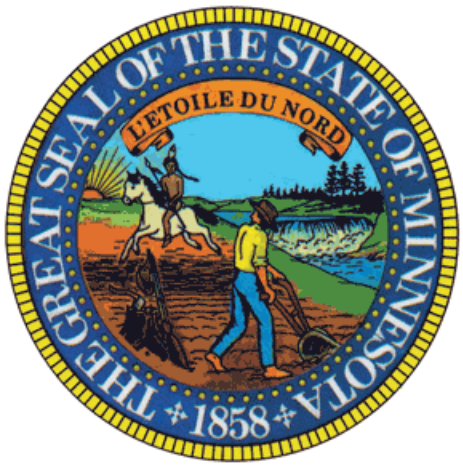
STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

Compliance Review of Fairview Health Services' Management Contracts with Accretive Health, Inc.

Volume 6
Compliance Issues



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VOLUME SIX

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6.1 Introduction. Health care is one of the most regulated industries in America. Virtually all participants in the health care delivery system are regulated by the federal or state governments, or both. States regulate health care organizations under a myriad of laws, including, to name a few, the laws governing health care plans,[1] utilization review organizations,[2] health maintenance organizations,[3] community integrated service networks (CISNs),[4] accountable provider networks,[5] hospitals,[6] medical practitioners,[7] third party administrators,[8] and nonprofit health service plan corporations.[9] Health care organization are typically accredited by pertinent self-regulatory organizations, such as the National Committee for Quality Assurance, the Utilization Review Accreditation Commission, or the Joint Commission on Accreditation of Healthcare Organizations.

In October of 2011, the Minnesota Attorney General's Office began an inquiry regarding the management of charitable Minnesota hospitals by Accretive Health, Inc. ("Accretive"). This review was conducted pursuant to the Office's authority under Minn. Stat. § 8.31, subd. 1, the Charitable Trust and Trustees Act (Minn. Stat. § 501.B.33-45), the Minnesota Nonprofit Corporation Act (Minn. Stat. § 317.821), and the Regulation of Charitable Solicitations (Minn. Stat. § 309.533).

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[1] Minn. Stat. ch. 62Q.
[2] Minn. Stat. ch. 62M.
[3] Minn. Stat. ch. 62D.
[4] Minn. Stat. ch. 62N.
[5] Minn. Stat. ch. 62T.
[6] Minn. Stat. §§ 144.50-.55.
[7] Minn. Stat. ch. 147.
[8] Minn. Stat. § 60A.23
[9] Minn. Stat. § 62C.

The Minnesota charitable organization laws require Fairview Health Services—and any manager of its revenue stream—to properly administer charitable assets. As discussed in Vol. 1, charitable organizations must operate in a manner that justifies continued support from the State of Minnesota through exemptions on property taxes, income taxes, sales taxes, and dividends on bonds, among other things.

In undertaking a compliance review, the Attorney General's Office must consider the charitable organization's relationships with for-profit corporations. *See, e.g.*, State of Minnesota Compliance Review of Fairview Health Services, 2005 (reviewing Fairview's relationships with debt collection agencies); State of Minnesota Compliance Review of Allina Health System, 2001 (reviewing substantial relationship between Medica Health Plans and United HealthGroup). In the case of Accretive, issues have been raised relating to compliance with a myriad of laws in such areas as collections, privacy, health management, credit scoring, and credit discrimination. These include:

- The Health Insurance Portability and Accountability Act ("HIPAA"), 29 U.S.C. §1181(a)(2).
- The Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. §1396dd.
- The Fair Debt Collection Practices Act ("FDCPA"), 15 U.S.C. §1692.
- The Equal Credit Opportunity Act, 15 U.S.C. 1691, ***et. seq.***
- The Fair Credit Reporting Act, ("FCRA"), 15 U.S.C. §1681, ***et. seq***.
- The Fair and Accurate Credit Transaction Act of 2003 ("FACT Act"), 15 USC §1681 – 1681y.
- Minnesota consumer protection laws.
- State privacy laws as it relates to medical data.
- State debt collection laws.
- Minnesota Human Rights Act, Minn. Stat. § 363A.001 ***et seq.***
- Americans With Disabilities Act, 42 U.S.C. § 12101 ***et seq.***

As part of the Compliance Review, Accretive produced over 100,000 pages of documents and provided written statements concerning Accretive's performance at Fairview. Fairview also provided documents and statements concerning Accretive's activities at Fairview. The

Minnesota Department of Commerce also provided information regarding its examination of the company.

It is customary for a company to produce licenses, regulatory opinions, or compliance opinions that give assurance that the company operated in compliance with applicable laws and regulations in this highly-regulated industry. Accretive did not.

The first five volumes discuss problems under Minnesota's charities and other laws regarding such topics as: 1) Fairview's pre-payment to Accretive of millions of dollars in charitable assets for base fees at the beginning of each quarter, 2) Fairview's prepayment to Accretive of millions of dollars in uncalculated and potentially unearned incentive payments, 3) Accretive's apparent failure to deposit into an escrow or trust account the "round trip" salary obligations of Fairview employees, 4) violations of state and federal debt collection laws, 5) violations of the agreement between Fairview and the Minnesota Attorney General relating to patient billing and collections practices, and 6) violations of state and federal privacy laws.

This volume discusses a variety of other compliance issues that Accretive does not appear to have thoroughly addressed. Lack of regulatory compliance appears to be a chronic problem with the company. For instance, Accretive did not register as a foreign corporation with the Minnesota Secretary of State until December 20, 2010—approximately eight months *after* it signed the revenue cycle agreement with Fairview. A company doing business in a foreign state should generally be familiar with such basic state-based corporate registration requirements. Accretive became licensed as a collection agency in Minnesota on January 20, 2011, a number of months *after* it began collection activity in Minnesota. Accretive also failed to license its individual collectors, contrary to Minnesota law. Accretive's debt collector license is believed to be the only license issued to the company for doing business in Minnesota.

6.2 Accretive and Patient Scoring.

6.2.1 Willingness to Pay (WTP) Scores and the Discrimination Laws. Accretive states in its 2010 Annual Report that it has developed a risk score on patient accounts:

> "Our service offerings employ a variety of proprietary data analytics and predictive modeling algorithms. For example, we identify patient accounts with financial risk by applying data mining techniques to the data we have collected."

(Ex. 1.)

An Accretive manual, entitled "Analytics Techniques and Process," states that it uses the risk score to further its collection of debt. Accretive states that the purpose of the risk score is to select the optimal methodology to contact the patient:

> "After scoring the entire eligible population with Willingness/Capacity to Pay Score (WTP) various strategies are developed in combination with additional financial and demographic data of the patient. These strategies are then used to apply ***differential treatments*** across various segments….Some of the differential treatments include:
>
> a. Discounts and Letters:….High WTP and High Operating Margin segments might receive lower discounts than medium WTP and High Operating Margin. Medium WTP accounts will also be accelerated through the process and move to legal sooner than accounts in other segments.
>
> b. Special Patient Financial Counselors:…to ensure right collector style matching.
>
> c. Dialer and IVR Strategy:.…Small Balances are dealt with a special team and IVR Blast Messaging leveraged."

(Ex. 2, emphasis in the original.)

Accretive states that its data mining technique starts with 142 data elements for each patient. (Ex. 3.) In response to an inquiry from Fairview, an Accretive manager stated that Accretive combines these 142 elements with census and demographic data such as socioeconomic zip coding, credit history and the like:

> "To calculate, we take the data provided by Fairview via the RETRO04D file (contains 142 different data elements straight from host system) combined with census data and push through a model. Some of the data points we use are demographics (zip code, **gender, marital status, religion,** insurance type, age of debt), **socio-economic data** (average household income, average dependents in a zip code), payment history (past paying performance gathered over time), and opportunity margin (what % of total balance will be paid and the value that corresponds to). Once these data points are obtained, we apply a positive or negative coefficient to each that determines the final score…."

(*Id*., emphasis added.)

It is not clear when in the "revenue cycle" Accretive uses the WTP score in connection with Fairview patients. Accretive states that its technology allows the "Willingness/Capacity to Pay," or WTP, scoring to be automatically applied to any account after the third statement is sent to the patient. (Ex. 4.) Other documents, however, indicate that Accretive can apply the WTP score the minute an accounts receivable (AR) is created. (Ex. 5.)

Still other documents suggest that Accretive not only uses the WTP score in back-end collection work, but that it also at least sometimes applies risk scores to patients on the front end. (Ex. 6.) Its Standard Operating Procedure Manual notes:

> "One of the examples of using statistical modeling within DMAIC framework is development of Willingness/Capacity to Pay Score. This score predicts patient's willingness/capacity to pay the debt and is being used across different touch points for patient over the lifecycle of debt (**including pre-service**, early out and bad debt collections)."

(Ex. 7, emphasis added.) A different chart seems to contemplate the integration of the WTP score into the front-end process. (Ex. 8.) Another chart refers (as "a work in progress") to having the WTP score integrated into the front-end work of registering a patient:

> "Provide charity scoring and targeted financial counseling at point of service in order **to mitigate risk on low scoring accounts**."

(Ex. 9, emphasis added.)

A major concern involves the type of hospital information that Accretive utilizes in formulating the WTP credit score. As noted above, in Ex. 3, Accretive states that it takes "142 different data elements straight from host [Fairview] system." Mark Eustis, the President of Fairview, sent a letter to the Attorney General, which states that Accretive denies such use of patient data:

> "As part of its services under the Revenue Cycle Agreement, Accretive Health calculates a "propensity to pay" score with respect to accounts. The purpose of this score is to estimate the responsible party's willingness and capacity to pay. We understand that the index takes into account several factors, such as patient demographics, payment history, available consumer credit data, debt age, debt type and outstanding balance…*We have been told that no patient diagnostic information is used in the calculation of the score*."

(Ex. 10, emphasis added.) Other Accretive charts seem to suggest that its "data mining" may sometimes include diagnostic information, at least for some hospitals. Accretive notes that the use of this data differentiates it from other companies that score debtors:

> "Accretive Health's Development team developed an algorithm which uses a multi-variant correlation data-mining analysis of historical facility data to predict probability of accounts receivable risk from day one of an account going unpaid."

(Ex. 11.) The diagram accompanying the above statement has two overlapped circles, with one circle entitled "Data Mining." Underneath this title are the words: "diagnosis," "physician," and "service" rendered to the patient. (*Id*.)

Chengny Thao is a manager at Accretive in charge of patient financial collections at the Stinson Boulevard office of Fairview. (Ex. 12.) The Fairview personnel involved with current balance collections and pre-balance collections (pre-registration and registration personnel) report to her. (*Id*.) Attached as Ex. 13 is an e-mail chain between Fairview and Accretive which keeps the collections staff notified of changes in diagnostic code and utilization data. The February, 2012 email starts: "**Attached please find a file that merges the Diagnostic Code and utilization data provided by Dave to Risk Score information.**" (Ex. 13, emphasis added.)

Mr. Thomas Merritt, one of Accretive's managers, stated in an email to Fairview that Accretive uses several demographic elements, including **religion, gender, and marital status**, to calculate the propensity to pay score. (Ex. 3.) The federal Equal Credit Opportunity Act ("ECOA") prohibits discrimination in credit transactions based on religion, sex, or marital status. 15 U.S.C. § 1691. The Board of Governors of the Federal Reserve System issued Regulation B under the ECOA, which states that the ECOA covers "every aspect" of a credit transaction, including "collection procedures." 12 C.F.R. § 202.02(n). "Discrimination" occurs under Regulation B when a person is treated "less favorably" than others. *Id*. If Mr. Merritt is correct that religion, gender, and marital status are used in Accretive's WTP score, serious compliance issues appear to be raised under the federal Equal Credit Opportunity Act.

If Accretive uses of religion and gender as bases for treating Fairview patients differently, the Minnesota Human Rights Act ("MHRA") may also be implicated. The MHRA broadly prohibits discrimination on the basis of religion and sex in the provision of "public accommodations." Minn. Stat. § 363A.02. The term "public accommodations" is a broad term, and includes any "business" whose "facilities" are "made available to the public." Minn. Stat. § 363A.03, subd. 34. The Act also broadly defines "discriminate" to include "separate" and "segregate." The MHRA also contains a section specifically devoted to credit discrimination. This section prohibits "discrimination" "in the extension of personal or commercial credit... or in the requirements for obtaining credit" based on religion, sex, or marital status. Minn. Stat. § 363A.16. If Accretive uses religion, sex and marital status in calculating its WTP or other scores, and uses the WTP as a basis to treat Fairview patients unequally, serious compliance issues would be raised under the MHRA. The use of a patient's medical diagnosis in determining whether to extend credit or make collections decisions may also be a violation of the

Americans with Disabilities Act, 42 U.S.C. § 12101, depending upon the type of diagnosis that is considered.

6.2.2 Willingness to Pay Scores and the Fair Credit Reporting Act. Accretive states that it has created "massive repositories with financial and operational data." (Ex. 14.) By preparing the WTP score, Accretive may become a credit reporting agency under the Fair Credit Reporting Act ("FCRA"), 15 USC §1681, *et. seq.* A credit report includes reports that are used for "collection of an account," 15 U.S.C. §1681b(a)(3)(A), as well as reports that are used as a factor in establishing the consumer's eligibility for credit. 15 U.S.C. §1681a(d)(1)(A). If Accretive, as an agent for Fairview, has used the WTP scores to treat certain patients less favorably than others, as indicated in Ex. 2, it appears that Fairview and/or Accretive may be required to send the patient that was treated less favorably a notice of "adverse action." 15 U.S.C. §1681m, *et seq.* In addition, Fairview and Accretive may be required to send notices to patients regarding consumer rights summaries, credit scoring notices, risk-based pricing notices, and affiliate sharing marketing notices. See 15 U.S.C. §1681g, *et seq.* The FCRA also has extensive procedural requirements that allow consumers to dispute inaccurate information that led to the unfavorable score. 15 U.S.C. § 1681i, *et seq.* It does not appear that these dispute procedures have been followed by Accretive or Fairview, and they should review their compliance with the above laws.

6.2.3 The Quality Total Cost of Care (QTCC) Program: Introduction. As discussed in Vol. 1, Accretive entered into a "Quality Total Cost of Care" ("QTCC") agreement with Fairview in 2010. It was the first, and remains the only, hospital in the country to do so. Mary Tolan, the CEO of Accretive, has predicted that the QTCC program will cut health care costs by 25% in three years. (Ex. 15.) Accretive at one point predicted to its Board of Directors

that the QTCC program may cut almost *one half billion dollars* in health care costs at Fairview by 2015. (Ex. 16.)

The essence of the QTCC program is the economic profiling of primary care physicians ("PCPs"). In other words, Accretive will measure the PCP's actual cost for services performed or ordered (including referrals to specialists) on behalf of patients. It will then compare these actual costs to the "predicted" costs for similar health events with similar patients. PCPs whose actual costs for a patient are less than the "predicted" costs are considered "cost efficient," while those whose actual costs exceed the "predicted" values are viewed as cost inefficient.[10] Based on this measured cost efficiency, PCPs who are deemed "efficient" are rewarded with incentive payments.

6.2.4 QTCC and Acuity Risk Scores. Because patients vary in complexity, the QTCC program proposes to measure each patient in a particular program by risk. In December, 2011, Accretive made a presentation to Fairview that discussed three risk models currently used for predictive modeling. (Ex. 17, pp. 10-11.) One is the Adjusted Clinical Group (ACG), used by Johns Hopkins University. The program evaluates disease management and predictive risk of each member of a contained population. The ACG case-mix system divides each patient into 82 discrete, mutually exclusive categories. (Ex. 18.) It is primarily used to identify high risk/high resource patients. Another program referenced by Accretive was OPTUM's Episode Risk Groups (ERG) model. This model assigns each patient to one or more of 120 possible medical condition categories based on diagnostic and procedural information available on medical and pharmacy claims. (Ex. 19.) The third program cited in the Accretive presentation is

[10] Thomas, "Should Episode-Based Economic Profiles be Risk Adjusted to Account for Differences in Patient's Health Risks?," Health Services Research, April, 2006.

the Diagnostic Cost Groups (DCG) program developed by Boston University, Health Economics Research and DxCG, Inc. (Ex. 17.) This program attempts to predict the cost of each patient by grouping diagnosis codes into 781 clinically homogeneous groups, thereafter arranging the groups according to 184 condition categories and 32 age/gender categories. (Ex. 19.)

According to Accretive's "Standard Operating Procedures" Manual, each Fairview patient will be assigned an acuity level by a member of the Accretive Acuity Care Coordination Team. (Ex. 20.) The acuity rating will have five levels of potential risk, ranging from 0-4, with 4 being the highest risk patient. (*Id.*) The Manual does not describe which of the above modeling programs, if any, will be utilized to make this predictive score, although it does say that the following domains are considered in measuring the patient:

- Utilization
- Disease state
- Medication
- Functional
- Psychosocial

(*Id.*)

In a separate document, Accretive describes the considerations it will use in assigning an acuity score to a patient, such as whether the patient has chronic conditions, is non-English speaking, or has psychosocial challenges. (Ex. 21.) In a presentation to Fairview, Accretive described the risk score as follows:

> "The risk assessment process entails feeding claims data submitted by physicians and other health care professionals (which may be supplemented by data from pharmacies, laboratories, and member-reported information) into risk-modeling computer programs. The methodology that these models use to predict and/or determine costs of care varies, but all modeling software produces a relative risk score for each member in a population. *The relative risk score demonstrates what the populations predicted risk or predicted cost of care will be to a payer. A relative score of 1.0 means the member is predicted to incur average health care costs for the next year. A score above 1.0 means the member is at risk for*

incurring higher than average costs, and score lower than 1.0 means the member has lower than average risk."

(Ex. 22, p.3, emphasis added.)

In other words, each patient is given a "handicap" when it comes to the predictive cost to be incurred by a PCP during the year. The PCP overall financial performance during the years is adjusted by each patient's acuity score and the overall acuity scores of his or her clinic. The profitability of the QTCC program is dependent upon the efficiency of each PCP. One chart, headed "Which PCP is most efficient?," discusses the performance evaluation of each physician, with a large incentive payment for the PCP who can bring down the costs of treating the patient. (Ex. 23.)

6.2.5 QTCC and Predicted Complexity Score. In January 2011, Accretive made a presentation to Fairview about the QTCC program. (Ex. 24.) A patient care plan on page 7 of the presentation points to an additional score--labeled a "Predicted Complexity" score--being assigned to each patient. Additionally, on page 15, the physician is provided a running score as to his efficiency and the costs incurred on a per patient per month (pm/pm) basis.

6.2.6 QTCC and Total Provider Allowed Amount: Matt Doyle's lost laptop computer contained a screenshot of various scores maintained by Accretive on patients. The screenshot, attached as Exhibit 25, identifies the following scores or data:

- Predicted Complexity Score
- Probability of Inpatient Stay Score
- Total Provider Allowed Dollar Amount

6.2.7 QTCC and Compliance Issues. Regardless of which score is used, regulatory issues are raised for the complexity score, the acuity score, the probability of inpatient admission score, and the total provider allowed score or amount. These scores appear to be utilized to incentivize PCPs as it relates to treatment of patients. Accretive and hospitals, prior to utilizing

the scores, should determine regulatory compliance as it relates to disclosure and use of patients' medical information, including under the following laws, among others:

- *Equal Credit Opportunity Act,* 15 U.S.C. §1691a, in that Accretive's scoring may improperly rely on religion, sex, and marital status as a basis for differential treatment of Fairview patients.
- *Fair Credit Reporting Act*, 15 USC § 1681, *et seq.*, and the *FACT Act* 15 USC §1681 – 1681y, in that patients appear to be scored as it relates to the cost of treatment to be provided, Accretive does not send a notice of "adverse action" to patients, and medical information may be used or furnished in connection with patient credit scores.
- *Americans with Disabilities Act*, 42 U.S.C. § 12101, to the degree that a patient's disability status and resultant score influences the type of treatment that the primary care physician (PCP) is induced to provide.
- *The Federal Anti-Kickback Law,* 42 U.S.C. § 1320A-7b(b), to the degree that the QTCC financial inducement to the PCP influences the PCP to refer services paid for under Medicare or a state health care program.
- *The Minnesota Human Rights Act*, Minn. Stat. § 363A.01 *et seq.*, to the degree that the patient's health treatment is being rated by the disability of the patient, or to the extent that gender, religion, and/or marital status are factors that influence patient's scores.

6.2.8 QTCC and Managed Health Care Regulations and Consumer Laws. Accretive describes the QTCC program as an Accountable Care Organization in which Accretive, the insurer, Fairview hospitals, and the Fairview Health Network (doctors) establish what is in essence a managed care organization effectively managed by Accretive.

The QTCC contract raises a host of public policy issues as it relates to the delivery of health care. Perhaps most disturbing about the 100,000 pages of documents produced by Accretive is that they do not discuss these regulatory issues. The most plausible explanation for this is that Accretive, licensed solely as a debt collector, styles itself as a "Revenue Cycle Manager." It entered the managed health care field with Fairview as its "inaugural" QTCC client, and no other hospital has retained it to provide QTCC services. Being a debt collector, Accretive perhaps is unfamiliar with the extensive regulatory infrastructure in the managed care environment.

The accuracy and reliability of the QTCC scoring methodology is beyond the scope of this compliance review. It is noted, however, that several articles raise concerns about the predictability of medical scores. One article notes that it is difficult to predict with great accuracy the highest cost members of a health plan. (Ex. 26, p. 73.) Another article notes that the ACG program may separate the very healthy from the very sick but does not distinguish well among persons with different degrees of illness. (Ex. 27, p. 59.) Another article points out the need to use large samples, larger than a small HMO, to conduct a validated profile analysis. (Ex. 28.) It appears that the Fairview population is similar to that of a small HMO.

The accuracy of the QTCC scores is significant not only to the PCP but also to the patient. The PCP is given a significant inducement by the QTCC program to contain health costs below a predicted score for each patient. (Ex. 23.) If the credibility of the predicted score is flawed, then so is the eventual efficiency ranking of the PCP. If the PCP believes he is "inefficient," the negative score could have a negative impact on the patient's treatment, particularly as it relates to diagnostic tests, specialty referrals, or prescriptions provided a patient. In short, the accuracy of the medical scores, and the credibility of the scoring program, becomes material to services delivered to the patient. Accretive and Fairview should review and determine the degree to which disclosure should be made under state and federal consumer laws to patients and physicians about, at a minimum: (1) implementation of the QTCC program, (2) the use of medical scores, and (3) the impact the medical scores could have on patient treatment.

6.3 Exchange of Fairview and North Memorial Business Operational Data.

6.3.1 Overlapped Accretive Employees. Accretive has revenue cycle contracts with both Fairview and North Memorial Health Care, two Twin Cities hospital groups. The contracts emphasize the importance of keeping their respective operations segregated.

Volume 4 discusses the theft of Matthew Doyle's laptop computer. It is significant that Mr. Doyle's computer was not encrypted. Perhaps even more significant is that Mr. Doyle's computer had confidential patient and hospital data on two hospitals where he no longer was deployed: St. John's Hospital of Michigan and Fairview in Minnesota. It appears that the confidential data of St. John's Hospital was still on Mr. Doyle's computer almost a year after he left the site.

Accretive was aware that North Memorial and Fairview were concerned about the exchange of personnel between the two hospital systems. Andrew Crook, a Vice President of Accretive, became the company's site lead at Fairview in 2010. (Ex. 29.) Accretive knew that North Memorial would be concerned about Mr. Crook's involvement at North, and so Accretive appears to have hidden his involvement from the North Memorial executives. On January 11, 2011, Etienne Deffarges, the Senior Vice President at Accretive, said that he didn't want Mr. Crook at a dinner with North Memorial executives. (Ex. 30.) Instead, he wanted North Memorial executives to believe the Accretive managers at Fairview and North Memorial were at an "arm's length distance." (*Id*.) This continued through the year. On October 4, 2011, for example, Mr. Crook told staff that they must take a "muted approach" when traveling between sites. (Ex. 31.)

Accretive apparently was only concerned about the appearance of impropriety, not the impropriety itself. In December of 2010, Mr. Crook prepared a Powerpoint presentation for

North Memorial about the benefit of the Accretive revenue cycle program. (Ex. 32.) In the accompanying email, he shares with the President of Accretive Quality, Tim Barry, information about Fairview's performance. While site lead at Fairview throughout 2011, Mr. Crook was continuously involved with critical issues facing North Memorial, ranging from preparation of a 100-day business plan for North Memorial in April (Ex. 33) to processing a credit balance backlog in May (Ex. 34) to preparation of high-level cost deck presentations for North Memorial in July (Ex. 35) to presiding over a team meeting to discuss North Memorial in October of 2011 (Ex. 31).

The convoluted relationship between Accretive, North Memorial, and Fairview is exemplified by the theft of Mr. Doyle's laptop on July 25, 2011. At the time of the theft, Mr. Doyle's laptop had substantial medical data on about 14,000 Fairview patients and 9,531 North Memorial patients. Accretive states that Mr. Doyle began employment with the company on August 9, 2010, starting at St. John's Hospital in Detroit. He was then transferred to Fairview on October 4, 2010 to work on "special projects" and remained there until April 14, 2011, when Accretive claimed that he was transferred to North Memorial as the site lead. (Ex. 37.)

While Mr. Doyle arguably was transferred to North Memorial effective April 15, 2011, he was substantially involved with Fairview after that date. On July 15, 2011, Mr. Doyle reviewed a "Base Fee Adjustment Summary" for Fairview sent to him by Mr. Crook. (Ex. 38.) Three days later, on July 18, 2011, Mr. Doyle prepared a "high level cost deck" for North Memorial that he sent to Mr. Crook. (Ex. 39.) Two days after that, he switched back to Fairview, receiving a summary of the "Fairview/Accretive Health Partnership Revenue Cycle Improvements" Powerpoint. (Ex. 40.) On July 20, 2011, Mr. Doyle received Fairview's performance scorecards. (Ex. 41.) In a presentation to North Memorial on September 14, 2011,

however, Mr. Doyle is identified as the site lead for North Memorial operations. (Ex. 42.) Seven days earlier, he was reviewing Fairview deck charts. (Ex. 43.) On October 13, 2011, Mr. Doyle obtained from Mr. Crook (the Accretive lead at Fairview) a copy of a presentation made to the Fairview CEO, and then shared it with his Accretive coworkers on the North Memorial account. (*Id.*) Later in October 2011, Mr. Doyle's dual role came to an end when, in the midst of the investigation over his stolen laptop, he was transferred to Accretive's Chicago headquarters. (Ex. 37.)

While Accretive executives may have been concerned about a "muted approach" when employees traveled between the two hospitals, they were not troubled about continuing the exchange of staff between the two hospital systems. Adam Toppin was working on North Memorial's credit backlog in May 2011 as a North Memorial operations lead. (Ex. 44.) Later, Mr. Toppin was the lead for back-end operations at Fairview, where he coordinated day-to-day efforts between Fairview's central business office and Accretive's India offices. (Ex. 45.) Matthew Olson was identified by North Memorial as its Operation Lead (Ex. 46), yet he is also identified as an Operations Lead at Fairview. (Ex. 47.) Thomas Hickey also appeared to take a "round trip" between the two hospitals. Mr. Hickey was employed at the Fairview site in July 2011. On July 18, 2011, Mr. Hickey was transferred to North Memorial as a back-end lead. (Ex. 48.) In January 2012, he apparently returned to Fairview, being identified by it as an Operations Lead at the Fairview site. (Ex. 47.) Anne Winter, a manager of back-end collections, also appears to have round-tripped from Fairview (Ex. 47) to North Memorial (Ex. 49), and back to Fairview.

Another Accretive employee, Stacey Sogard, is listed as a manager at North Memorial in September 2011 (Ex. 49) and also listed as a manager on the Fairview roster in January 2012.

(Ex. 47.) Similar transfers between the hospitals occurred with Natalie Au. Ms. Au was transferred from Fairview to be a Credit Balance Lead at North Memorial (Ex. 50) and thereafter seemingly transferred back to Fairview as an Operations Lead. (Ex. 51.) Harry Crane also was deployed to North Memorial (Ex. 52) and then to Fairview. (Ex. 47.) Similarly, Kathy Ragusa was deployed to North Memorial (Ex 53) and then became a director of front-end work at Fairview. (Ex. 54.)

There is an inevitable knowledge transfer when so many management level employees transfer back and forth between two competing hospitals. It is not known whether Accretive disclosed the inherent conflicts created with these transfers or obtained the consent of the two hospitals before making the transfers.

6.3.2 Exchange of Competitive Business Data and the Antitrust Laws. The exchange of data between competing hospitals seems to have been a persistent problem for Accretive. The exchange of such data can lead to problems under the antitrust laws and potentially could impact and raise the rates that patients and managed care companies pay for treatment. Under the antitrust laws, "unreasonable restraints of trade or commerce" are prohibited. Minn. Stat. § 325D.51 (2010). Accretive's sharing and facilitation of the exchange of non-public and competitively-sensitive information and financial data among competitors potentially could lead to price fixing, market allocation, production control, and other related violations of law. *See* Minn. Stat. § 325D.53 (2010) (listing non-exclusive violations constituting per se violations of Minnesota antitrust law).

Under the agreements entered into between the Minnesota Attorney General and Minnesota hospitals, including Fairview and North Memorial, the hospitals must charge uninsured patients a price no more than they would charge their "most favored insurer" for the

same treatment. (Vol. 3, Ex. 1, p. 14.) The "most favored insurer" is the non-governmental third party payor that provides the most revenue to the hospital. Thus, the discount rate charged to uninsured patients under the Attorney General Agreement not only reflects the prices charged to uninsured patients, but also reflects the competitive prices charged to the managed care company that delivers the most revenue to the hospital. The discount rate is generally closely guarded by insurance companies and hospitals because it can impact the prices charged or demanded by others, leading to an increase in health care prices.

On September 13, 2011, an Accretive employee at Fairview, Jonathan Clark, asked Mr. Doyle, an Accretive employee at North Memorial, for information about North's inpatient admissions, outpatient visits, and patient revenue. (Ex. 55.) Later that night, Mr. Doyle responded, asking Mr. Clark to provide him with the price charged by Fairview to uninsured patients. (*Id*.) Mr. Doyle wrote:

> "Can you return the favor? **Pat Boran (NM CFO) is trying to determine the proper uninsured discount to use at NM. He wants to compare it to other hospitals.** Can you tell me what FV's uninsured discount rate is, and how its determined."

(*Id,* emphasis added.) The next morning, Mr. Clark replied: "You bet:…That discount amount is [redacted]%." (*Id*.) Later that week, Michael Grand, an Accretive employee working for North Memorial, emailed an Accretive employee who appears to work at Columbia St. Mary's Hospital in Milwaukee, Wisconsin (part of Ascension Health). Mr. Grand posed the following question: "I am researching our AG agreement for our CFO who is trying to determine the proper uninsured discount to use at North Memorial. He wants to compare it to other hospitals. Can you tell me what CSM's uninsured discount rate it, and how its [sic] determined." (Ex. 56.)

Earlier in the year, in May, Matthew Olson, an Accretive employee who was described to the Attorney General's Office as an "operations lead" by both Fairview and North Memorial,

prepared a collections script for North Memorial. (Ex. 57.) In it, he tells uninsured patients that they will receive a particular percentage discount on their bills pursuant to the Attorney General Agreement. (*Id*.) The discount he wrote into the script is the exact same discount Fairview had recently used for uninsured patients. (Ex. 58.)

The revelation of this type of information seems to be an ongoing problem for Accretive. As noted in Vol. 4, at one point it appears that Fairview employees may have been able to access the contract data of other Accretive hospital clients, and vice versa. (Ex. 59.) Other competitive data was similarly exchanged. On August 24, 2011, an Accretive manager working for Fairview supplied to an Accretive manager for North Memorial what appears to be a spreadsheet of discounts applied to patients who were rebilled for prior balances. (Ex. 60.) In July 2011, Mr. Crook provided Fairview "scorecards" to Mr. Doyle (working for North Memorial) who then provided them to Mr. Ducharme (working for North Memorial). (Ex. 61.) The scorecards appear to contain detailed Fairview information by entity of its payor yield, case management earnings, enrollment of uninsured patients in government programs and the like. (*Id.*) It is curious that Mr. Crook, the top Accretive official at Fairview, would provide Fairview information to Accretive's North Memorial representatives. He told the President of Accretive Quality that North Memorial is "**the north side hospital in the worst part of town…where we defer some of our uninsured patients.**" (Ex. 62, emphasis added.)

6.4 Charity Care. Perhaps more than anything else, the delivery of charity care to patients in need is a core mission of a non-profit hospital.

This is how the courts define "charity care" for a non-profit hospital:

> "…dispensing charity to all who need it and apply for it and placing no obstacles in their way—are more than guidelines; they are essential criteria; they go to the heart of what it means to be a charitable institution."[11]

This is how the MBA-types at Accretive define charity care:

"Metric	Definition
Charity	Gross AR [accounts receivable] lost due to insufficient assets from patients"

(Ex. 63.) The culture clash between the mission of Accretive—a for-profit corporation that makes money by cutting costs at client hospitals—and the mission of the hospitals themselves is exemplified in the way Accretive views charity care.

To qualify for exemptions from income taxes (Minn. Stat. § 290.05, subd. 2), sales taxes (Minn. Stat. § 297A.70, subd. 7), and property taxes (Minn. Stat. § 272.02, subd. 7) under state law, a nonprofit organization must prove that it operates for a "charitable purpose." *N. Star Research Inst. v. Cnty. of Hennepin*, 236 N.W.2d 754, 757 (Minn. 1975). In addition to having a charity care policy, a nonprofit hospital must advertise and promote the policy to patients in need of help. *Allina Med. Clinics v. Cnty. of Meeker*, 2005 WL 473908, at *10 (Minn. Tax Div. 2005) (state tax exemption did not apply where "all patients are first asked to pay. Charity care is not made available until all other avenues of payment are exhausted."); *Riverside Med. Ctr. v. Dept. of Revenue*, 795 N.E.2d 361, 365-66 (Ill. Ct. App. 2003) (non-profit clinic not entitled to tax exemption where 97 percent of revenue came from patients and clinic did not advertise charity care). The administrative write-off of bad debt after collection efforts fail is not a charitable activity; rather, it is "no more than writing off uncollectable bills, a business practice…." *Chisago Health Servs. v. Comm'r of Revenue*, 462 N.W.2d 386, 391 (Minn. 1990); *Provena*

[11] *Provena Covenant Med. Ctr. v. Dept. of Revenue*, 894 N.E.2d 452, 468 (Ill. Ct. App. 2008) (upholding denial of non-profit hospital's property tax exemption application in part because of its deficient charity care and collection practices).

Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1149 (Ill. 2010) (hospital not entitled to property tax exemption where "there was little to distinguish the way in which [it] dispensed its 'charity' from the way in which a for-profit institution would write off bad debt"). As one court held: "Charity is more than rhetoric. The term 'charitable purpose' signifies 'concrete, practical, objective charity, manifested by things actually done for the relief of the unfortunate and the alleviation of suffering….'" *Provena Covenant Med. Ctr. v. Dept. of Revenue*, 894 N.E.2d 452, 470 (Ill. Ct. App. 2008).

As noted in Volume 3, Fairview and North Memorial entered into agreements with the Minnesota Attorney General regarding their debt collection policies. (Ex. 64.) The agreements were filed in the Ramsey County District Court, which entered an order requiring the hospitals to comply with their provisions. The agreements require the board of directors of the hospital to adopt a charity care policy "that takes into consideration the financial ability of the patient to pay a medical bill." The hospital may not send an account to a collection agency unless the patient has been given a reasonable opportunity to submit an application for charity care. The hospital must train its own staff and its outside collection agencies about the hospital's charity care policies and how a patient may submit an application. Debt collection agencies must refer patients who may be eligible for charity care back to the hospital. If a patient submits an application for charity care after an account has been referred to collections, the hospital must suspend all collection activity until the charity care application has been processed and the patient has been notified of a decision.

Accretive's involvement in the delivery of charity care at Fairview prompted a complaint to the Attorney General that Accretive, "a for-profit corporation, which owns Fairview's revenue

stream" "has no interest in giving any sort of care away for free," making "it really difficult on patients who need it." (Ex. 65.)

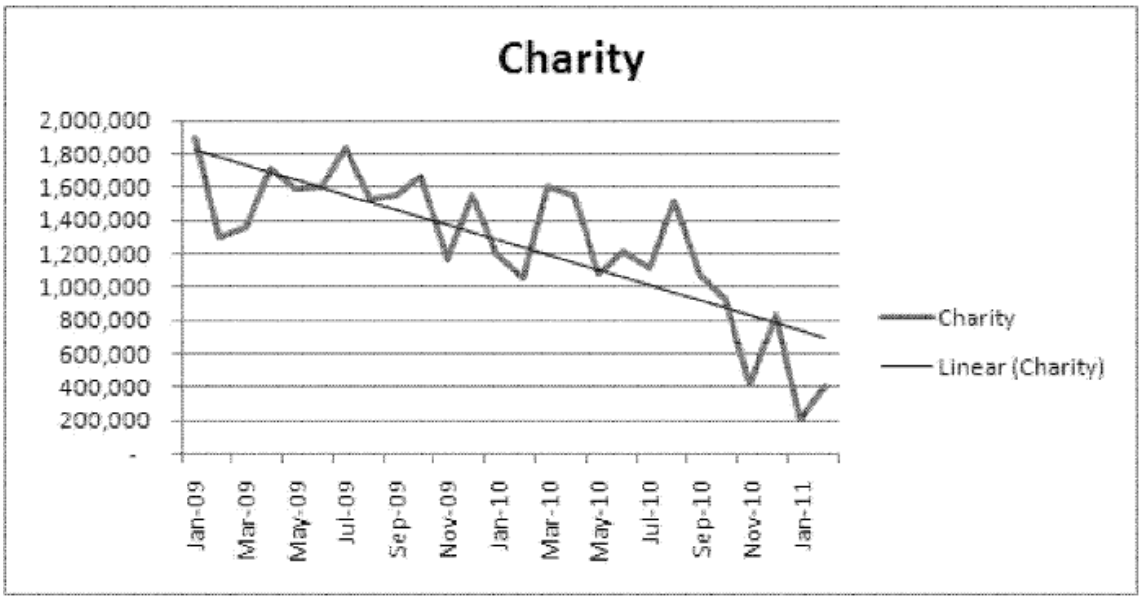
As noted above, the Attorney General Agreement requires Fairview's collectors to be trained in the hospital's charity care policy and refer patients who need charity care to the hospital. In a May 5, 2011 audit prepared by Fairview, the hospital found that Accretive was not familiar with Fairview's charity care policy. (Ex. 66.)

On September 13, 2010—after Accretive imposed requirements that patients be aggressively pursued for payments—a Fairview employee noted that patients on charity care were still facing collections activity. The hospital employee wrote: "They will ask the patient to pay and if the patient self discloses that they are on pending and/or approved [charity care] then they are not going to collect." (Ex. 67.) When another employee responded that the Attorney General Agreement prohibited patients on charity care from being pursued for collections, an Accretive manager minimized the problem by asking her if she was "aware of any penalties we will incur" for not identifying charity care accounts as exempt from collections activity. (*Id.*)

On September 23, 2011, Fairview told Andrew Crook, the Accretive executive in charge of the Fairview account, that because Accretive had failed to follow the Attorney General Agreement, "we have not been writing off accounts to charity care." (Ex. 68.) On October 24, 2011, Fairview told Accretive that its requirement that charity care patients set up a credit card payment plan is "not very practical, and may even be in violation of the AG agreement - in fact I'm pretty sure it is." (Ex. 69.)

In a 2011 report to Fairview, Accretive called charity care a "form of leakage." (Ex. 70.) In a March 2011 Leadership Update, Accretive told Fairview that it was aiming for a

"1/4 reduction in annual charity write-offs." (Ex. 71.) Accretive's goal of restricting the "leakage" seems to have succeeded, if this chart presented by Accretive to Fairview is accurate:



(*Id.*)

Conclusion. Accretive is at the center of one of the most highly regulated industries in America. Its activities directly impact the health and financial well-being of patients, many of whom are sick and infirm. Despite this, it has shown a persistent lack of attention to matters of regulatory compliance.

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