fulfill their valued mission of providing high-quality and affordable care to patients.

Accretive Health assists in getting complete patient information and validate insurance coverage benefits so that services can be properly billed to

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[1] For example, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record those payments as bad debt. Historically, Medicare reimbursed hospitals for 100 percent of Medicare bad debt, but the bad debt reimbursement rate has been cut substantially over the years, and more cuts may be made in the future. Cuts to the Medicare bad debt reimbursement rate directly hit a hospital's bottom line and have forced hospitals to do a better job collecting the revenue they are owed. American Hospital Association, *Reject cuts in Medicare bad debt reimbursement for hospitals* (Sept. 2011), *available at* http://www.aha.org/content/11/110909-baddebt.pdf.

the appropriate parties. A major focus of Accretive Health's work is with uninsured patients to determine whether their care can be covered by Medicaid, COBRA, automobile insurance, workers' compensation, disability, compensation for victims of crime, parental insurance coverage, student coverage, military benefits or the hospital's charity assistance program. Since its founding in 2003, Accretive Health has helped over 250,000 uninsured patients obtain coverage for their care – coverage for which these patients often were not aware they qualified.

Accretive Health is continually analyzing work flow processes and technology to make improvements in the quality of the payment solution process and to lower costs. With escalating operating costs outpacing revenue growth, healthcare providers must strive to realize all of the revenue to which they are entitled, in order to avoid improper cost shifting or being unable to meet the costs of providing critical healthcare services. With Accretive Health's software tools, healthcare providers typically eliminate a significant number of process errors. This leads to improved and more accurate insurance billing and enrollment, thereby increasing provider revenues. These increased revenues allow hospitals to provide a higher quality array of healthcare services to a larger patient population. In addition, with accurate reimbursement, patients' out-of-pocket expenses for healthcare are often reduced.

In addition to recovering more of the money that is owed to providers, Accretive Health also saves providers money by delivering these services more efficiently. For example, Accretive Health works to streamline operations and avoid unnecessary or duplicative work in the revenue cycle, while striving to improve the quality of operations.

Anyone who has filed an insurance claim or struggled to understand an explanation of benefits knows that the insurance system is a complicated maze. Our expertise and technology enable us to assist our clients in processing and coordinating payments for their patients among multiple parties, including insurance companies, federal and state government payors, private charities, and individual payors.

A key component of Revenue Cycle Management involves educating and counseling patients. We advise patients about their insurance coverage, estimate the patient share component, and provide options for making payment. This work with patients helps to demystify the financial side of healthcare and eliminate delays or errors in billing and reimbursement. For those without insurance, we work to find third-party coverage solutions. It is our experience that patients appreciate the education, expertise, and compassion that we

provide through these efforts and our financial counseling. With the permission of the individual involved, we share the following example of our valuable services written by a woman who reached out to her Accretive Health financial counselor within hours of the death of her spouse:

> Hi [Accretive Health Employee],
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> I should be calling you, but it's late and the next few days are going to be insane, so first I must apologize for this email – I am sorry.
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> So – [patient] passed away in the ICU up there [date/time]. I don't know what happens now – and don't know what you might need from me. I know that we still have some sort of balance and am more than willing to setup some type of plan. My mind is moving so fast that I know I can't write to you what is really in my heart, but I wanted you to know how much he appreciated your patience, kindness and help. He really respected you and was so flabbergasted by how much you really cared and wanted to help us through this with as little financial burden as possible. It's hard to explain how much that meant to us. We had two WONDERFUL months together after his first trip to the ICU and not having to constantly worry about the hundreds and hundreds of thousands of dollars we were racking up was a huge reason why we were able to just enjoy our time together. And to be able to walk away with that, is precious. It's hard to imagine there is anyway this could be more awful a situation – but it could have been in so so many ways – this being a huge one. We never once felt like his care would be compromised because of our ability (inability really) to pay. So – from the bottom of my heart I thank you.
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> I pray that someday I am able to pay it forward – and help others walking down that same terrifying path. I know he would have wanted that.

Quality and Total Cost of Care

Accretive Health introduced its Quality and Total Cost of Care service ("QTCC") in 2010. Accretive Health believes that it can contribute to the important aims of improving the quality and affordability of healthcare. Many

studies have found that U.S. healthcare costs are the highest in the developed world, and high costs do not always equate with the highest quality care. We, along with other leading institutions, believe there is an opportunity to improve the quality of care and, by doing so, lower overall healthcare costs. As explained below, we believe that our QTCC service focuses on the right issues and, as a result, we can help our clients in their mission to provide more integrated, better care to patients.

The QTCC service first helps healthcare providers identify the patients who would benefit most from more integrated or intensive care and then works with the healthcare providers to give these patients additional support to enhance their quality of care, thereby avoiding repeated hospital admissions or unnecessary visits to the emergency room. Preventing repeated hospital admissions for a condition that can be managed without hospitalization is better for the patient and lowers overall healthcare costs. Emergency room visits for non-emergency conditions are highly inefficient and costly. Accretive Health supplies the processes and experienced advisors, and then works with healthcare providers to help them educate patients, coordinate care among various providers, supply behavioral support resources, and assist the patients' own engagement with their care plan and their doctors' recommendations.

As with its Revenue Cycle Management service, Accretive Health's technology adds significant value for its QTCC clients. Accretive Health's QTCC software tools – which were created with the aim of ensuring that patients receive the right care at the right time from the right providers – provide an integrated picture of visibility into the care plan of patients. Accretive Health's QTCC software is focused to maximize direct and meaningful coordination of patient care.

With Accretive Health's QTCC service, total healthcare costs decline and the quality of care increases. The doctors, hospitals, payors, and patients (by not having to pay their portion of the costs of unnecessary hospital visits) all share in the savings. Thus, the incentives and the preferred outcomes (higher quality of care with lower costs) are all aligned. Through better care coordination and management, we have helped patients with chronic conditions such as congestive heart failure, kidney disease, Crohn's disease, diabetes, and cancer gain more coordinated access to their doctors and other resources in order to manage symptoms and improve their quality of life. Helping our clients keep these patients healthier improves the affordability of healthcare for all.

Accretive Health and Fairview

Fairview Health Services ("Fairview"), a regional healthcare system based in Minneapolis, Minnesota, contracted with Accretive Health for both its Revenue Cycle Management and QTCC services. The Accretive Health/Fairview contracts covered seven hospitals[2] and more than 40 primary care clinics.

One goal of the Accretive Health/Fairview partnership was for Accretive Health to assist Fairview in obtaining "Accountable Care Organization" ("ACO") status with the Centers for Medicare and Medicaid Services ("CMS").[3] The ACO-model builds on the Medicare Physician Group Practice Demonstration and the Medicare Health Care Quality Demonstration. While the ACO model is designed to be flexible, there are three core elements for all ACOs:

1. Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients;

2. Payments linked to quality improvements that also reduce overall costs; and

3. Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care.[4]

With Accretive Health's assistance, Fairview was able to demonstrate to CMS its ability to provide patients coordinated, high-quality, and cost-effective

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[2] The seven hospitals are the Southdale, Ridges, Lakes, and Northland hospitals, and the University of Minnesota Medical Center (comprised of the Riverside campus, Amplatz Children's Hospital, and the University of Minnesota campus). Across these facilities, there was variation in how Revenue Cycle Management and QTCC functions were carried out, driven in large part by the needs, policies, and capabilities of the individual facilities.

[3] An Accountable Care Organization is a group of healthcare providers and doctors who work together to provide coordinated, high-quality, and cost-effective care for Medicare beneficiaries.

[4] McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES. *A National Strategy to Put Accountable Care Into Practice*, Health Affairs, 29, no. 5 (2010), 982, *available at* http://content.healthaffairs.org/content/29/5/982.full.html.

care. As a result, in December 2011, Fairview was selected as one of 32 pioneer ACOs.

In early 2012, as part of Accretive Health's agreement with the Minnesota Attorney General to resolve the pending litigation (which the Attorney General subsequently violated), Fairview and Accretive Health decided to amend their Revenue Cycle Operations Agreement to transition the management of those operations back to Fairview leadership. Subsequently, in the face of heightened pressure from the Attorney General, Fairview announced its intent to terminate its QTCC contract with Accretive Health. This is an unfortunate setback for the people of Minnesota whose care and quality of life was improved through the QTTC program, and for the approximately 130 individuals whose careers were devoted to the QTTC mission. Nevertheless, Accretive Health will continue to assist Fairview through transition to preserve the good results that have been achieved and will continue to work with its other provider partners in these areas.

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What follows are Accretive Health's responses to Senator Franken's questions. These responses are based on our company's good faith efforts to respond accurately in light of the review that has been possible in the two weeks since receiving the Senator's requests. In the limited time available to prepare this response, it was impossible to interview each of the thousands of Accretive Health's individual employees or review all of the documents that may be relevant to this matter. Should our continuing investigation provide reason to supplement these responses in any way, Accretive Health expressly reserves its right to do so.

1. Did Accretive employees[5] request payment or attempt to collect past debts from Fairview patients *before* they received medical treatment?

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[5] Many of the questions posed by Senator Franken ask about the conduct of Accretive Health employees. Accretive Health worked in a strategic partnership with Fairview hospitals and clinics to provide the Revenue Cycle Management services described above. During this time, there were a total of approximately forty Accretive Health employees, along with over twelve hundred Fairview employees, working throughout the entire Fairview system, to manage and improve Fairview's Revenue Cycle processes. Regarding Question 1 in particular, approximately fifteen to twenty Accretive

At Fairview, as at many hospitals, there were two different approaches to assisting patients, depending upon whether they were making a scheduled visit or coming into the emergency room.[6] In addition, there were different procedures depending on whether a patient was insured or uninsured.

Scheduled Patients with Insurance

Insured patients with scheduled procedures (such as laboratory testing, imaging, rehabilitation therapies, and planned surgeries) were provided information regarding their insurance coverages and estimates of their patient share balances before their appointments. In most cases, this conversation occurred by telephone as a part of the pre-registration process, seven to ten days in advance of the patient's appointment. In some cases, if the patient could not be reached by telephone, this conversation occurred during patient registration at the facility on the day of the patient's appointment.

During the pre-registration or registration process, Revenue Cycle employees verified the patient's insurance information in order to obtain any necessary authorization for insurance coverage of the scheduled procedure. This can be a time-sensitive process.[7] The next step was to provide the patient with an estimate of his or her share of the treatment cost, including any co-payment or co-insurance obligation.[8] (The patient's share of the treatment cost is often referred to as the "residual balance.") This helped patients understand their cost of care well in advance of receiving the first bill and helped them to avoid unnecessary confusion or concern. A critical part of compassionate care is reducing the patient's anxiety about the potential treatment cost. Hospitals are one of the few places a consumer will go where the cost of the service is ambiguous.

Health employees would have had pre-treatment discussions with patients concerning payment while hundreds of Fairview employees would have had such discussions.

[6] At Fairview, as with all of our provider clients, Accretive Health only implemented those policies and practices that Fairview chose to enact.

[7] For example, some insurers require clinical information before they will authorize payment for service. In some instances, failure to provide correct and complete information can lead to the insurer's refusal to pay some or all of a claim.

[8] The process of determining the patient share of the treatment cost is described in response to Question 3.

If applicable, the patient was also advised of any prior balances.[9] Informing patients of prior balances at the time of registration is consistent with the "recommended practices" advocated by the Healthcare Financial Management Association ("HFMA"), a leading membership organization for healthcare financial management executives that has published guidelines for "Patient-Friendly Billing" procedures.[10]

Discussions with patients about prior balances included asking the patient to pay the amounts for which he or she was responsible. But more often, it was the case that the insurance claim for the prior balance had been delayed or denied improperly because the patient did not submit complete information to support of the claim. (At Fairview, for example, in the fourth quarter of 2011, over 98 percent of resolved prior balances – approximately $19 million – was resolved by public or private insurance, while less than two percent – about $300,000 – was paid by patients themselves.) By discussing prior balances with patients, Revenue Cycle employees could obtain the patient's assistance in re-submitting the claim to the patient's insurer. When successful, the prior balance became the insurer's obligation. The patient was not burdened by unnecessary debt and the hospital was more likely to be paid.

Payment of residual balances for current episodes of care and prior balances for past episodes of care were optional. Indeed, the majority of Fairview patients chose not to pay their residual or prior balances during pre-registration or registration, opting instead to be billed. All Revenue Cycle employees were instructed never to insist that patients pay residual or prior balances or suggest to patients that they would not receive treatment unless they paid. Training materials and employee scripts for both Accretive Health and Fairview employees emphasized this in red, bolded, capitalized type:

> **PLEASE READ: NOT ONLY ARE PATIENTS NEVER TO BE DENIED SERVICE FOR NON-PAYMENT, THEY ARE NEVER TO BE GIVEN THE IMPRESSION THAT SERVICE WOULD BE DENIED FOR NON-PAYMENT.**

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9 A "prior balance" was an amount owing for prior episodes of care.

10 HFMA states that patients should be reminded of any past-due balances at the time of registration. *See* HFMA, "Patient-Friendly Billing: The Link Among Patient Billing, Revenue, and Patient Satisfaction" (Summer 2002), *available at* http://www.hfma.org/HFMA-Initiatives /Patient-Friendly-Billing/Patient-Friendly-Billing.

Scheduled Patients with No Insurance

Fairview had a slightly different policy for uninsured patients with scheduled appointments. The Fairview deferral policy – which predated Fairview's relationship with Accretive Health and was administered exclusively by Fairview employees – applied to these patients. Under the Fairview deferral policy, as Accretive Health understands it, uninsured patients who were scheduled for outpatient procedures more than 48 hours in the future or inpatient procedures more than 72 hours in the future were referred to pre-appointment financial counseling. (If the uninsured patient was within the 48- or 72-hour window before his or her appointment, the appointment went forward as scheduled and financial counseling was postponed until the time of service.)

To the best of Accretive Health's knowledge, the purpose of the pre-appointment financial counseling was to identify a third-party funding source to cover the cost of the patient's care. If the Fairview financial counselor was unable to help the patient find government assistance or another third-party funding source, and the patient did not qualify for Fairview's charity policy, Accretive Health understands that Fairview would ask the uninsured patient to pay a deposit. If he or she would not do so, Fairview would defer the patient's procedure. We understand, however, there was a "clinical override" that permitted an uninsured patient's procedure to go forward as scheduled, even without third-party funding, charity care or a deposit, if the Fairview clinician decided, in their discretion, that the procedure should go forward.

a) If so, did they make these requests for emergency room patients?

Emergency Room Patients

At Fairview, emergency room patients were given a medical screening examination by a clinician and any necessary stabilizing treatment. While emergency room patients went through the same registration process as scheduled patients, this process occurred **after** the patient had been screened and, if necessary, stabilized.[11] Revenue Cycle employees were permitted to

[11] This practice is also consistent with the "recommended practices" advocated by the HFMA. HFMA places great emphasis on "early, transparent financial communications" with patients so that they understand ***before*** treatment their possible out-of-pocket costs as well as any available payment alternatives. HFMA advises that "[i]f urgent care needs prevent these steps from being taken before services are delivered, providers complete these steps

speak with emergency room patients as dictated by the clinicians and the patient's condition, but only during "down times" (such as when the patient was waiting for test results or otherwise was not being treated by clinicians), and only after the patient had been screened and stabilized. The main focus was to verify the patient's insurance and to obtain any necessary authorizations which may be time sensitive.

After screening and stabilization, and as a part of the registration process, emergency room patients, like scheduled patients, were provided estimates regarding their cost of care, counseling regarding available payment alternatives, and an opportunity to pay their own calculated portion of the balance if they so chose. Accretive Health and Fairview's policy, however, was that an emergency room patient's treatment was **never** conditioned on payment.[12]

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As a part of its recent review, Accretive Health evaluated the impact that requesting payment of residual balances had on patient satisfaction at Fairview. Specifically, Accretive Health reviewed data in its possession concerning calls made to a Fairview-operated customer service line between October 1, 2010 and February 1, 2012. During this time period, there were over 3 million episodes of care at Fairview hospitals and clinics, and the Fairview customer service line logged 351,804 calls inquiring about all kinds of issues, including requests to update personal information, make a payment, or inquire about a bill. Based upon our review of this data, it appears that approximately one tenth of one percent of episodes of care resulted in a call by a patient who complained about the collection of residual balances. And it appears that only six of these calls

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as soon as appropriate after service." *See* HFMA, "Early, Transparent Financial Communications: A Patient-Friendly Billing Recommended Practice," *available at* http:www.hfma.org/HFMA-Iniatives/Patient-Friendly-Billing/Early-Transparent-Financial-Communications (emphasis supplied).

[12] The Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, provides that "[a] participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) [of the Act] or further medical examination and treatment as required under subsection (b) … in order to inquire about the individual's method of payment or insurance status." 42 U.S.C. § 1395dd(h). To date, our review has not uncovered any EMTALA violations.

related to the manner in which the residual balance was collected from the patient at the time of service.

b) Is Accretive aware of any information[13] suggesting that these practices led to longer wait times for patients?

Hospital wait times vary based on a number of factors, such as the number of patients with appointments and the availability of clinicians on a given day. As far as Accretive Health knows, Fairview did not track patient wait times, so it is not possible for Accretive Health to say with certainty what wait times were or how they compared with other hospitals.

As discussed above, most scheduled patients pre-registered by telephone, seven to ten days in advance of their appointments. Fairview and other hospitals have long recognized pre-registration as a best practice. Fairview registrars met with all patients (regardless of whether they had pre-registered) and helped those patients complete standard insurance forms and requested payment for the patient portion of the service. Those patients who did not present with insurance consulted with a Fairview financial counselor to identify any existing coverage, government program eligibility, and charity care program eligibility. Both processes typically take no more than a few minutes, and similar processes are followed by virtually every hospital and clinic in this country upon registration. While it is theoretically possible that filling out routine forms and making any payment arrangements could have led to a slight delay (assuming that treatment was immediately available for non-emergency care within the first minutes of arrival), the benefits provided patients from the registration process – including assistance in understanding insurance benefits

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[13] Several questions ask if Accretive Health is aware of ***any*** information suggesting that something occurred. These questions are very broad and could be misread as seeking answers based upon perfect knowledge of the actions of every employee throughout the company. Moreover, Accretive Health is certainly aware that the Minnesota Attorney General has made allegations concerning various topics, although it is clear that the Attorney General's report is highly misleading and was not informed by even a single meeting with any current Accretive Health employee. Accretive Health's investigation of these allegations is ongoing. For these reasons, it is not possible for Accretive Health to state whether ***any*** current or former Accretive Health or Fairview employee had ***any*** knowledge, or whether there is ***any*** document in the possession of either Accretive Health or Fairview, concerning a particular topic.

or help with having insurance companies resolve prior balances – in our experience generally outweighed any such slight delay.

Illustrating this, numerous Fairview patients have, by comment cards, letters, and emails, expressed their gratitude for the efforts of individual Accretive Health employees. Examples include:

- "She was INCREDIBLY HELPFUL and provided me PEACE OF MIND."
- "You were very efficient. You were compassionate and asked me questions without just turning me away. You explained the hospital policy but immediately looked into my situation."
- "Without your help I and my family would be in a very difficult situation."
- "[T]hank you for all of your knowledge, guidance, pep talks, and all of the laughs. You truly are doing what you were meant to do, this is your calling. You make such a difference in people's lives."
- "It is so good to know there are still caring and knowledgeable people working at the hospital who can focus on the problem without passing judgment or having an attitude."
- "Worked to figure out with me [sic] and gave me direct contact info in the event of a question. Personable, respectful, helpful – yeah!"
- "Thank you for your caring attitude and generosity to all those you come in contact with. You truly are a blessing to this facility!"

These are a very small sample of the many expressions of appreciation Accretive Health employees regularly receive.

c) Is Accretive aware of any information suggesting that these practices led to any patients refusing treatment or leaving a hospital before receiving treatment?

In every hospital, there are a small number of patients who choose to leave the emergency room without treatment.[14] There are a variety of reasons for

[14] *See*, *e.g.*, Centers for Disease Control, *National Hospital Care Survey* (2008), *available at* http://www.cdc.gov/nchs/data/ahcd/nhamcs_ emergency/

this: for example, some patients may determine that they do not need emergency medical treatment. As far as Accretive Health knows, Fairview did not track patients who left the hospital without first receiving treatment, so it is not possible to know why patients left.

To the best of our knowledge, the patients identified in the Minnesota Attorney General's report as "walk-offs" did, in fact, receive treatment. Our understanding is that these patients would be documented in Fairview's records only if they had received treatment. While our investigation is ongoing, it appears as though each of these patients left the hospital after receiving treatment, but without completing the registration process.

2. Did Accretive employees in any way suggest to patients that they would not receive treatment if they could not pay for it or if they could not pay a past debt?

As outlined in response to Question 1, payment of residual and prior balances was optional. Revenue Cycle employees were instructed never to suggest to patients that they would not receive treatment unless they paid.[15] Training materials and employee scripts for both Accretive Health and Fairview employees emphasized this in red, bolded, capitalized type:

> **PLEASE READ: NOT ONLY ARE PATIENTS NEVER TO BE DENIED SERVICE FOR NON-PAYMENT, THEY ARE NEVER TO BE GIVEN THE IMPRESSION THAT SERVICE WOULD BE DENIED FOR NON-PAYMENT.**

a) The report states that Accretive employees were directed to "put together a 'pre-balance stop list' the night before patient appointments so that the patient can be stopped for payment before treatment is rendered." *See* Swanson Report § 5.3. Is this true?

2008_ed_web_tables.pdf (finding that 1.6 percent of sampled emergency room patients left without medical screening).

[15] As explained in detail in response to Question 1, Fairview employees (but NOT Accretive Health employees) did administer a Fairview "deferral" policy under the narrow circumstances in which a patient had an appointment scheduled days in the future for a procedure that was not medically urgent, did not qualify for third-party assistance or charity care, and declined to work with a financial counselor or provide any payment.

This statement is misleading. The purpose of stop lists was not to "stop" treatment. Rather, stop lists identified patients scheduled for certain procedures, including radiology and imaging (all Fairview hospitals), laboratory tests (Lakes), and surgeries (Southdale and Ridges), with whom Revenue Cycle employees needed to meet to resolve prior balances. As discussed above, informing patients of prior balances at the time of registration is consistent with the HFMA's "recommended practices."[16]

Consistent with these "recommended practices," Revenue Cycle employees worked with these patients to, for example, provide insurance companies with the necessary information to have them pay claims that had been previously delayed or denied. As described above, for the fourth quarter of 2011, at Fairview, over 98 percent of resolved prior balances – approximately $19 million – was resolved by public or private insurance, while less than 2 percent – about $300,000 – was paid by patients themselves.

As explained above, employee scripts made very clear that Revenue Cycle employees were never to suggest to patients that their treatment was conditioned on payment.

b) Did Accretive employees create "stop lists" for patients who were scheduled for surgery?

Patients at certain Fairview facilities scheduled for certain procedures were included on stop lists so that Revenue Cycle employees could contact these patients and meet with them to resolve their prior balances. As mentioned above, these prior balances most often could be moved to insurance companies or other third-party payors, resulting in a reduction or elimination of the patient's portion of the balance. If the patient was not able to pay his or her portion of the balance, employees helped the patient identify potential sources of third-party coverage. And again, Accretive Health to date has located no instance where a Fairview patient was stopped from undergoing surgery based upon amounts owed for past care.

c) Is Accretive aware of any information suggesting that these practices led to longer wait times for patients?

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[16] *See* HFMA, "Patient-Friendly Billing: The Link Among Patient Billing, Revenue, and Patient Satisfaction" (Summer 2002), *available at* http://www.hfma.org/HFMA-Initiatives /Patient-Friendly-Billing/Patient-Friendly-Billing.

As discussed above, hospital wait times vary based on a number of factors. As far as Accretive Health knows, Fairview did not track patient wait times, so it is not possible for Accretive Health to say with certainty what wait times were or how they compared with other hospitals.

At Fairview, only patients with scheduled appointments were included on stop lists. Most scheduled patients pre-registered by telephone, days in advance of their appointments. Those who did not pre-register were asked to fill out standard forms required by most every healthcare provider (which typically take only a few minutes to complete), and to provide payment if the patient elected to do so. While it is theoretically possible that filling out the routine forms and making any payment arrangements the patient elected to pay could have led to a slight delay (assuming that treatment was immediately available for non-emergent care within the first minutes of arrival), the benefits provided patients by the process – including assistance in understanding insurance coverage or help with having insurance companies resolve prior balances – in our experience generally outweighed any such slight delay.

d) Is Accretive aware of any information suggesting that these practices led to any patients refusing treatment or leaving a hospital before receiving treatment?

We are aware of certain reports in the media that patients left Fairview prior to receiving care. We can not exclude the possibility that a patient who becomes aware of his or her treatment cost or payment obligations might make an informed decision to pursue alternative care. However, and though our investigation is ongoing, we have not identified any instances of this.

3. The report states that Accretive instructed Fairview employees to predict the "likely" diagnosis and treatment in order to bill patients prior to treatment. *See* Swanson Report § 5.4. Is this true?

a) If so, how did Accretive instruct its employees or others to make these predictions?

b) If so, how did Accretive identify erroneous predictions?

c) If so, how does Accretive ensure timely refunds to patients who overpaid?

To the extent possible, and in advance of non-emergency treatment, patients were provided with estimates of their share of the treatment cost so as

to avoid confusion or surprise later. As discussed above, this practice is consistent with the "recommended practices" advocated by the HFMA.

It is not accurate to say that "likely" diagnosis and treatment were "predicted" "in order to bill patients." Rather, estimates about a patient's cost of care were based upon diagnostic codes included in referrals or other documents that hospitals routinely use to schedule appointments. Through the use of Accretive Health's software tools and diagnostic codes, including the American Medical Association's CPT (Current Procedural Terminology) Codes, reasonable estimates of the cost of care were prepared in advance, in order to pursue insurance options and other reimbursement. At the same time, an estimate of the patient's share of the cost was generated.

After Fairview received the insurer's payment, Revenue Cycle employees compared the total amount paid by both the patient and insurance company to the total charges for the patient's treatment. As a result of this process, Accretive Health was able to determine patient overpayments (requiring patient refunds) or patient underpayments (requiring additional payments). Accounts requiring patient refunds were worked by a dedicated Fairview team. This team processed the refunds in a systematic manner, from oldest to newest and largest dollar value to smallest.

Accretive Health provided significant value to Fairview and its patients. With the use of Accretive Health's residual balance calculator, during the period from November 2010 to February 2012, Fairview decreased the number of refunds owed by approximately sixty percent.

4. Did Accretive employees request or discuss payment or attempt to collect past debts from patients *while* they received medical treatment or were interned at the hospital?

Accretive Health works with its hospital partners to develop policies concerning whether and when employees can contact patients for discussions about payment. At Fairview, most discussions with patients about payment occurred during pre-registration or registration (which, for emergency room patients, occurred after medical screening and any necessary stabilizing treatment). But if a conversation about payment did not occur during pre-registration or registration, Revenue Cycle employees contacted select patients to discuss their financial obligations during the course of their hospital stay. These contacts were limited to patients willing to talk with Revenue Cycle employees and at a time the clinician deemed appropriate.

Policies implemented at Fairview barred employees from contacting several categories of patients at any point during their time in the emergency room regarding payments:

- Patients with heart conditions;
- Patients with life threatening injuries; or
- Patients who received a high triage score (level 1 or 2) in the emergency room.

Aside from these exceptions, Revenue Cycle employees generally attempted to contact all patients who sought treatment at Fairview. We believe that Revenue Cycle employees worked to communicate with patients with the greatest possible compassion, in a manner appropriate to the patient's individual situation. The goal of these discussions was to help patients understand their cost of care and assist them (if necessary) in obtaining third-party coverage for that care. Accretive Health's corporate code of conduct mandates that each employee commit to delivering services in an ethical, professional manner, and that all patients are treated with respect and dignity.

a) If so, did they do so for emergency room patients?

Emergency room patients who did not fall into one of the above categories were contacted for discussions about payment as a part of the registration process, after medical screening and any necessary stabilizing treatment. All financial discussions with emergency room patients, as with all patients, were optional.

b) If so, did they do so for patients in the neonatal intensive care unit (NICU)?

Under Fairview's policies, the parent of a child in the neonatal intensive care unit ("NICU") was contacted for two purposes: (1) to assist the parent with the process of adding the child to the parent's insurance policy or obtaining government assistance, or (2) to prepare a birth certificate. Even in these situations, the practice differed depending on the hospital:

- At the Southdale and Ridges hospitals, the practice was to wait until the day the mother was discharged from the hospital.
- At the University of Minnesota hospital, where Revenue Cycle employees played no role in preparing birth certificates, the practice

was to contact parents only when the child had been in the NICU for 30 to 60 days and the parent had not yet added the child to his or her insurance policy. If, when contacted, the parent did not want to talk, the parent was given contact information for an employee who could later assist with the process of adding the child to the parent's insurance policy.

The remaining hospitals in the Fairview network did not have NICUs.

c) Were Accretive employees directed to "collect at bedside post patient assessment," as the report alleges? *See* Swanson Report § 5.4.

Within the limitations described above, Revenue Cycle employees strived to contact and counsel each Fairview patient, and under certain circumstances that included bedside financial counseling, or post-patient assessments. As set forth in the document referenced in the Minnesota Attorney General's report, the objective of bedside counseling was to:

- Register basic information and insurance information;
- Verify insurance and authorization requirements;
- Identify co-payments and deductibles;
- Obtain at bedside post-patient assessment by clinicians; and
- If no insurance: refer to the financial counselor.[17]

All conversations were optional. Through these discussions, Revenue Cycle employees sought to compassionately resolve a major concern for many patients: their personal financial obligations for treatment. Employees would also answer patient questions, and financial counselors would visit uninsured patients to help them obtain third-party coverage or apply for charity assistance.

As described above, bedside contacts were limited to patients willing to engage with Revenue Cycle employees and at a time when the clinician deemed appropriate. And, as described in response to Question 4, Revenue Cycle employees did not contact several categories of patients in the emergency room, such as patients with heart conditions or life-threatening injuries.

[17] MN AG Volume 5, Exhibit 27.

5. The report appended an email in which an Accretive employee wrote: "We need to get cracking on labor and delivery. There is a good chunk to be collected there [...]" The report also cited a separate email in which an Accretive employee was instructed to prepare a daily report to "identify moms that admitted yesterday" to target collections toward those individuals. *See* Swanson Report § 5.3. Does Accretive stand by these statements?

a) Is it or has it ever been Accretive policy to direct its employees to focus collections on patients in maternity units?

b) If so, has Accretive changed its practices in this regard?

The Minnesota Attorney General's report takes these emails out of context and misidentifies the author of the first email. The first email stating that "[w]e need to get cracking on labor and delivery" was not written by an Accretive Health employee. It was written by a Fairview employee, and this is obvious from the face of the document. In that email, the Fairview employee was offering her opinion on where Fairview should focus its efforts to collect co-payments and prior balances. The second email was part of an employee evaluation, in which the employee's supervisors developed a check-list of responsibilities, one of which was "Calculate residuals for L&D patients for financial counselors; (a) Pull spooled report each morning to identify moms that [sic] admitted yesterday; (b) Calculate residuals and provide necessary information to [financial counselor]." Both emails refer to Fairview's initiative of including the labor & delivery floors in financial counseling services, as was being done for other segments of the hospital.[18]

During Fairview's relationship with Accretive Health, Revenue Cycle employees did not contact women who were in labor or who had just given birth. Hospitals in the Fairview system established various policies, such as the examples below, that governed when employees were permitted to contact new mothers:

- At the Southdale and Ridges hospitals, the practice was to contact new mothers on the day they were discharged.
- At the University of Minnesota Medical Center, and at the Northland and Lakes hospitals, the practice was that new mothers

[18] MN AG Vol. 5 Ex. 13.

were eligible to be contacted after they had been moved into recovery. At that point, an employee would contact a new mother and offer to provide her with information about medical coverage for her and her child. Only when the mother indicated that she wanted to talk did the staff member schedule a time, at the mother's convenience, to meet with her in her room.

As discussed above, Revenue Cycle employees attempted to contact all patients (aside from those falling under the categories listed in response to Question 4). The goal of these discussions was to help patients understand their cost of care and assist them (if necessary) in obtaining third-party coverage for that care.

6. What specific medical data did Accretive make available to its *post-treatment* debt collection agents[19]?

Since February 2011, Accretive Health employees working for Medical Financial Solutions ("MFS") have had access to the following patient health information:

- Patient name and contact information;
- Guarantor (person financially responsible, if not the patient);
- Date of service;
- Patient type (e.g., emergency room, outpatient, diagnostic); and
- Easily understood description of the diagnosis code.

This information allowed employees to engage with patients and answer questions about amounts owed.

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[19] The Fair Debt Collection Practices Act ("FDCPA") expressly distinguishes between "defaulted" debt, which is subject to the Act, and merely "delinquent" or "pre-collect" or "pre-defaulted" debt, which is not. 15 U.S.C. § 1692(a)(6)(F)(iii) (excluding from definition of "debt collector" someone seeking to collect "a debt which was not in default"). As such, not all Medical Financial Solutions employees' contacts with patients constituted "debt collection" within the meaning of the FDCPA.

7. The report states that Accretive debt collection agents were able to access information indicating that a specific Fairview patient suffered from "major depression, alcohol intoxication, migraines, attention deficit disorder and attempted suicide by cutting his wrist." *See* Swanson Report § 4.7. Is this accurate?

a) If so, why does Accretive permit its debt collection agents to access this information?

The Minnesota Attorney General's report references a screenshot of patient information contained in Fairview's electronic medical records system (called "PASS"). PASS is Fairview's patient accounting system used to streamline patient billing and assist claim submissions. We understand that Fairview implemented PASS decades before the Accretive Health contract and continues to use the system to bill patients. As configured by Fairview, PASS did not restrict information contained in patient files. It is Accretive Health's understanding that the information its employees received from the Fairview PASS system is consistent with what others in the industry received from patient accounting systems used by other hospitals.

For a period of time, PASS was the only source of information to answer patient questions about amounts owed. In November 2010, only eight months after entering into its Revenue Cycle Management contract with Fairview, Accretive Health began implementing a software technology tool that limited employee access to medical information to the data listed above in response to Question 6. This software tool became fully operational in February 2011, though some employees continued to have access to Fairview PASS files until early 2012.

b) The report alleges that "patient health information was used to collect debts." *Ibid* at § 4.7. Is this accurate, and if so, how exactly was patient health information used to collect debts?

The use of "patient health information" is described in response to Question 6. As stated above, access to patient health information allowed employees to engage with patients and answer questions about amounts owed.

c) Does Accretive change its collection practices on the basis of a patient's diagnosis or treatment? Have Accretive employees done so in the past?

Accretive Health does not make or change collection decisions based on a patient's diagnosis or treatment, except under certain appropriate circumstances. For example, as set forth above, there are stricter limits on the timing of financial counseling or efforts to obtain payment for services for certain types of patients, such as those with heart conditions or life threatening injuries. In addition, there are certain medical conditions (e.g., kidney dialysis, legal blindness, amputation, end-stage renal disease, certain types of leukemia, etc.) that almost always qualify a patient for Medicaid or disability insurance. Thus, when such conditions are identified early in the process, a patient's payment obligation would likely be eliminated.

8. The report states that Accretive debt collection agents identify themselves as "financial counselors" as opposed to "debt collectors" when seeking payment for past debts from patients. *See* Swanson Report § 5.7. Is this true?

As explained below, financial counselors primarily helped patients find sources of payments for their bills.

Accretive Health had three different groups of employees who worked to collect overdue payments from Fairview patients: (1) the Revenue Cycle employees at Fairview's facilities (approximately 15-20 Accretive Health employees working with and approximately 1200 Fairview employees); (2) the approximately 15 employees of MFS, a division of Accretive Health that engages in pre-collect and dormant (*i.e.* defaulted) debt collection from a call center; and (3) four Revenue Cycle employees at the same call center who, along with approximately 50 Fairview employees, pre-registered patients over the telephone for scheduled appointments.

Of this first category, there were two different types of Revenue Cycle employees on-site at Fairview: (1) those that registered patients and performed other functions; and (2) financial counselors that primarily helped uninsured patients find third-party coverage for their medical procedures. If there was a prior balance, the financial counselor (whether a Fairview or Accretive Health employee) should have mentioned the balance to the patient and discussed payment options. While the Revenue Cycle employees in the call center working to collect payments from patients typically referred to themselves as patient financial advisors or debt recovery specialists, these employees also may have from time to time identified themselves as financial counselors.

a) Did Accretive require all patients to meet with a financial counselor before receiving treatment?

No, all consultations with financial counselors at Fairview were optional.

9. The report states that Accretive refused to provide documentation verifying a debt when requested by consumers. *See* Swanson Report § 5.9. Is this true?

a) Did Accretive continue to seek payment of debts after verification was requested?

Accretive's policy for dormant accounts is to cease all collection efforts upon receipt of a written validation request as mandated by the Fair Debt Collection Practices Act. Accretive Health also uses the same practice for precollect accounts as well, although not required to do so by the FDCPA. Fairview annually reviewed the collection efforts of its hospitals and collection agencies as required by the settlement it had entered into with the Minnesota Attorney General's Office. One such audit resulted in MFS retraining its representatives handling Fairview accounts on appropriate practices for itemized statement requests. MFS also implemented a minimum 30-day hold on seeking payment following itemized statement requests on disputed pre-collect (*i.e.* not defaulted) debts.

10. The report states that Accretive employees lost six laptops to theft in three separate incidents between February and June 2011. *See* Swanson Report § 4.6. Is this accurate?

According to Accretive Health records, nine company laptops were stolen in 2011.[20] All but one was encrypted. Context is important: in 2011, Accretive Health had approximately 1,400 laptop and desktop computers in use by its employees.

a) How many Fairview patients had medical information that was contained in the lost laptops?

b) How many other individuals had medical information that was contained in the lost laptops?

[20] Two of these were recovered within hours.

Safeguards available on all but one of the stolen laptops allowed Accretive Health to take steps to deny any unauthorized user access to the contents. Because of these safeguards, Protected Health Information ("PHI") was not at risk and no further investigation was required as to the particular number or identity of patient files.

A laptop stolen in July 2011 (also discussed below in response to Question 11) was password-protected, but not encrypted. Efforts were made to identify the files containing PHI contained on the laptop and to identify the hospitals associated with these PHI-laden files. Pursuant to its obligations under the Health Insurance Portability and Accountability Act ("HIPAA"), *see* 45 C.F.R. § 164.410, Accretive Health provided information about the identification of individuals and types of PHI in the PHI-laden files – as well as copies of the PHI-laden files themselves – to the appropriate hospitals, who in turn evaluated which patients needed to be notified about the incident because they faced significant risk of financial, reputational or other harm. Accretive Health has been informed by the outside vendor responsible for the notifications, that to date, Fairview has notified 13,922 individuals and North Memorial has notified 9,457 individuals about the incident.

11. The report provides a redacted screenshot of a patient's medical data file that was contained on the laptop lost in the Seven Corners neighborhood of Minneapolis on July 25, 2011. That file contains the patient's full name, address, date of birth and a checklist indicating that the patient suffers from bipolar disorder, diabetes, a lipid metabolism disorder, and hyperthyroidism. The file template also permits identification of a range of other conditions and diagnoses, including depression, schizophrenia, Parkinson's disease, and HIV positive status. *See* Swanson Report at § 1.7.

a) How many files like this one were contained in the lost laptops?

As discussed in response to Question No. 10, only the one unencrypted laptop stolen in July 2011 was examined in detail in order to determine its contents. All other stolen laptops were successfully encrypted. As discussed above, Accretive Health provided copies of the files from the unencrypted laptop to all affected hospitals, and notice was provided as described above to approximately 23,000 individuals.

b) How many of these files were encrypted? How were they encrypted?

c) How many of the files were protected in another way (password protection, etc.)? How were they protected?

d) If any of the files were not encrypted, why were they not encrypted?

The laptop stolen in July 2011 was password-protected, but its files were not encrypted, due to the oversight of an individual IT employee. This laptop was one of approximately 30 laptops (out of 1,400 laptop and desktop computers) missing Accretive Health's required encryption software. When this was discovered, the IT employee was terminated. Following this incident, Accretive Health added redundancies to its IT practices so that multiple employees work independently to ensure that each Accretive Health laptop is properly encrypted. In addition, Accretive Health conducts reviews at least five days a week to confirm that every laptop remains properly encrypted.

e) The report alleges that the user of the laptop was a "revenue cycle" employee. *Ibid* at § 4.6. Is this accurate? If so, what is a "revenue cycle" employee, and why does such an employee require access to these customer records?

The Revenue Cycle employee is, in this case, an Accretive Health employee who performs Revenue Cycle Management services (described in the Background section above) for Accretive Health's clients. The employee had worked at Fairview, then transferred to North Memorial Health Care. While at Fairview, the employee, seeking to become better acquainted with Accretive Health's QTCC program, accessed QTCC data including that described in Section 1.7 of the Minnesota Attorney General's report.

12. What other patient medical information was contained in the lost laptops?

a) Was that information encrypted or protected in any way?

Please see the responses to Questions 10 and 11.

b) Has Accretive changed its encryption practices since these thefts? If so, how? If not, why not?

Accretive Health has added redundancies to its IT practices, as described in response to Question 11(d). Accretive Health also has begun to upgrade its encryption software to higher than industry standards, and is pursuing additional high-trust encryption certification.

13. Does Accretive believe that it has acted in compliance with the federal Emergency Medical Treatment and Active Labor Act?

Accretive Health takes very seriously its obligations under all applicable federal and state laws and regulations. We note the Minnesota Attorney General has not brought any claims against Accretive Health for violation of EMTALA, and we believe that our policies and practices are in full compliance with EMTALA and have not identified any EMTALA violation in our investigation to date.

14. Does Accretive believe that it has acted in compliance with the federal Fair Debt Collection Practices Act?

Accretive Health takes very seriously its obligations under all applicable federal and state laws and regulations. We incorporate by reference our responses to the questions above, as well as our motion to dismiss the Attorney General's FDCPA claims in which we request that those claims be dismissed in their entirety with prejudice.

15. Does Accretive believe that it has acted in compliance with the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act?

Accretive Health takes very seriously its obligations under all applicable federal and state laws and regulations. We incorporate by reference our responses to the questions above, as well as our motion to dismiss the Attorney General's HIPAA and HITECH claims in which we request that those claims be denied in their entirety with prejudice.

16. Does Accretive believe that it has met its obligations under its February 18, 2010 business associate agreement with Fairview?

To the extent the Business Associate Agreement with Fairview contractually obligated Accretive Health to comply with applicable HIPAA requirements, Accretive Health respectfully incorporates by reference our responses to the questions above and our motion to dismiss, in which we request that all claims be dismissed in their entirety with prejudice. With respect to the

other obligations imposed by the Business Associate Agreement, Accretive Health believes that it has met its obligations.

17. Does Accretive believe that it has treated Fairview patients fairly and ethically?

Yes, Accretive Health has a mission and a culture founded on treating all patients, including Fairview patients, fairly and ethically.

Accretive Health and its employees work every day to help our healthcare providers strengthen their financial stability so that Fairview and our dozens of other provider partners can fulfill their mission of providing high-quality healthcare to patients and their families.

What we do is critical for our customers and their patients. And we are proud of what we do. Every day, our employees interact with thousands of patients and families, many of whom are confused, worried, or even fearful about what their visit to the hospital will bring. They have questions and we provide answers, respectfully, trying always to do so with great sensitivity. We help uninsured patients get insurance through Medicaid and other programs. We help insured patients maximize the amount that their insurance company will pay for their care. For patients who cannot pay, we help with applications for charity care. For patients with insurance, Accretive Health works to secure full realization of their insurance benefits. For patients who can pay, we develop payment plans so that the cost of being sick does not become too much of a burden. Accretive Health's mission to help patients and health care providers is one we are always refining, and if even a single patient believes he or she has not received the proper, compassionate assistance from Accretive Health, that is one too many. We recognize that a company of our size cannot be perfect. But we are always looking for way to learn and improve our contribution to the patient experience.

* * * *

Accretive Health takes very seriously its obligations under all applicable federal and state laws and regulations and intends to vigorously defend itself in the pending litigation.

Meanwhile, Accretive Health intends to continue to focus on its core mission: helping our healthcare provider partners strengthen their financial stability so that they in turn can deliver better care to their local communities, thereby increasing healthcare access for all. We are committed to this mission,

and we are committed to ensuring that it is carried out fairly and ethically, in full compliance with all applicable laws.