

**STATEMENT OF GREGORY KAZARIAN
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BEFORE THE
COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS
UNITED STATES SENATE
“ENSURING PATIENTS’ ACCESS TO CARE AND PRIVACY:
ARE FEDERAL LAWS PROTECTING PATIENTS?”
MAY 30, 2012**

Senator Franken, thank you for this opportunity to discuss healthcare issues that we know are of concern to you and other Minnesotans. We are extremely pleased that you will be holding a hearing on this important subject because it gives us a chance to tell the people of Minnesota who we are and what we really do. Accretive Health and its thousands of employees (including roughly 130 Minnesotans) work every day to help hospitals strengthen their financial stability so that they can fulfill their purpose of providing high-quality healthcare in the communities they serve. We strive to carry out this mission with strict adherence to our values, reflected in our company’s policies, which all of our employees are bound to follow. Chief among these is that we work with patients in a respectful and compassionate way, guided by the patient’s individual circumstances and needs.

Over the last several weeks, there have been a number of misstatements and mischaracterizations about Accretive Health concerning who we are and what we do in Minnesota. We appreciate the opportunity that we have had to work with your office and inform you of the facts. We are aware of reports that individual Accretive Health employees may not have acted in a manner consistent with Accretive Health’s values and policies. From our review of the record, we have been able to

confirm that many of these reports are grossly distorted or flatly wrong. To the extent that even some of what has been reported occurred, however, such conduct is not tolerated by our company. In a company of our size, it is unfortunately the case that there will inevitably be instances where individual employees do not conform to our highest expectations. As a company though, our view is that if even a single patient has not received compassionate and appropriate assistance from Accretive Health, that is one patient too many. We are committed to taking whatever corrective actions are appropriate to ensure that any patient who interacts with Accretive Health receives the compassionate care and counseling they deserve. We welcome this hearing and the opportunity to publicly respond to these misstatements and mischaracterizations, to correct the record, and to make our position clear.

It is unfortunate that recent mischaracterizations about our company have detracted from the serious debate which we all must have about healthcare policy. There is in this country a large and growing problem of hospitals not being compensated for the care they provide. According to the American Hospital Association (“AHA”), community hospitals provided \$39.3 billion in uncompensated care in 2010 alone.¹ As uncompensated care escalates, hospitals will be forced to eliminate services, downsize, or even go out of business. Or, ever-increasing costs

¹ American Hospital Association, *Uncompensated Care Fact Sheet* (Jan. 2012), available at <http://www.aha.org/content/12/11-uncompensated-care-fact-sheet.pdf> (last visited May 25, 2012). In large part, uncompensated care results not from the patient’s inability to pay, but rather from errors and inefficiencies in the third-party payor system.

for healthcare will be shifted to those patients who responsibly pay their own fair share of their healthcare costs, and who will be forced to subsidize those patients who do not.

Our Revenue Cycle Management service helps hospitals overcome this threat to their ability to deliver high quality healthcare by improving their financial stability. We utilize people, processes, and proprietary and cutting-edge technology to achieve this outcome in a number of ways:

- In the vast majority of cases, our work involves helping hospitals to recover the significant amounts of money owed them **by insurance companies**. This involves ensuring that hospital bills are accurate and correctly coded, that insurer reimbursements are accurate, and that insurer denials are promptly and effectively challenged.
- We work to have timely and transparent conversations with every patient concerning his or her cost of care. Based on the work of industry experts, and what we routinely hear from patients, we understand that clear communications with patients are a fundamental part of compassionate care.
- We help uninsured patients obtain third-party coverage (e.g., Medicaid, COBRA, charity assistance) for their care. When successful, this is a “win-win”: it removes the burden of payment from the patient while also ensuring that the hospital will be paid. Since 2003, we have helped **more than 250,000 uninsured patients** obtain coverage for their care.

We believe that many of the recent allegations are founded upon a fundamental misunderstanding of who we are and what we do. We hope it is now clear that Accretive Health is not principally a “debt collector.” Far from it: **over 95 percent** of the revenue that we help hospitals collect comes from **insurance companies and other third-party payors**. And the revenue that we help hospitals collect from individual patients overwhelmingly consists of fees for current

services (which hospitals simply must collect if they are to remain financially viable), not past “debt.”

To meet these challenges, Fairview adopted policies and practices, reflected in Accretive Health initiatives, which closely follow those adopted by many hospitals across the United States. However, these policies and practices have now come under close scrutiny. For example, some now appear to question the practice of Accretive Health and Fairview employees having timely, transparent conversations with patients about the cost of care. But these questions reflect a fundamental misunderstanding of how hospitals work to serve the interests of their patients.² Numerous third-party organizations have recognized the significant benefits for patients of timely and transparent conversations about the cost of care. One leading organization, the Healthcare Financial Management Association (“HFMA”) conducted eight years of research and dialogue to define a set of practices

² They also reflect a fundamental misunderstanding of the regulations and policy guidance that the federal government imposes on hospitals under the Medicare program. For example, the Centers for Medicare and Medicaid Services (“CMS”) requires that hospitals, as a condition of receiving Medicare reimbursement for bad debt, engage in “reasonable collection efforts.” 42 C.F.R. § 413.89(e)(2); *see also* Centers for Medicare and Medicaid Services, Provider Reimbursement Manual, ch. 3, § 310, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html> (last visited May 25, 2012). CMS guidance expressly permits hospitals to use collection agents and engage in direct conversations with patients regarding collections. *See id.* Further, CMS and the Office of the Inspector General of the U.S. Department of Health and Human Services (“OIG”) have recognized the benefits for patients of conversations about the cost of care, even in the emergency room setting. *See* 64 Fed. Reg. 61353, 61355 (Nov. 10, 1999); 68 Fed. Reg. 53222, 53227 (Sept. 9, 2003).

determined to represent patients' "optimal financial experience."³ The practices that Accretive Health employees worked with Fairview to implement are based upon HFMA's recommended practices.

Let me be clear: there is nothing illegal or wrong in talking with patients about the cost of care, and there is nothing illegal or wrong in requesting the appropriate payment from patients with the means to pay their healthcare costs. Hospitals operate on very small margins, averaging approximately 2.6 percent in 2011.⁴ As employers and individuals increasingly choose health insurance with lower annual costs but higher co-payments and deductibles, it becomes ever more critical for hospitals to actually collect patients' share of healthcare costs. Otherwise, hospitals will not remain financially viable. For its part, Accretive Health works very hard to ensure that its employees conduct conversations about such matters in a respectful, compassionate way. Those who would challenge the need for such conversations must answer several questions: how are Fairview and other hospitals to be paid for the services they provide? Should they (and can they) continue to provide billions of dollars in uncompensated care? If hospitals are foreclosed from recovering amounts owed them, how are they to continue providing quality care to patients? And is it really the best solution to leave patients to fend for themselves in navigating the complexities of health insurance reimbursement?

³ Healthcare Financial Management Association, *Early Transparent Financial Communications: A Patient-Friendly Billing Recommended Practice*, available at <http://www.hfma.org/Templates/InteriorMaster.aspx?id=327> (last visited May 25, 2012).

⁴ Moody's Investor Service, *Fiscal Year 2011 Preliminary Financial Medians for Not-for-Profit Hospitals and Health Systems* (May 2012).

Perhaps even more serious questions in need of answers relate to our Quality and Total Cost of Care (“QTCC”) service, which has also been in place at Fairview. The most important question relating to this program is simply this: why was this successful program put in jeopardy, even though it has nothing to do with hospital revenue or debt collection? QTCC is focused on helping healthcare providers identify and coordinate care of their most chronically ill patients. Recent surveys have found that half of all healthcare expenses are attributable to only five percent of patients.⁵ By providing these patients with more integrated and intensive care, providers can reduce costly hospitalizations and emergency room visits and improve healthcare outcomes. With Accretive Health’s QTCC service, the quality of care increases while total healthcare costs decline.⁶

Accretive Health’s QTCC service is on the leading edge of healthcare delivery. One goal of the Fairview/Accretive Health QTCC partnership was for Accretive Health to assist Fairview in obtaining “Accountable Care Organization” (“ACO”) status with CMS.⁷ ACOs have the potential to achieve a major, positive

⁵ See, e.g., U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *The Concentration and Persistence in the Level of Health Expenditures Over Time: Estimates for the U.S. Population, 2008-2009* (Jan. 2012), available at http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml (last visited May 25, 2012).

⁶ It is worth noting that Accretive Health’s QTCC service is fully-aligned with former CMS Administrator Dr. Don Berwick’s “three-part aim” for a Medicare program that achieved (1) “better care for individuals,” (2) “better health for populations,” and (3) “lower growth in expenditures.” 76 Fed. Reg. 67802, 67804 (Nov. 2, 2011).

⁷ An ACO is a healthcare delivery model in which a group of healthcare providers and doctors work together to provide coordinated, high-quality, and cost-effective care for patients.

transformation of the healthcare delivery system. With Accretive Health's assistance, in December 2011, Fairview was selected by CMS as one of only 32 pioneer ACOs for Medicare beneficiaries.⁸

Fairview's recent termination of its QTCC contract is a needless and unfortunate setback for the Fairview patients whose care and quality of life was improved through the QTCC program and for the approximately 130 individuals whose careers were devoted to the QTCC mission. Nevertheless, Accretive Health will continue to work with Fairview to preserve the good results that have been achieved through this program.

We vigorously contest recent allegations against our company, most of which have been brought outside the judicial process through a distorted public campaign. Our review of the record shows that they are primarily the product of exaggeration or misunderstanding. And to the extent that any of these allegations are true, they do not reflect the policies or values of our company. But in this moment of public scrutiny, we also see this as an opportunity to create a new consensus about how to move forward. To this end, on May 15, 2012, Accretive Health announced that it would support a panel of prominent healthcare and policy leaders – including former Secretary of Health and Human Services Michael Leavitt, former Senator Tom Daschle, former Senator Bill Frist, and former Secretary of Health and Human Services Donna Shalala – to create detailed and uniform national standards for how

⁸ News Release, *Fairview Named One of 32 Pioneer ACOs by CMS* (Dec. 19, 2011), available at http://www.fairview.org/About/MediaCenter/News/S_073059 (last visited May 25, 2012).

hospitals and other providers interact with patients concerning their financial obligations.⁹

SUMMARY OF KEY ISSUES

First, consistent with the recommended practices of the HFMA and AHA and based on what we have heard from patients, Accretive Health believes that timely and transparent conversations about the cost of care benefit both patients and hospitals. The cost of care often is a major source of anxiety for patients and their families. For this reason, Accretive Health believes that conversations with patients are an important part of compassionate care. These conversations also benefit hospitals; for example, allowing hospitals to obtain from the patient information necessary to secure insurance authorization or payment.

Second, as a part of the pre-registration or registration process at Fairview, patients were informed of their share of the cost of care and asked – *but never required* – to make a payment. Employees were trained and instructed *never* to suggest that payment was a condition of care. Indeed, scripts provided to employees emphasized this fundamental point 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.

⁹ News Release, *Accretive Health Initiates Panel of Health Care Policy Experts to Establish National Standards for Health Care Providers' Financial Interactions with Patients* (May 15, 2012), available at <http://ir.accretivehealth.com/phoenix.zhtml?c=234481&p=irol-newsArticle&ID=1696156&highlight=> (last visited May 25, 2012).

Third, while emergency room patients were expected to complete the same reasonable registration process as other patients, conversations with patients concerning the cost of care occurred only **after** medical screening and any stabilizing treatment, and, consistent with EMTALA, were **never** permitted to delay screening or treatment.

Fourth, Accretive Health did not “control” Fairview or its employees. Accretive Health’s Revenue Cycle Operations Agreement with Fairview defined the parties’ relationship as a “collaborative” one, with Accretive Health “accountable” to a Fairview executive. Importantly, Accretive Health’s work with Fairview – like its work with all of its hospital clients – was reflective of and bounded by Fairview’s own policies.

Fifth, Accretive Health takes very seriously the confidentiality of patient health information and has in place robust policies and practices to ensure that patient information is well-protected. In the aftermath of the July 2011 theft of an unencrypted company laptop, Accretive Health terminated the responsible IT employee, strengthened its laptop encryption practices, rolled out a new email encryption system, and is in the process of implementing higher-than-industry standard encryption software.

Sixth, Accretive Health takes reasonable steps to ensure that patient health information is accessible by only those employees who need the information for their jobs.

Seventh, in February 2012, Accretive Health entered into a consent order with the Minnesota Department of Commerce and agreed to suspend those debt collection activities in the State of Minnesota requiring a collector's license.

Eighth and finally, there have been numerous mischaracterizations of Accretive Health documents and misstatements of key facts concerning practices at Fairview that, Accretive Health believes, call into question the overall accuracy of the recent report by the Minnesota Attorney General's Office. These errors are unfortunate, but they could have been avoided: in compiling its report, the Attorney General's Office did not interview *any* current Accretive Health employees (either in the field or at headquarters) despite our request to have a productive dialogue. We welcome this opportunity to explain the facts.

DISCUSSION OF KEY ISSUES

I. PRACTICES AT FAIRVIEW WERE CONSISTENT WITH INDUSTRY "RECOMMENDED PRACTICES" AND COMPLIED WITH APPLICABLE LAWS.

A. Accretive Health Believes That When Patients Are Provided With Information About Their Cost of Care, Everyone Benefits.

Many of the recent allegations concern the practice of discussing with Fairview patients their cost of care prior to or at the time of service.¹⁰ The Attorney General's Office apparently believes that these conversations should not occur. Based on what we have heard from patients, Accretive Health could not disagree more.

¹⁰ See generally Compliance Review at Vol. 2.

First and foremost, conversations about the cost of care benefit patients. A hospital is one of the only places a consumer will go where the cost of service is ambiguous and unknown. The cost of care often is a major source of anxiety for patients and their families. Accretive Health believes, as do many others in the healthcare industry, that timely and transparent conversations about the cost of care – together with the option of speaking with a financial counselor – are a critical part of compassionate care. Accretive Health provides hospitals with the tools to have these conversations in a compassionate way.

Second, conversations with patients about the cost of care are a key part of ensuring that patient bills are accurate and appropriate. For example, patients seeking treatment at Fairview occasionally had prior balances. In most cases, the prior balance resulted from an insurance claim that had been delayed or improperly denied, or where the information needed to submit the claim had not been provided at the time of service. By discussing prior balances with patients, Accretive Health and Fairview employees could obtain the patient's assistance in submitting or re-submitting the claim to the patient's insurer. When successful, this was a win-win: the patient was no longer burdened by unnecessary debt and Fairview was more likely to be paid. The data confirm that Accretive Health's approach yielded significant benefits for both Fairview patients and Fairview itself. For the fourth quarter of 2011, over 98 percent of resolved prior balances at Fairview – approximately \$19 million – was paid by *public or private insurance*, while less than two percent – about \$300,000 – was paid by patients themselves.

Both CMS and OIG have concluded that conversations about the cost of care – even in the emergency room setting – can be helpful to patients.¹¹ CMS and OIG have suggested that these conversations occur with “well-trained and knowledgeable” individuals – the hallmark of the Accretive Health business model. Third-party organizations also have recognized the significant benefits to patients and providers of timely and transparent conversations about the cost of care. Among other organizations, HFMA places great emphasis on “early, transparent financial communications” with patients so that they understand their possible out-of-pocket costs before undergoing treatment.¹² Based on its eight years of research and dialogue, HFMA has defined the patients’ “optimal financial experience” as including the following steps:

1. Providers gather detailed information before and at the time of service to prospectively estimate patients’ expected out-of-pocket costs.
2. Providers use tools to help estimate the amounts and terms of payment that patients can afford. The resulting information allows providers to:
 - Identify and aid patients who need financial assistance, either through in-house programs, Medicaid, or other assistance programs.
 - Efficiently reach an agreement on payment amounts and terms for patients who are able to pay all or a portion of their bills.

¹¹ See 64 Fed. Reg. 61353, 61355 (Nov. 10, 1999); 68 Fed. Reg. 53222, 53227 (Sept. 9, 2003)

¹² See Healthcare Financial Management Association, *Early Transparent Financial Communications: A Patient-Friendly Billing Recommended Practice*, available at <http://www.hfma.org/Templates/InteriorMaster.aspx?id=327> (last visited May 25, 2012).

3. Providers communicate earlier, so that patients understand their financial obligation before they undergo treatment.¹³

This recommended approach is the basis for the steps that Accretive Health employees worked with Fairview to implement.

B. Accretive Health and Fairview Employees Asked – But Did Not Require – That Fairview Patients Make a Payment Toward Their Cost of Care.

At Fairview, most conversations with patients about the cost of care occurred during telephone pre-registration, seven to ten days in advance of the patient's appointment. (If the patient could not be reached by telephone, this conversation occurred during patient registration on the day of the patient's appointment.) As a part of this process, an Accretive Health or Fairview employee verified the patient's insurance information, thereby enabling Fairview to obtain any necessary authorization for insurance coverage of the patient's care. The employee also used Accretive Health's sophisticated software to estimate the patient's share of the cost of care (called the "residual balance") and advised the patient of this estimated amount as well as any prior balances. The patient was then asked to make a payment. But payment was optional. In fact, the vast majority of patients chose not to pay their residual or prior balances during pre-registration or registration, opting instead to be billed.

Importantly, employees were instructed never to insist that patients pay residual or prior balances or suggest that payment was a condition of care.

¹³ *Id.*

Training materials and employee scripts emphasized this fundamental point 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.

Accretive Health understands from media reports that, notwithstanding our significant efforts to be clear that care would always be provided, certain Fairview patients have indicated they had the false impression that they may not receive treatment unless they made a payment toward their cost of care. This is obviously regrettable. These reports are not consistent with the vast majority of the feedback we have historically receives, and are certainly at odds with our company's values and policies. But Accretive Health's view is that if even a single patient believes that he or she has not received compassionate and appropriate assistance from Accretive Health, that is one patient too many.

C. Accretive Health and Fairview Employees Never Delayed Screening or Stabilizing Treatment of Fairview Emergency Room Patients.

The Attorney General's Office makes very serious – but ultimately unsupported¹⁴ – allegations that Fairview and Accretive Health violated the Emergency Medical Treatment and Labor Act (“EMTALA”).¹⁵ In fact, practices at

¹⁴ Specific instances constituting alleged EMTALA violations are discussed in Section V, below.

¹⁵ See Compliance Review at Vol. 2, pp. 16-17. The Emergency Medical Treatment and 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

Fairview emergency rooms were fully consistent with EMTALA requirements. While patients presenting at Fairview emergency rooms were expected to complete the same reasonable registration process as other patients, this process occurred only *after* the patient had received a medical screening examination and any necessary stabilizing treatment. At no time was an emergency patient's screening examination or stabilizing treatment delayed because of registration.

Even after screening and stabilization, employees were allowed to speak with emergency patients only as permitted by clinicians and only during "down times" (such as when the patient was waiting for test results). As with non-emergency patients, the focus of registration was to verify the patient's insurance information, enabling Fairview to obtain any necessary insurance authorizations. Emergency patients were also provided with an estimate of their share of the cost of care and asked to make a payment. But payment was optional and most emergency patients opted to be billed. Further, both Fairview and Accretive Health had in place policies that an emergency patient's treatment was *never* to be conditioned on payment.

examination and treatment required under subsection (b) ... in order to inquire about the individual's method of payment or insurance status." 42 U.S.C. § 1395dd(h).

II. ACCRETIVE HEALTH DID NOT “CONTROL” FAIRVIEW OR ITS EMPLOYEES.

Fairview contracted with Accretive Health in March 2010 for its Revenue Cycle Management service and in November 2010 for its Quality and Total Cost of Care service. The Fairview/Accretive Health contracts covered seven hospitals¹⁶ and more than 40 primary care clinics.

The Attorney General’s Office has alleged that Accretive Health gained “breathtaking” control over Fairview and its employees¹⁷, but this is not true. The parties’ contracts defined their relationship as a “collaborative” one¹⁸, with Accretive Health “accountable” to the Fairview “Client Sponsor,” i.e., a Fairview executive.¹⁹ Fairview retained and exercised control over the hiring, compensation, reassignment, and termination of Fairview employees.²⁰ Fairview also had the authority to remove Accretive Health employees working at Fairview.²¹ Further, as with its other hospital clients, Accretive Health enacted at Fairview only those policies and practices that Fairview chose to enact.

¹⁶ The seven hospitals are 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.

¹⁷ See Compliance Review at Vol.. 1, pp. 7-8.

¹⁸ See, e.g., Revenue Cycle Operations Agreement, Preamble (“The Parties desire to enter into a broad-based collaborative relationship....”).

¹⁹ *Id.*, ¶ 15.

²⁰ *Id.*, ¶¶ 17-20.

²¹ *Id.*, ¶ 8.

In March 2012, as a part of Accretive Health's agreement with the Attorney General's Office to resolve the pending litigation, Fairview and Accretive Health decided to amend their Revenue Cycle Operations Agreement to transition the management of those operations back to Fairview. Subsequently, Fairview announced its intent to terminate its unrelated QTCC contract with Accretive Health.

III. ACCRETIVE HEALTH TAKES VERY SERIOUSLY ITS OBLIGATION TO PROTECT PATIENT HEALTH INFORMATION.

A. Accretive Health Takes Reasonable Measures to Ensure That Company Laptops Containing Protected Health Information Are Secure.

The Attorney General's Office uses the unfortunate theft in July 2011 of a company laptop to suggest that Accretive Health has not acted reasonably to secure protected health information ("PHI").²² We share the Committee's concern, and that of Senator Franken in particular, that PHI is secured. However, we believe that Accretive Health has acted reasonably and appropriately to protect PHI, both in response to the July 2011 laptop theft and more broadly.

The relevant facts are as follows: in July 2011, an unidentified person stole a company laptop from an Accretive Health employee's locked automobile. The locked automobile had been unattended for less than thirty minutes. The laptop, which was password-protected but not encrypted, contained the PHI of thousands of patients. As required by federal law, Accretive Health notified the affected hospitals, which in turn notified the affected patients. Fortunately for all involved,

²² Compliance Review at Vol. 4 pp. 7-8.

there is no indication that any patient information contained on the laptop has been compromised.

It is Accretive Health's policy that all laptops be encrypted. But due to the oversight of an individual IT employee (who was promptly terminated), the laptop stolen in July 2011 was one of approximately 30 – out of more than 1,400 – that was not encrypted due to this employee's error. Since the July 2011 theft, Accretive Health has strengthened its policies for ensuring laptop encryption. Today, multiple employees independently confirm that each laptop is properly encrypted. Additionally, Accretive Health conducts reviews at least five times each week to confirm that every company laptop remains properly encrypted.

Aside from the specific measures taken in response to the July 2011 laptop theft, Accretive Health continues to work to enhance its protections for PHI. In early 2012, Accretive Health adopted a new email encryption system. And, Accretive Health recently began the process of upgrading its encryption software to higher-than-industry standard.

B. Accretive Health Acted Reasonably to Limit the Protected Health Information to Which Employees Had Access.

Medical Financial Solutions (“MFS”), an Accretive Health division, engages in the collection of pre-collect and dormant debt from individual patients. The Attorney General's Office alleges that MFS employees had access to “personal and confidential data of Fairview patients.”²³ But the discussion of this issue fails to reflect two important points. First, given their work, MFS needed access to certain

²³ *Id.* at 11.

patient information to respond to patient questions. Often, when contacted about a past-due bill, a patient will ask questions about the date of service or the reason for the hospital visit. As is standard, MFS employees were provided access to certain patient information so that they were able to respond to these questions.

Second, when Accretive Health began its work at Fairview in March 2010, the only source of patient information was PASS, Fairview's patient accounting system. Accretive Health understands that Fairview implemented PASS decades ago and continues to use the system to bill its patients. Accretive Health also understands that the information its employees received from PASS is consistent with what others in the industry receive from patient accounting systems used by other hospitals.

However, beginning in November 2010, shortly after Accretive Health began working with Fairview, Accretive Health discontinued its use of PASS for this purpose and moved to different software that limited employee access to certain patient information: (1) patient name and contact information; (2) guarantor (person financially responsible, if not the patient); (3) date of service; (4) patient type (e.g., emergency room, outpatient); and (5) an easily understood description of the diagnosis code. This software became fully operational in February 2011, though some employees continued to have access to PASS until early 2012.

IV. ACCRETIVE HEALTH SUSPENDED DEBT COLLECTION ACTIVITIES IN THE STATE OF MINNESOTA.

The Attorney General's Office makes a number of statements concerning Accretive Health's compliance with the Federal Debt Collection Practices Act and Minnesota debt collection laws. Many of these statements concern matters at issue in the January 2012 lawsuit brought by the Attorney General's Office against Accretive Health. For this reason, Accretive Health respectfully incorporates by reference its April 30, 2012 motion to dismiss. However, Accretive Health notes that, in February 2012, it entered into a consent order with the Minnesota Department of Commerce and agreed to suspend those debt collection activities in the State of Minnesota requiring a collector's license.

V. MANY ALLEGATIONS CONCERNING PRACTICES AT FAIRVIEW ARE FOUNDED ON MISCHARACTERIZATIONS OF DOCUMENTS AND MISSTATEMENTS OF KEY FACTS.

The Attorney General's Office makes a number of statements concerning Accretive Health and Fairview's practices of collecting residual and prior balances at the time of treatment, but does not specify how these practices violated any law other than EMTALA (addressed above). However, these allegations are, more often than not, founded on mischaracterizations of Accretive Health documents and misstatements of significant facts. For example:

- The Attorney General's Office discusses a December 2011 "incident" at the University of Minnesota Amplatz emergency room during which an Accretive Health financial counselor allegedly delayed the treatment of a child.²⁴ But the Attorney General's Office grossly mischaracterizes this "incident." In fact, the child's father asked to meet with a

²⁴ Compliance Review at Vol. 2, pp. 16-17.

financial counselor to discuss his family’s financial situation and the cost of care. Following the meeting, Fairview’s Risk Management Consultant thanked Accretive Health for “working diligently” with the family.

- The Attorney General’s Office claims that numerous patients left Fairview emergency rooms and suggests that these patients were deterred from seeking treatment.²⁵ This is not accurate. As evidenced by their inclusion in the cited records, *each of the patients discussed was treated at Fairview* but left before completing the patient registration process.
- The Attorney General’s Office states that employee scripts “can lead a patient or her family to believe the patient will not receive treatment until payment is made.”²⁶ But the Attorney General’s Office neglects to mention that each employee script included the following message 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.

- The Attorney General’s Office cites an Accretive Health email, allegedly stating that “Fairview line staff has expressed concerns regarding collecting patient share at the time of registration ... the impact has been most felt at the Fairview management level – there have been some emotional responses.”²⁷ The suggestion is that Fairview staff were upset by Revenue Cycle Management practices. But the Attorney General’s Office’s selective quotation of this email is misleading. From the full text of this email, it is clear that the “concerns” and “emotional responses” of the Fairview employees are directed *at the Attorney General’s Office* because the January 2012 lawsuit against Accretive Health seemed “off-base.”²⁸

²⁵ Compliance Review at Vol. 2, p. 16.

²⁶ Compliance Review at Vol. 2, p. 14.

²⁷ Compliance Review at Vol. 2, p. 19.

²⁸ Compliance Review at Vol. 2, Ex. 93.

- The Attorney General’s Office claims that an Accretive Health employee dismissed doctors’ concerns about “stop lists” as “country club” talk and suggests that the employee took no action.²⁹ But the Attorney General’s Office mischaracterizes what the Accretive Health employee actually said. The first portion of the employee’s email – which the Attorney General’s Office does not cite – identifies numerous steps that Accretive Health could take to address any doctors’ concerns.³⁰
- The Attorney General’s Office claims that Fairview does not pay timely refunds to patients.³¹ In fact, Accretive Health worked with Fairview to implement a comprehensive and effective system to identify accounts where refunds are owed and process and pay such refunds in a timely manner. Indeed, with Accretive Health’s assistance, we understand that Fairview sped up the payment of refunds to patients and reduced the number of refunds owed by approximately sixty percent.
- The Attorney General’s Office cites an email chain among employees discussing a patient’s financial situation, stating that the employees “discuss[ed] the condition of the patient’s disease and tr[ie]d to figure out if her cancer was terminal or simply disabling” and otherwise “discuss[ed] her cancer.”³² This email chain includes numerous messages among Accretive Health employees discussing the patient’s financial status and her eligibility for third-party coverage. But it does not include any “discussion” of the patient’s medical condition beyond that relevant to finding her third-party coverage.³³ In fact, the email chain illustrates the great lengths to which Accretive Health employees would go to help Fairview patients find coverage for their care.

The Attorney General’s Office makes a number of other allegations concerning practices at Fairview patients, but fails to present accurate or complete facts:

²⁹ Compliance Review at Vol. 2, p. 15.

³⁰ Compliance Review at Vol. 2, Ex. 80.

³¹ Compliance Review at Vol. 2, p. 20.

³² Compliance Review at Vol. 4, p. 13.

³³ Compliance Review at Vol. 4, Ex. 14.

a. “Stop Lists”

The Attorney General’s Office discusses “stop lists,” but this discussion is misleading. Never have “stop lists” been used to “stop” patients from receiving treatment. Rather, Accretive Health and Fairview employees used stop lists to identify patients scheduled for certain procedures with whom employees would meet to resolve prior balances.³⁴ As described above, Accretive Health and Fairview employees typically resolved prior balances by obtaining additional information from the patient, and then using this information to secure payment from the patient’s insurance company.

Accretive Health to date has located no instance where a Fairview patient was barred from undergoing treatment due to a prior balance.

b. “Bedside Collections”

The Attorney General’s Office discusses “bedside collection,” but this discussion omits several significant facts. At Fairview, Accretive Health and Fairview employees attempted to meet with all patients to discuss their cost of care. When these conversations did not occur during pre-registration or registration (which, for emergency patients, occurred after screening and any necessary stabilizing treatment), they typically occurred during the course of the patient’s hospital stay. However, “bedside” contacts with patients occurred only after certain conditions were met. First, all conversations were optional. Second, conversations occurred only at a time a clinician deemed appropriate. Third, Fairview policies

³⁴ The procedures included radiology and imaging (all Fairview hospitals), laboratory tests (Lakes), and surgeries (Southdale and Ridges).

restricted employees from contacting certain categories of patients, such as emergency patients with life-threatening injuries or heart conditions.

Accretive Health believes that its employees making “bedside” contacts did so with the greatest possible compassion, in a manner appropriate to the patient’s individual situation and consistent with the practices agreed upon by Fairview and Accretive Health.

c. Labor and Delivery

The Attorney General’s Office discusses practices in Fairview hospitals’ labor and delivery departments, but, again, this discussion omits several significant facts. Fairview policies determined when Accretive Health and Fairview employees could contact mothers of newborn infants. At the University of Minnesota Medical Center, and at Northland and Lakes hospitals, the practice was that new mothers could be contacted only after they were moved into recovery. If, upon contact, the mother indicated that she wanted to talk, the employee would schedule a time to meet with the mother in her room. At the Southdale and Ridges hospitals, the practice was to contact new mothers on the day they were discharged. As a general matter, employees did not contact women who were in labor or who had just given birth.

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Accretive Health believes that the mischaracterizations and misstatements summarized above call into question the overall accuracy of the recent allegations by the Attorney General’s Office.

ACCRETIVE HEALTH: MOVING FORWARD

Accretive Health is a company that strives to make the healthcare system better. We are made up of thousands of dedicated men and women who are excited to go to work every day because they believe in our mission of helping hospitals provide better patient care and lowering healthcare costs for all. We look forward to working with others in our industry on developing detailed and uniform national standards for how hospitals and other providers interact with patients concerning their financial obligations.

We will also continue to defend ourselves in the lawsuit brought by the Minnesota Attorney General's Office. But we remain hopeful for a renewed and more productive dialogue between our company and the Attorney General's Office: a dialogue that ends with Minnesotans continuing to benefit from Accretive Health's services.

Helping hospitals become financially stable and receive all the payments they are due is not at odds with transparent, compassionate, and quality patient care. Senator Franken, thank you again for the opportunity to discuss Accretive Health's work in Minnesota on behalf of Minnesotans. I am happy to answer any questions you may have.