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ENSURING PATIENTS' ACCESS TO CARE AND PRIVACY: ARE FEDERAL LAWS PROTECTING PATIENTS?

FIELD HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

ON

EXAMINING ENSURING PATIENT'S ACCESS TO CARE AND PRIVACY, FOCUSING ON WHETHER OUR FEDERAL LAWS ARE DOING ENOUGH TO PROTECT PEOPLE WHEN THEY ARE MOST VULNERABLE, WHEN THEY ARE SICK AND IN NEED OF MEDIAL CARE

MAY 30, 2012 (St. Paul, MN)

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C O N T E N T S

STATEMENTS

WEDNESDAY, MAY 30, 2012

ENSURING PATIENTS' ACCESS TO CARE AND PRIVACY: ARE FEDERAL LAWS PROTECTING PATIENTS?

WEDNESDAY, MAY 30, 2012

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
St. Paul, MN.

The committee met, pursuant to notice, at 10 a.m. in Hearing Room 15, Minnesota State Capitol, Rev. Dr. Martin Luther King Jr. Blvd., Hon. Al Franken presiding.

Present: Senator Franken.

OPENING STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. This field hearing of the Senate Health, Education, Labor, and Pensions Committee will be called to order.

This hearing will focus on whether our Federal laws are doing enough to protect people when they are at their most vulnerable, when they are sick and in need of medical care. Being in the hospital, even under the best of circumstances, is a stressful experience. When you or someone you love is in urgent need of care, nothing else matters. I think everyone has had the experience of powerlessness and vulnerability when you're in pain and you don't know what's wrong, or when your child or your parent or your spouse is hurting, and at that moment the last thing on your mind is your wallet.

That's why I found Attorney General Lori Swanson's report about Accretive's alleged activities at Fairview extremely disturbing. I would find it absolutely abhorrent if any patients had been badgered by debt collectors in the emergency room or if any patients had been given the impression that they wouldn't be seen unless they pre-paid for their care. That type of activity is not acceptable anywhere, and is certainly not acceptable here in Minnesota.

I've read that patients in extreme pain were asked for payment for health services in Fairview's emergency room before they even knew what was wrong with them, and I've heard that parents of premature infants were approached about their bills while they were in the neonatal intensive care unit. I've even heard that offsite debt collectors had access to detailed protected health information about patients, including their mental health conditions and other diagnoses, which may be in violation of Federal privacy laws.

And I'm worried. I'm worried that if patients know they'll be asked for pre-payment of services, that they'll stop going to the

emergency room when they're sick, which isn't just dangerous for them but could result in the spread of disease and in entire communities getting sick. And I'm worried that if patients hear that their protected health information isn't going to be kept private, that they won't share important information with their doctors such as what medications they're taking, and that could lead to even worse health problems and higher costs if doctors don't have the information that they need.

I'm worried that activities like the ones that have been alleged could bring down the quality of health care that Minnesotans receive when they go to the hospital, and that would be a real tragedy. Our State has always been a national leader in providing high-quality health care, and Fairview Health Services is a prime example. I visited Fairview Hospital many times and I've spoken at length with their doctors and their nurses. I'm convinced that they are among the best health care providers anywhere, and I think we'll hear from people today who will bear that out.

But I also know that there's another part of the equation dealing with the administrative side of things, and so I look forward to working with Fairview and all of Minnesota's health care leaders to make sure that patients are fully protected.

It's possible that the laws that protect consumers from debt collection and those that protect our privacy don't go far enough, and although we're still getting all the facts about the activities that may have taken place, I look forward to hearing from our experts about whether we need to strengthen the laws that protect us when we are at our most vulnerable.

Before we can move forward in strengthening our patient protections, we need to understand what took place, and that's why I've called this hearing and asked our witnesses to testify today, because I want to hear all sides of the story. I'm not here to sit as judge or jury. I'm not here to resolve the dispute between Accretive and the attorney general. That will be left to the court system.

But I do want to find out what happened the best that I can, how patients were affected and whether existing laws are doing enough to protect Minnesotans when they go to the hospital. Take the Health Insurance Portability and Accountability Act, or HIPAA, for example. That law is intended to protect both the privacy and the security of patients' sensitive health information. In this case, though, nobody disputes that data from more than 20,000 Minnesota patients were compromised, and it appears that debt collectors had access to more protected health information than they needed to perform their jobs.

So that raises questions for lawmakers. Does HIPAA need to be strengthened? Does it require clarification? Is it being enforced adequately?

Take the Fair Debt Collection Practices Act as another example. That statute puts in place important protections for consumers. It governs when and how debt collectors may approach a person about a payment. But there's a dispute in this case as to whether that law even applies to Accretive's alleged activities. Again, it will be for a court to resolve that dispute. But again, there are questions for lawmakers here. For example, are Federal statutes suffi-

ciently broad in their coverage to protect Minnesotans from abusive debt collection practices?

And finally, there is the Emergency Medical Treatment and Active Labor Act of 1986, or EMTALA, as it is known, which was put in place to prevent the practice of patient dumping, where hospitals would turn patients away from the emergency room if they were unable to pay for their care. The idea here was that anyone who desperately needs help should get it regardless of their ability to pay, and I think it is important to remember the underlying goal of this law is to provide emergency care to everyone who needs it.

I know that hospitals across the country are being squeezed right now. Reimbursements are low. Costs are rising every year, and budgets are tight for everyone, and hospitals, particularly hospitals here in Minnesota which provide such high-value care, deserve to be paid for the services they provide. But especially in this time of economic hardship, we have to make sure that those with the least voice are heard and that patients aren't the unintended victims of budget shortfalls, and that's what we'll be hearing about today, whether patients are being protected and what we can do better to protect them.

Now I'd like to introduce our first panel of witnesses.

Lori Swanson is Minnesota's attorney general, the first woman ever to hold that seat. She was elected in 2006 and re-elected in 2010 and has been named one of the top 10 lawyers in America by Lawyers USA in 2009. She previously served Minnesota as Solicitor General and Deputy Attorney General.

Mike Rothman was appointed the Minnesota Commissioner of Commerce in January 2011. Like the attorney general, Commissioner Rothman has extensive experience with consumer protection issues. Prior to his current role, Commissioner Rothman was an attorney with Winthrop and Weinstein PA in Minneapolis.

Thank you both for being here today. Please proceed with your testimony.

First I would just like to take a moment to remind all witnesses to stick to 5 minutes of testimony today, although, as you know, you may submit your statements for the record. We are going to have someone, Katherine here, holding up some time warnings just to let you know, because we do have a lot of witnesses today and we want to get through it.

Thank you, Attorney General Swanson, and please go ahead. You can begin.

STATEMENT OF LORI SWANSON, ATTORNEY GENERAL OF THE STATE OF MINNESOTA, ST. PAUL, MN

Ms. SWANSON. Chairman Franken, thank you for expressing so much concern and compassion for America's patients and for holding this hearing, especially in Minnesota, where so many patients and Minnesotans can have the opportunity to participate.

Charitable health care organizations in Minnesota, get a lot of breaks from the taxpayers in Minnesota. They don't pay income taxes, sales taxes, property taxes. They get the privilege of issuing tax-exempt bonds. Over the years, the Office of the Minnesota Attorney General has had a strong focus on whether charitable hos-

pitals and health care organizations in particular operate in a manner consistent with their charitable tax-exempt status and duties.

Following a compliance review of Fairview in 2005, which found that the hospital engaged in overly aggressive collection practices, our office entered into a court order consent decree with the hospital to reform and modify its billing and collection practices. We entered into a similar consent order with North Memorial, as well as other hospitals.

More recently we initiated a compliance review of both Fairview and North Memorial to evaluate their compliance with the consent decree, and also whether their conduct was consistent with the duties and responsibilities of tax-exempt charitable hospitals.

At Fairview, we examined the delegation of management activities by a charitable hospital to Accretive Health, a for-profit Chicago company. The Fairview compliance report is complete, and one of your next witnesses is Chuck Mooty, the Fairview chairman and soon-to-be incoming interim CEO. I have worked with Mr. Mooty over the last several months and can tell you that I believe he is in command in addressing our concerns and has great concern and empathy and compassion for the patients of Fairview.

The compliance review of North Memorial is under way.

The Fairview compliance review found that Accretive repeatedly ignored the court order between the hospital and the attorney general. This chart is an e-mail from an Accretive manager asking its collectors to sign an agreement that they were familiar with the court order, but then telling the collectors don't worry, the court order won't change their behavior anyway. It's just so we can say we have it.

This chart is a Fairview issues log from the very same month, finding that Accretive tried to collect money from patients who were current on their payment plans, that it sent 6,000 accounts to collections without ever having asked a patient for payment first, and that it sat on 300 payments made by patients, resulting in artificially high bills.

This chart is from a Fairview internal audit in May 2011 that found numerous violations by Accretive of the consent decree.

This chart is a Fairview e-mail to Accretive from September 2011 advising Accretive that it was in violation of the consent decree, that its action were resulting in numerous patient complaints and confusion for patients and saying we're not going to be able to keep doing business with you.

This chart is from another Fairview internal audit in December 2011 concluding that Accretive continued to ignore the consent decree and that it had violated the debt collection laws and the patient privacy laws.

Senator, it's apparent from the compliance review that, No. 1, Accretive thought it was above the law; No. 2, that Accretive's management contract unduly incentivized the company to ignore the cultures and mission and duties and values of a charitable hospital organization; and No. 3, that the hospital was unable to restrain Accretive.

I'm going to focus, in the interest of time, in just one area of the compliance review, and that's bedside collection visits in the emergency room.

Mr. Chairman, 20 percent of Americans face a life-changing event in an emergency room. It's where husbands lose their wives, wives lose their husbands, kids lose their parents, and parents lose their children. It's a place of both medical trauma and emotional suffering. It is a solemn place, and it should be and remain a very solemn place.

This chart shows that Accretive differentiates itself from other companies with what it calls the Accretive secret sauce, and it uses words very frankly, Senator, that are not befitting for a hospital or an emergency room that are insulting to the patients.

The document concedes that typical hospitals don't collect money in the emergency room. It then describes, though, the placement of collectors in the emergency room as one of Accretive's secret sauce ingredients. Now, I've personally met with about 25 patients who were hit up by the Accretive secret sauce. My office has interviewed and spoken with many others. About 20 of those patients and their families are sitting here today behind me, and I want to thank them for coming and being part of this hearing.

Senator, they are here because they don't want any other patient in America to ever be subjected to the kind of tactics to which they were subjected.

We have heard from patients who received bedside collection visits in the emergency room while suffering from chest pain, strokes, blood clots, labored breathing, diabetic attacks, appendicitis, elevated heart rates, elevated blood pressure, kidney stone attacks, disorientation, and even while hemorrhaging blood. Some were asked to pay money while they were in so much pain that they thought they were going to die. Others were asked to pay money while dazed and confused and disoriented. Some were asked to pay money while hooked up to morphine drips, heart monitors, IVs, or with tubes shoved down their throat.

Senator FRANKEN. I'm sorry, Madam Attorney General, but we are through with your 5 minutes. Could you wrap it up real quick?

Ms. SWANSON. Yes, I will wrap it up.

Many were laying undressed on a gurney in pain. Most had insurance, yet they were still asked to find their credit cards or checkbooks while suffering in the emergency room. Some were over-charged because the secret sauce aimed high and demanded that they pay too much money, and some had to fight for refunds. Others were surprised to be stop-listed on early morning hours before their surgery while weak and suffering.

Mr. Chairman, there is a time and a place to collect money, but what these patients went through is not the right time or the right place. Our office doesn't enforce EMTALA, but we do regulate charitable organizations in Minnesota. Accretive's management contract unduly incentivized the company to scorn the culture, mission and values of a charitable hospital. It's not appropriate for a management company to orchestrate this type of collection conduct at a charitable hospital that receives tax exemptions from the people of Minnesota. American patients deserve better.

And, Mr. Chairman, I thank you again for holding this hearing.

[The prepared statement of Ms. Swanson follows:]

PREPARED STATEMENT OF LORI SWANSON

I. INTRODUCTION

I thank the Senate Committee on Health, Education, Labor, and Pensions ("HELP") and Senator Al Franken, for convening this committee hearing today on the important issue of ensuring patients' access to health care and protecting the privacy of patients' medical information.

II. THE ATTORNEY GENERAL AND CHARITABLE ORGANIZATIONS

Charitable health care organizations in Minnesota benefit from tens of millions of dollars annually through exemptions on property taxes, sales taxes, and income taxes and their ability to issue tax-exempt bonds. The Minnesota attorney general regulates charitable organizations in the State of Minnesota. Most hospitals and health care organizations in Minnesota are charitable institutions; as a result, the Minnesota attorney general's office has had a strong historical focus on whether Minnesota charitable hospitals and health care organizations operate in a manner consistent with their charitable, tax-exempt status, mission, and duties.

For example, one of the more significant cases in the history of the Minnesota attorney general's office involved a compliance examination and report on the Sister Elizabeth Kenny Foundation. The Sister Kenny Foundation operated a nonprofit hospital in Minnesota to treat and research polio. Former Minnesota attorneys general Miles Lord and Walter Mondale commenced a review and issued a report exposing, among other things, that a Chicago-based third party vendor had overcharged and misled the charitable hospital. The report eventually led to prosecutions of certain officers of the vendor and the charitable organization. More recently, the Minnesota attorney general's office issued compliance review reports of Allina Health System, Medica Health Plans, HealthPartners, Blue Cross and Blue Shield of Minnesota, and Fairview Health Services. A 2001 Compliance Review of Allina Health System eventually led to the divestiture of Medica Health Plans (an HMO) from its parent organization, Allina, and the removal of directors and officers of the organization.

III. THE 2005 FAIRVIEW COMPLIANCE REVIEW REPORT

In 2005, the office conducted a Compliance Review of Fairview Health Services (Fairview). Among other things, the Compliance Review Report found that Fairview had engaged in inappropriate and overly aggressive collection practices. Like other hospitals at the time, it also charged up to three times more for medical treatment to uninsured patients than it charged to insurance companies for the same services. After the Report was published, the office entered into an agreement with Fairview to modify its billing and collection practices. The agreement required Fairview to adhere to certain collection standards, to develop internal collection and charitable giving policies at the Board of Directors level consistent with the obligations of a charitable organization receiving tax-exempt benefits, and for the Board to annually review the hospital's collection and charity care activities. The agreement required Fairview to have a zero tolerance policy for abusive, harassing, or oppressive conduct, both by its own employees and by third party vendors engaged in collections activity. The agreement also required Fairview to charge uninsured patients no more than it charged to the insurance company delivering the most revenue to the hospital (*e.g.* which is typically the insurer that negotiates the lowest prices from the hospital). The agreement was filed as a Consent Decree in Ramsey County District Court. The Consent Decree was renewed in 2007.

In 2005 and 2007, North Memorial Health Care ("North Memorial") signed similar Consent Decrees with the Minnesota attorney general.

IV. THE 2012 FAIRVIEW COMPLIANCE REVIEW REPORT; THE NORTH MEMORIAL COMPLIANCE REVIEW; AND THE ACCRETIVE HEALTH LAWSUIT

In January 2012, the office filed a lawsuit against a vendor of Fairview and North Memorial named Accretive Health, Inc., a Chicago-based debt collection management company. The lawsuit relates to violation of patient privacy rights and unlicensed and unlawful debt collection activities. The lawsuit is in its early stages.

The attorney general's office also initiated compliance reviews of Fairview and North Memorial to determine, among other things, if they were in compliance with the Ramsey County District Court Consent Decree and if their conduct was otherwise consistent with the duties and responsibilities of a tax-exempt charitable health care organization in the State of Minnesota.

As part of the Compliance Review of Fairview, the office reviewed over 100,000 pages of documents from Fairview and Accretive. While the Compliance Review of Fairview has been completed, we are still conducting the review of North Memorial. North Memorial entered into a revenue cycle agreement with Accretive in March 2011.

V. THE 2012 COMPLIANCE REVIEW FINDINGS RELATING TO ACCRETIVE'S MANAGEMENT CULTURE

The Fairview Compliance Review focused on the delegation of management activities by a charitable hospital organization to Accretive, a for-profit company. Fairview paid Accretive approximately $100 million in 2011 to manage the Fairview employees who collect money from patients and insurance companies and to provide certain administrative services such as coding and transcription. Accretive both assumed day-to-day management responsibility over the Fairview employees who performed so-called "revenue cycle" functions and embedded its own employees into Fairview facilities. Through its embedded workforce, Accretive managed the hospital patient registrars.

The Compliance Review Report makes numerous findings. Among them is that Accretive repeatedly ignored the Consent Decree between Fairview and the Minnesota attorney general.

In April 2011, about 1 year after Accretive entered Fairview, an Accretive manager had Accretive collectors sign an acknowledgment that they received a copy of the Consent Decree's requirements. The Accretive manager then said: "Very little of this will drive collector behavior—it's just so we can all say we have it."

The same month, Fairview prepared an "issues log" of problems with Accretive. Among other things, the log noted that Accretive had tried to collect money from patients who were current on their payment plans, referred 6,000 accounts to collections without ever having sent the patient a letter requesting payment, and failed to timely credit 300 patient payments.

The next month, in May 2011 Fairview published an audit of Accretive's lack of compliance with the Consent Decree. The audit found numerous violations by Accretive, including that the company was not familiar with the Consent Decree and Fairview's charity care policy, did not halt collection efforts when patients asked for more documentation, and did not send itemized statements to patients who requested them. Accretive was copied on the audit.

In September 2011 Fairview again advised Accretive that it did not comply with the Consent Decree or Fairview's charity care policies, that Accretive targeted patients in payment plans with collection notices and phone calls, and that Accretive's actions were "resulting in numerous patient complaints and confusion for patients." Fairview told Accretive: "Fairview cannot continue this relationship. . . ."

In December 2011, Fairview again audited Accretive. The audit showed that Accretive continued to ignore the Consent Decree. The audit noted violations of the Consent Decree, Federal debt collection laws, State debt collection laws, and patient privacy laws.

It is apparent from the Compliance Review that: (1) Accretive thought it was above the law, (2) Accretive's management contract unduly incentivized Accretive to ignore the culture, mission, and duties of a charitable hospital organization, and (3) the charitable hospital organization was unable to restrain Accretive.

Because of the limited time allotted for testimony, I will focus on just two areas of the Compliance Review Report:

1. Patients Are Not Told That Their Medical Data is Being Accessed in Other Countries or Being Used to Predict Their Profitability.

Medical privacy is a bedrock principle of the doctor-patient relationship. Over 2,500 years ago, the early Hippocratic Oath for physicians provided: "All that may come to my knowledge in the exercise of my profession . . . I will keep secret and will never reveal." Patient confidentiality encourages a full and frank exchange of information between patients and their doctors.

The Minnesota Supreme Court has recognized the right to privacy like this:

> "The right to privacy is an integral part of our humanity; one has a public persona, exposed and active, and a private persona, guarded and reserved. The heart of our liberty is choosing which parts of our lives shall become public and which parts we shall hold close."

Lake v. *Walmart Stores, Inc.*, 582 N.W.2d 231 235 (Minn. 1998.)

Accretive's treatment of patient privacy is disturbing. Its own records describe "Common Accretive HIPAA Incidents" to include "[l]aptops, unencrypted e-mails, too much access."

In the fall of 2011 Minnesota newspapers reported that a laptop with patient data was stolen out of a car in the Seven Corners district of Minneapolis. The laptop belonged to an Accretive employee and was left in his rental car. The laptop had patient data on over 23,000 patients of Fairview and North Memorial, as well as data from St. John's Hospital in Detroit, MI (part of Ascension Health).

The Compliance Review Report includes a copy of a screen shot provided to a Fairview patient who asked what information about her was on the stolen laptop. The information on the laptop included, among other things, her name, social security number, a numeric score to predict the "complexity" of the patient, a numeric score to predict the probability of an inpatient hospital stay, the dollar amount "allowed" to the patient's provider, whether the patient is in a "frail" condition, and fields to denote whether the patient had any of 22 chronic medical conditions, including bipolar disorder, depression, HIV, or schizophrenia.

Accretive employees embedded at hospital facilities operate largely on laptop computers, some of which are left in plain sight in cars and some of which were never encrypted. Accretive acknowledges that its laptops often contain "tons of patient health and financial information."

As it turns out, a year before the Accretive employee described above left his laptop (with information on 23,000 Minnesota patients) in the car, another Accretive employee working for Fairview also had a laptop stolen out of his rental car while having dinner at a restaurant. Accretive did not notify Fairview at the time that the laptop had been stolen. Fairview learned of the compliance breach through anonymous tips. Fairview questioned whether the second stolen laptop containing its patient data could have been prevented if Accretive had informed Fairview about the first stolen laptop 13 months earlier.

In February 2011 Accretive management stated that there had been four "smash and grabs," or computers stolen out of employee cars, in the last 3 months alone.

On May 11, 2012 Accretive told Senator Franken's office that the company had experienced nine stolen laptops.

It told my office in March 2012 that it found 32 unencrypted laptops.

The Compliance Review Report documents other troubling findings about how Accretive handles private medical data.

Patients were not told that their patient data is being used and accessed by Accretive.

A Fairview audit from December 2011 found that Accretive did not properly encrypt e-mails that contained patients' private information.

Fairview patient health information was accessed and used by Accretive collectors in Kalamazoo, MI. It was accessed by Accretive "revenue cycle" employees embedded at Fairview.

Accretive also engaged in extensive "data mining" and "consumer behavior modeling" using patient data. For instance, company indicates that it develops a "Willingness to Pay" score about patients using approximately l40 "data elements" obtained from client hospitals. An e-mail from one company manager stated that the "Willingness to Pay" score contains various elements, including patients' religion, gender, and marital status.

Accretive allowed employees at its business office in New Delhi, India to access Fairview patient data. One of Accretive's clients uncovered a password sharing breach in India, according to the company's records.

Patients are not aware that their data was being sent to Accretive offices or that it was accessed out-of-state in Michigan or overseas in India. Patients were not advised that Accretive would use their patient health data for collection purposes, to calculate the likely profitability of their future treatment, or to develop "Willingness to Pay" scores.

Mr. Chairman, the American people deserve better.

2. Accretive Turned the Attorney General Consent Decree on its Head by Orchestrating Bedside Collection Visits in Hospital Emergency Rooms and Using Surprise "Stop Lists" to Collect Money From Medically Distressed Patients on the Morning of Their Surgery.

An estimated 20 percent of Americans face a life-changing event in the Emergency Room. It is a place where husbands lose wives, wives lose husbands, parents lose children, and children lose parents. It is a place of medical trauma and emotional suffering, both for patients and their families. It is and should be a solemn place.

The Compliance Review Report includes a document prepared by Accretive which identifies how it differentiates itself from other companies. Encapsulating the culture of Accretive, the chart refers to its method as the "Accretive Secret Sauce," saying on the cover page: "Check out our ASS!" and "You've never seen ASS like ours!"

The "Accretive Secret Sauce" concedes that "a typical hospital" does not collect money from patients in the Emergency Room. By contrast, one of Accretive's "Secret Sauce" devices is to place collectors into Emergency Rooms.

Our Compliance Review Report found a culture clash between Accretive's "Secret Sauce" and its self-described "numbers driven culture," on the one hand, and the mission and duties of a charitable hospital, on the other hand. Accretive—which was responsible for day-to-day management of the hospital revenue cycle employees—publicized quotas for how much money hospital registration staff had to collect from patients, publicized who among individual patient registrars was ahead and who was behind in the "race" to collect, incentivized hospital employees to collect more money with prizes and gifts, and promised to dress up as clowns or turkeys or to shave their head if hospital patient registrars met their collection quotas.

The "Secret Sauce" drove a culture of aggressive collections from medically distressed patients. As one Fairview employee said in a 2010 survey finding 40 percent of Fairview staff to be uncomfortable with the collection activity: "As far as the Accretive initiatives, all we really know is that it is about money and how much we can collect."

We have heard from patients who had insurance, but were still asked to take out their credit cards or checkbooks while suffering on Emergency Room gurneys.

We've heard from patients who were overcharged because the Accretive "Secret Sauce" aimed high and demanded that patients pay too much money.

We've heard from patients who had to fight for refunds.

We've heard from patients who were surprised to be stop listed in the early morning hours before their surgery, hit up to pay while weak and suffering before their treatment at a time of medical distress and high angst.

We've heard from patients who received a bedside collection visit in the Emergency Room. Some of these patients were asked to pay money while writhing in pain. Others were asked to pay money while disoriented on pain medication. Most of these patients were on a gurney in various stages of undress. In some cases, the collectors had to bring them their wallet from their pants, and in other cases patients had to haggle over their ability or need to pay the bill.

As noted above, the Ramsey County District Court Consent Decree requires Fairview to have a zero tolerance policy for abusive, harassing, or oppressive collection conduct, whether by its own employees or by third parties engaged in collections activity. When three doctors said in March 2011 that the collection activity was generating complaints and turning patients away, a top Accretive executive at Fairview trivialized their concerns as "country club" talk.

Our office does not enforce the Emergency Medical Treatment and Active Labor Act (EMTALA). We do enforce the charitable organization laws in Minnesota. Accretive's management contract unduly incentivized the company to ignore the culture, mission, and duties of the charitable hospital. It is not consistent with the mission and duties of a charitable hospital organization that receives tax exemptions from the citizens of Minnesota for a management company to orchestrate this type of collection conduct toward Minnesota patients.

Senator, I thank you for hosting this hearing. I am particularly pleased that the hearing was located in St. Paul, where Minnesotans can participate and see their government at work.

Senator FRANKEN. Thank you, Attorney General Swanson.

Commissioner Rothman, please go ahead with your testimony.

STATEMENT OF MICHAEL ROTHMAN, COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA, ST. PAUL, MN

Mr. ROTHMAN. Thank you, Mr. Chair. My position as commissioner comes with important responsibilities of protecting consumers and the public interest. Specific to today's hearing, the Commissioner of Commerce has the powers and duties and responsibilities under Minnesota law to regulate collection agencies.

Under Minnesota law, any collection agency doing business in Minnesota first must be licensed by the Department of Commerce, a collection agency must be a financially responsible entity, and any person wishing to act as a debt collector in Minnesota must register with the Department.

Minnesota law also sets forth a regulatory scheme for debt collection practices and activity. To maintain licensure and compliance with State regulations, no collection agency or collector shall engage in any of the following prohibited practices, among others: use or threaten to use methods of collection that violate Minnesota law; communicate with consumers in a misleading or deceptive manner by using instruments which simulate the form and appearance of judicial process; violate any of the provisions of the Fair Debt Collection Practices law, the Federal law; in collection letters or publications or in any communication, oral or written, imply or suggest that health care services will be withheld in an emergency situation; when attempting to collect a debt, fail to provide the debtor with the full name of the debt collection agency as it appears on their license.

The public has entrusted the Department to enforce these regulations, and law-abiding debt collectors rely on us to ensure fair competition in the marketplace. These laws and our consistent enforcement of them are a crucial line of defense for Minnesotans, meant to protect their rights and dignity.

The protections are particularly important for the most vulnerable among us, the poor, the sick, the disabled, the elderly, and those facing urgent health care needs. When our Department receives complaints about unlicensed collection activity or other consumer issues, our staff works to carefully determine the merit of the complaints. When warranted, the Department's review may move to the stage of a formal and comprehensive investigation which may result in consent orders, formal statement of charges, administrative hearings, or settlements.

With respect to Accretive Health, the Commerce Department has begun a thorough investigation of allegations that the company and its employees were conducting prohibited collection activity and had allegedly gone to great lengths to disguise its role as a collection agency from consumers. I directed the Enforcement Division at the Department to look into these allegations to determine their merit and pursue a formal investigation.

Allegations investigated by the Department were based on the extensive complaint filed by the attorney general. These allegations of unlicensed activity and prohibited collection practices raised serious concerns, and the Commerce Department exercised its regulatory authority to promptly put a stop to this activity in Minnesota.

After an initial investigation, I signed a consent cease and desist order on February 3, 2012 that was agreed to by Accretive Health to summarily terminate any further collection activity until its collection practices came into full compliance with Minnesota law. Specifically, the consent order directed Accretive to, first, cease and desist from any further activity requiring a collector's license in Minnesota until it meets certain specific conditions, including full compliance with Minnesota law; second, to provide copies of documents and evidence regarding communications provided to debtors in their attempts to collect debts, their screening process for hiring employees, training materials, and the policies and procedures for protecting personal information.

The cease and desist order agreed to by Accretive Health was an important first step in ensuring the full protection of Minnesota consumers in response to these troubling allegations. We have a continuing full and detailed investigation. The details relating to this ongoing investigation are classified as private until the investigation is complete in accordance with Minnesota Chapters 13 and 45 under our statutes. The investigation will require, though, the full cooperation of Accretive Health.

False and deceptive collection practices from any collector or collection agencies, licensed or unlicensed, will not be tolerated on my watch. I want to make it clear that to the extent the evidence collected in our investigation substantiates these allegations, such allegations would represent a severe and troubling disregard for consumer rights and a clear violation of Minnesota law.

Mr. Chair, I appreciate the time. We take all our responsibilities seriously, and I am pleased to answer any questions.

[The prepared statement of Mr. Rothman follows:]

PREPARED STATEMENT OF MICHAEL ROTHMAN

Good morning. Chairman Franken and members of the committee, my name is Mike Rothman, and I am the commissioner of the Minnesota Department of Commerce serving for Governor Mark Dayton. Thank you for the opportunity to testify today on Accretive Health, Inc.

I. DEPARTMENT JURISDICTION

The Minnesota Department of Commerce has a broad and diverse jurisdiction, serving as the State's regulator of financial institutions, real estate sector, securities and investments, insurance products and producers, weights and measures, the energy sector, telecommunications, and other business sectors. My position as commissioner comes with the important responsibilities of protecting Minnesota consumers, and safeguarding the public interest.

Specific to today's hearing, the commissioner of commerce has the powers, duties and responsibilities under Minnesota law to regulate collection agencies, including the licensing of debt collection companies, registration of individual debt collectors, and regulation of the eligibility and activities of collection agencies and their collectors pursuant to Minnesota Statutes Section 332.

Under Minnesota law, any collection agency wishing to do business in Minnesota first must be licensed by the Department of Commerce. A collection agency must be a financially responsible entity and ensure a proper screening process for its collectors to verify eligibility. Any person wishing to act as a debt collector in Minnesota must also register with the Department.

Minnesota law also sets forth a regulatory scheme for debt collection practices and activity. Pursuant to Minnesota Statutes Section 332.37, to maintain licensure and compliance with State regulations no collection agency or collector shall engage in any of the following prohibited practices, among others:

> (3) use or threaten to use methods of collection that violate Minnesota law; . . .
>
> (5) communicate with consumers in a misleading or deceptive manner by using . . . instruments which simulate the form and appearance of the judicial process; . . .
>
> (12) violate any of the provisions of the Fair Debt Collection Practices Act of 1977, Public Law 95–109, while attempting to collect on any account, bill or other indebtedness; . . .
>
> (14) in collection letters or publications, or in any communication, oral or written, imply or suggest that health care services will be withheld in an emergency situation; . . .
>
> (16) when attempting to collect a debt, fail to provide the debtor with the full name of the collection agency as it appears on its license; . . .
>
> (21) when initially contacting a Minnesota debtor by mail, fail to include a disclosure on the contact notice, in a type size or font which is equal to or larger than the largest other type of type size or font used in the text of the notice.

The disclosure must state: "This collection agency is licensed by the Minnesota Department of Commerce."

The Minnesota Department of Commerce takes these and other laws regulating debt collection activity very seriously. The public has entrusted the Department to enforce these regulations, and law-abiding debt collectors rely on us to ensure fair competition in the marketplace. These laws, and our consistent enforcement of them, are a crucial line of defense for Minnesotans, meant to protect the rights and dignity of consumers. The protections are particularly important for the most vulnerable among us: the poor, the sick, the disabled, and the elderly.

When our Department receives complaints about unlicensed collection activity, harassment of consumers, violations of consumer rights, or violations of the Fair Debt Collection Practices Act, our staff works to carefully determine the merit of these complaints. When warranted, the Department's review may move to the stage of a formal, comprehensive investigation.

If I as commissioner determine, based on the evidence of our investigations, that there has been a violation of the law, I reserve the authority to impose a civil penalty of up to $10,000 per violation and/or revoke or suspend an agency license or collector registration. If the Department's investigation reveals allegations of criminal activity, the Minnesota Department of Commerce may refer the case to local, State, or Federal law enforcement authorities for further investigation and criminal prosecution.

II. RECENT ENFORCEMENT ACTIONS

The Department has taken a number of actions in response to serious allegations in the debt collection industry. For example, in October 2011, I signed consent orders involving eight Minnesota collection agencies that allegedly: (1) hired convicted felons; (2) harassed consumers; (3) forged signatures; (4) failed to properly report instances of criminal identity theft; and (5) doctored financial documents. In February 2012, the Department took action against 49 debt collection agencies nationwide based on allegations that their parent company failed to properly screen employees and employed known felons.

In addition, the Minnesota Department of Commerce engaged in discussions and worked with the collections industry during the 2012 Minnesota Legislative Session to address underlying issues that have led to recent compliance and other regulatory issues. Working together, we clarified and strengthened laws to improve collector screening processes and achieved other important reforms.

III. INITIAL INVESTIGATION

In light of its regulatory responsibilities, the Minnesota Department of Commerce has begun a thorough investigation of allegations that Accretive Health, Inc. was conducting unlicensed and prohibited collection activity in the State of Minnesota and had allegedly gone to great lengths to disguise its role as a collection agency from consumers. I directed our Enforcement Division to look into these allegations, determine whether they had any merit, and pursue a formal investigation.

Allegations investigated by the Minnesota Department of Commerce were based on an extensive complaint filed in U.S. District Court by the Minnesota Office of the Attorney General in January 2012. The Attorney General's complaint included allegations that Accretive Health, Inc. committed the following wrongful conduct:

1. Failed to implement policies and procedures to prevent, detect, contain and correct data security violations of 45 CFR §164.308(a)(1) and the Minnesota Health Records Act, Minn. Stat. §144.293, in violation of Minn. Stat. §45.027, subd. 7;
2. Engaged in a practice of allowing unregistered persons to act as debt collectors in violation of Minn. Stat. §332.33;
3. Failed to provide proper notice to Minnesota debtors in violation of Minn. Stat. §332.37;
4. Used false, deceptive, or misleading representations or means in connection with the collection of debts in violation of the Fair Debt Collection Practices Act, 15 U.S.C. §1692e and Minn. Stat. §332.37; and
5. Used unfair or unconscionable means to collect or attempt to collect debts in violation of Minn. Stat. §332.33.

These allegations of unlicensed activity and prohibited collection practices raise serious concerns, and the Minnesota Department of Commerce promptly exercised its regulatory authority to effectively put a stop to this activity in Minnesota. After an initial investigation, I signed a Consent Order ("Consent Order") on February 3, 2012, that was agreed to by Accretive Health, Inc. to summarily terminate any fur-

ther collection activity until its collection practices came into full compliance with Minnesota law. Specifically, the Consent Order directed Accretive Health, Inc. to do the following:

1. Cease and desist from any further activity requiring a collector's license in Minnesota until:
   a. The company provides at least 10 days prior notice to the commissioner of its intent to resume licensed collector activity; and
   b. The company files with the commissioner an affidavit signed by an officer authorized by the company to sign on its behalf that Accretive is in compliance with Minnesota debt collection laws.
2. Provide a copy of all letters and notices, including dunning notices or other communications, provided to debtors in their attempts to collect debts from Minnesota consumers;
3. Provide its debt collector screening process to the Department;
4. Provide all collector training materials;
5. Provide all policies and procedures for protecting and safeguarding of consumers' personal information; and
6. Provide any and all other documents requested by the Department.

IV. ONGOING INVESTIGATION

The Consent Order agreed to by Accretive Health, Inc. was an important first step in ensuring the full protection of Minnesota consumers in response to these troubling allegations. Our Enforcement Division is continuing a full and detailed investigation of these allegations: to determine their merit, to identify any violations of State or Federal law, and to take appropriate and decisive action to enforce the law and correct and appropriately penalize any unlawful wrongdoing.

Under Minnesota Statutes section 13.39, the details relating to an ongoing investigation are classified as confidential until the investigation is no longer active. This ongoing investigation will require the full cooperation of Accretive Health, Inc.

V. SEVERITY OF ALLEGATIONS

False and deceptive collections practices from any collector or collection agency—licensed or unlicensed—will not be tolerated on my watch. I want to make it very clear that to the extent that the evidence collected in our investigation substantiates these allegations, such actions would represent a severe and troubling disregard for consumer rights and a clear violation of both State and Federal law.

As I stated earlier, I take our Department's regulatory responsibilities very seriously. As Commerce commissioner, I will not allow the rights of consumers to be violated. The public, consumers and businesses alike, have entrusted us to fairly and consistently enforce the law. It is our responsibility and our charge to carefully review these allegations, investigate the matter fully, make an objective determination, and enforce the full measure of the law.

VI. CONCLUSION

The Minnesota Department of Commerce is committed to protecting consumers and the public interest, and to working with the debt collection industry to ensure a fair marketplace. Mr. Chair and members of the committee, thank you for inviting me to speak with you here today. I would be pleased to answer your questions.

Senator FRANKEN. Thank you, Commissioner Rothman.

Attorney General Swanson, thank you for your testimony and for providing us with background on your investigation, which has garnered quite a bit of attention. I think that's probably because just about everyone needs medical attention at some point in his or her life, so these issues affect all of us.

I know you've worked extensively with non-profit hospitals across the State and, as you noted in your report and in your testimony, non-profit hospitals qualify for exemptions from all these different taxes that you laid out. In order to qualify for these tax exemptions, non-profit hospitals are subject to specific Federal and State requirements.

Could you tell us about the agreements that you developed with hospitals across the State to make sure they're providing a benefit to the community?

Ms. SWANSON. Yes. Thank you, Chairman Franken.

In 2005, I think every single charitable hospital in Minnesota signed an agreement with the attorney general's office, which was then renewed in 2007 and which we are in the process of renewing again for a 5-year period. That agreement was entered into after we did a compliance review that found troubling conduct, overly aggressive collection practices, and the agreement requires that hospitals have in place charity care policies and collection policies. They are to be approved at the board of directors level, making sure that in exchange for these significant breaks the hospitals do good, provide charity care to the poor and make sure people can still get their treatment.

It requires the hospitals to undertake periodic audits of both their internal and their external collection practices to make sure those practices are in accord with various detailed written standards of our agreement, as well as to make sure those practices are in accord with the hospital's own policies.

The agreements also prohibit both internal and external third-party vendors from engaging in aggressive, harassing, abusive collection practices. The intent of the agreements were, No. 1, to make sure that hospitals were using what I call kinder, gentler debt collection practices, recognizing that hospital bills are different than other kind of debt and that people are often—if you're sick, you need treatment, and especially in troubling economic times not everybody can pay for that treatment immediately.

Also the agreements require hospitals to charge the uninsured the same price they charge to insurance companies for the same treatment. Up until the time of that agreement, hospitals were charging uninsured patients three or four times more than insurance companies for the exact same treatment. You had this perversity where patients paid an artificially high sticker price if they had no insurance that nobody else paid. The Government didn't pay it. Insurers didn't pay it.

I think that the agreement really reflects what are community standards in our State and would, frankly, be good policy for Congress to look at for the whole country.

Senator FRANKEN. What was Accretive's responsibility as a for-profit company contracting with Fairview, a non-profit hospital, to comply with this agreement? Do you believe that Accretive violated your agreements, the AG agreements with Fairview and others?

Ms. SWANSON. Yes. Chairman Franken, Accretive specifically contracted with Fairview that it would be in compliance with all aspects of our agreement. That was something that Fairview wrote into the agreement with Accretive, which is, you have to honor and comply with the attorney general agreement.

As I've pointed out, Fairview engaged in a variety of audits and was repeatedly warning Accretive that they were in violation of the hospital agreement and that Fairview wasn't going to stand for that violation. In many, many ways, they violated the hospital agreement, and we've laid that out in a whole separate volume of our report.

Senator FRANKEN. Do you believe that Accretive's activities at Fairview created a culture conflict with the kind of quality-driven culture that we expect from health providers here in Minnesota?

Ms. SWANSON. Chairman Franken, I do. One of the things that became very apparent during the compliance review is that Fairview has good doctors, good nurses, people who are very compassionate and view their work as almost missionaries to take care of the sick, the infirm and the ill. A charitable hospital, and especially an emergency room, should be a sanctuary to take care of people at the worst time in their life. I think that's certainly the values that have been expressed by the care providers at Fairview.

On the other hand, Accretive is a for-profit, Wall Street, money-making company. It wanted to create a numbers-driven culture at Fairview. We have a document in our report that says that we want it to be numbers driven. The problem, Senator, is that health care isn't about numbers. It's about patients. It's about the patients sitting behind me today who experienced very tough times in their life and had a collector visit them in the emergency room, and that created a collision in values, the culture of a non-profit charitable institution on the one hand, and the culture of a very hyper-aggressive collection enterprise on the other.

Senator FRANKEN. Well, it seems to me that hospitals are also in a tough situation. The cost of health care is increasing. Hospitals are being squeezed on the revenue side, and at the end of the day they're operating on a very thin margin. Hospitals have to find a way to collect the money that's owed to them, and I'm sure you'd agree.

Collecting payment from patients at the time they get care is one way to do it. A recent article in *Forbes* says, "Increasing point-of-service collection has become a major weapon in the health care industry arsenal to bring bad debt under control." But the same article criticized your investigation into Accretive, saying that you were erroneously attacking an important billing practice.

How would you respond to that criticism? Are you concerned with point-of-service practices generally, or is your concern with the way they were implemented in this particular case?

Ms. SWANSON. Chairman Franken, there is a time and a place for hospitals to collect money. There's a right way to do it and a wrong way to do it. What Accretive orchestrated at Fairview is the wrong way to do it.

Hitting up patients in their bedside gurney in various stages of undress where they're hooked up to morphine drips or have feeding tubes shoved down their throats is not the time and the place to collect money. This is a time of medical distress. It's a time of trauma. Some of the patients who were hit up in the emergency room hadn't yet been on pain medication and they were, as I mentioned, in so much pain they literally thought they were going to die.

Other patients, on the other hand, were hooked up to morphine drips and they were groggy, confused, disoriented, and the way that this company orchestrated the collection campaign was not the time and the place to collect money.

Other times patients were stop-listed early in the morning, before surgeries. They were told don't eat, don't drink for 12 hours. They got up at 3 a.m. to leave their house, came to the hospital

at 5 for very, very important surgeries, only to be surprised to be stop-listed and told, "We need your credit card right now before you move ahead," at a time that they were weak and frail and suffering and groggy. That is not the time and the place to collect money.

We have not tried through this compliance report to draw all the boundaries for point-of-service collections, but I can tell you the kinds of activity that we've outlined I don't believe is consistent.

Senator FRANKEN. Attorney General Swanson, I believe that when patients' privacy is violated, everyone is harmed. If patients can't trust that their health information will remain private, they will be less likely to tell their doctors what conditions they have and what medications they are taking.

In Volume 4 of your compliance report, you talk about the importance of privacy. You say that patients are less likely to be candid with their doctors if they think their information isn't private.

What sort of protections are in place to protect patients' privacy, and are those protections adequate?

Ms. SWANSON. Chairman Franken, privacy is a bedrock principle of the doctor-patient relationship. Twenty-five-hundred years ago, the Hippocratic oath for doctors said, "That which I shall learn in the carrying out of my profession I will keep secret and never reveal," the idea being that patients need to know their information is kept sacrosanct, that it's going to be treated confidentially. I know that's been a concern of many of the patients that have come forward to our office, that they were concerned about their privacy.

Chairman Franken, one of the things we've seen in our compliance report, we have a screenshot of the information about a particular patient who was on the laptop computer, and it lists her name and Social Security number on the laptop, whether she has any of 22 chronic medical conditions, including HIV, schizophrenia, bipolar disorder, whether she is depressed, what is her likelihood of future hospital treatment, is she frail.

In another example in our report, we have a screenshot of the type of information that could be collected or accessed by the Kalamazoo, MI debt collectors of Accretive, and this particular screenshot is a fellow who was depressed and attempted suicide by cutting his wrist. You can only imagine what a debt collector can do with that type of information.

Now, under HIPAA, there are certain privacy protections in place. One of those is that a hospital and a third-party vendor are supposed to have in HIPAA parlance what's called a business associate agreement, and that agreement is supposed to lay out what the protections will be and how data will be protected. As it turns out, Fairview had a business associate agreement with Accretive, only Accretive violated that business associate agreement.

At North Memorial, as it turns out, there apparently was no business associate agreement in place at all. North Memorial entered into a contract with Accretive in March 2011, and in October 2011 I sent a letter to North Memorial saying please produce to my office your business associate agreement with Accretive. In the few days afterward there were a series of e-mails between North Memorial and Accretive basically concocting to create a business associate agreement, basically back-dated or retroactively dated for presentation to my office. Greg Kazarian, I think one of your next

witnesses from Accretive, is on this particular e-mail from the CFO of North Memorial. It's dated October 13, and it says, "Greg, we're sending you the BAA. Could you sign and return so we can include it with our AG response?"

North Memorial and Accretive thereafter concocted a business associate agreement. It's dated March 21, or effective March 21, 2011, and it was presented to my office as if they always had a business associate agreement. In fact, that agreement that was presented to my office was really signed in October 2011.

Senator FRANKEN. OK, that's news. You have those documents?

Ms. SWANSON. Chairman, I do.

Senator FRANKEN. OK. OK. I would like to see those.

Ms. SWANSON. I would be happy to present them. I think it would be very troubling to the patients that their information is being shared without that type of written contract.

Senator FRANKEN. OK. Thank you. I need to move on.

Ms. SWANSON. Sure.

Senator FRANKEN. Commissioner Rothman, we have debt collection laws for a reason, to protect consumers. Can you explain why it's important that debt collectors register as such with your commission and why it is important that debt collectors disclose to customers that they are debt collectors and that they are calling to collect a debt?

Mr. ROTHMAN. Mr. Chair, it's vitally important. We have both requirements for the companies and the individuals to be licensed and registered, registered by the individuals. It's important because we want to know who are the people that are authorized to do debt collection in Minnesota, and then therefore are also required to follow the law for what are prohibited practices.

There have been other investigations that I've looked into in which debt collectors were either unlicensed, unregistered, or not eligible because of their prior history in terms of whether or not they're qualified; meaning, for example, they cannot have certain criminal background history.

These laws are meant to be a first line of defense for consumers generally, and then in particular in the context of the medical profession to also make sure that these are professionals and abiding by the laws of our State.

Senator FRANKEN. One of the issues presented in this case is whether the people who were collecting payments at the hospitals and from the call center were—and I'm going to use a term of art—debt collectors or financial counselors. What do you make of this distinction, and why does it matter?

Mr. ROTHMAN. Let me speak to Minnesota law. Under our law, under section 332, it defines what a collection agency is and what it means and who a person is that does debt collection.

The collection agency means it includes any person engaged in the business of collection for others any account, bill, or other indebtedness except as hereinafter provided, and these exceptions don't apply here. It's a relatively broad definition. It's a little different than what the Federal law defines as what a debt collection agency is. And a collector is somebody who acts under the authority of an agency to do those things.

In Minnesota, Accretive Health did obtain and does have a license from the Department of Commerce to be a collection agency. Individuals who do debt collection activity under Minnesota law would therefore also need to be registered, and to the extent they were not and if they were not, they would be serious and troubling violations of the law.

Senator FRANKEN. OK. In the interest of time, I would like to move on, and I want to thank you, Attorney General Swanson and Commissioner Rothman. You are now excused.

Would the next panel please come forward?

Mr. ROTHMAN. Thank you, Mr. Chairman.

Senator FRANKEN. As they're being seated, I would like to introduce our second panel of witnesses.

Charles Mooty is the chairman of the board and soon will serve as interim CEO of Fairview Health Services. He is also the former CEO of International Dairy Queen and recently became the owner of the Minnesota textiles firm Faribault Woolen Mills Company. Mr. Mooty began his career working at Adina-based Dairy Queen in 1987.

Greg Kazarian has been senior vice president of Accretive Health since January 2004. He previously served as Accretive's general counsel. Prior to joining Accretive, Mr. Kazarian spent 16 years with the law firm of Peterson and Haupt, where he worked on issues related to employment, intellectual property, creditors' rights, dispute resolution, and out-sourcing.

Thank you for joining us, Mr. Mooty and Mr. Kazarian. I know that it's not an easy thing to take time away from your schedules to participate in this hearing and to give testimony. I really do appreciate your time.

Mr. Mooty, please go ahead with your testimony.

STATEMENT OF CHARLES MOOTY, CHAIRMAN OF THE BOARD OF DIRECTORS AND INTERIM CEO, FAIRVIEW HEALTH SERVICES, MINNEAPOLIS, MN

Mr. MOOTY. Good morning, Chairman Franken. My name is Charles Mooty and I am the chair of the Fairview Health Services board of directors and will serve as Fairview's interim chief executive officer beginning August 1, 2012. Thank you for inviting me to be here today with you.

As you know, Fairview has had a long and strong reputation of providing exceptional health care to the communities we serve. Fairview's reputation is built on a long track record of quality care and contributions to the local community.

The issues that have come to the fore recently have been challenging for our employees, physicians and leaders. Most importantly, we know that these issues created challenges for some of our patients who do not feel that they were treated with respect and dignity. To those patients, I offer my personal apology and firm commitment on behalf of the entire Fairview organization to regain your trust.

The Minnesota Attorney General's compliance review includes several examples from patients and employees of business practices that are not in keeping with Fairview's values and code of conduct. And while Fairview is not a defendant in any attorney general law-

suit, I can assure you that we are cooperating with the attorney general's office in order to reassure our patients that we are committed to compliance with all laws and regulations and, above all else, improving patient care.

Fairview has taken action to remedy the issues that have been identified prior to the attorney general's suit. Fairview terminated its work with Medical Financial Solutions, a part of Accretive Health, on January 6, 2012 because of their failure to comply with the State attorney general's billing and collection agreement.

In addition to terminating our agreements with Accretive Health, we also have initiated better approaches for escalating patient, employee, and physician concerns so that they receive prompt attention. We are reviewing and revising our training tools to ensure each patient interaction reflects Fairview's core values. We've stopped collecting past due balances and co-insurance payments in emergency departments, and we're reviewing emergency department and registration workflow processes.

We also have reallocated resources to functions within Fairview that handle refund and credit balance processes to ensure prompt repayment of amounts due to patients.

In short, we are shouldering our share of the responsibility and taking actions to address concerns for our patients, employees, and physicians.

Fairview's first priority is and always will be the care for our patients. All of our employees—physicians, leaders, and even board members—are dedicated to patient well-being. The Fairview team strives to deliver exceptional care at all times in a respectful manner and in compliance with the relevant laws and regulations. Moving forward, Fairview leadership and governance members are going to do a better job of listening and acting upon patient and staff concerns and recommendations, and as Fairview transitions to a new leadership, I can assure you that governance will now have our renewed commitment to carry this forward.

Thank you for inviting me here today, and I welcome your questions.

[The prepared statement of Mr. Mooty follows:]

PREPARED STATEMENT OF CHARLES MOOTY

Good morning, Chairman Franken. My name is Charles Mooty, and I am chair of the Fairview Health Services board of directors and will serve as Fairview's interim chief executive officer beginning August 1, 2012. Thank you for inviting me to be here today.

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Moving forward, Fairview leadership and governance members are going to do a better job of listening to and acting upon patient and staff concerns and recommendations. And as Fairview transitions to new leadership, governance will ensure that our renewed commitment carries forward.

Thank you for inviting me to be here today, and I welcome your questions.

Senator FRANKEN. Thank you for your testimony, Mr. Mooty.

Mr. Kazarian, thank you for being here.

I will note that I asked Accretive CEO to participate in this hearing, but she was unable to do so. But I understand that you are the head of compliance for Accretive and probably are the best person to talk about these issues that we're discussing today, so I'm glad that you're here, Mr. Kazarian.

Thank you. Please go ahead with your testimony.

STATEMENT OF GREGORY KAZARIAN, SENIOR VICE PRESIDENT, ACCRETIVE HEALTH, INC., CHICAGO, IL

Mr. KAZARIAN. Thank you, Senator, and good morning. My name is Greg Kazarian, and I'm the senior vice president of operations and the corporate responsibility officer at Accretive Health. I came to Accretive Health in 2004 because I believed in the company's mission and its vision for helping patients and hospitals navigate the challenge of rapidly rising health care costs. I came to Accretive Health because I saw tremendous opportunity to make improvements in a broken and struggling health care system.

I'm 49 years old, and I have a wife and three children. Between us, we have four aging parents, two of whom live across my backyard. As a family, we've experienced all of the usual medical issues that families experience every day. I know firsthand how important high-quality, compassionate care is, and I know firsthand how important it is that patients understand what insurance and public assistance they're eligible for, as well as their own financial obligations for their medical care.

There are three things I'd like to cover quickly in these opening remarks. First, I want to thank you, Senator. Thank you for inviting us to speak with you today, for the time your staff has spent with us discussing these important issues, for your willingness to listen, and for your efforts to have an open and honest discussion as to how health care can and should be improved. I thank you on behalf of myself as well as the 3,000 employees who work at Accre-

tive Health. Approximately 150 of those employees live and work right here in Minnesota. These individuals work as nurses, financial counselors, and social workers. Over 50 of them have chosen to attend this hearing voluntarily on their own time today.

Senator, it's important that the work of these trusted, dedicated colleagues be understood and appreciated, and that is something I'm going to try to achieve in our time today.

Today I want to explain what we at Accretive Health do. I suspect that many people in this room had never heard of Accretive Health before the last few weeks. Unfortunately, we've been portrayed in a way that distorts and misrepresents our business and our work.

True debt collection is less than 1 percent of what we do. The core of what we do every day, everywhere we work, is help hospitals find all available coverage for patients and ensure that insurance companies and government programs pay the hospitals the money they're owed for the care they provide.

For example, we go to bat for patients who have been denied insurance coverage for pre-existing conditions and we get those claims paid. We advocate for patients when their insurance company refuses coverage for conditions that are medically necessary, and we get those claims paid. We fight to get patients who qualify onto disability so that they can get coverage for the care they need. Over 95 percent of the revenue we secure for hospitals come from insurance companies or government payers.

As part of our work, we also help hospitals collect the amounts due to them from patients, and we help the patients themselves understand the coverage they have and how it's going to respond to that episode of care, and the benefits they may be eligible for. This is information patients want to know and need to understand.

We're proud of the work we do, and particularly proud of the fact that we've helped more than 250,000 formerly uninsured people obtain coverage for their care, 16,000 of those people right here in Minnesota. Sixteen-thousand people who didn't know they had coverage for the care they were receiving were connected to that coverage so it would pay for their claims.

And for those who cannot pay and for whom we cannot find another source of coverage, we assist hospitals in getting those patients charity care and other financial counseling, including discounts and payment plans.

The work of our Quality and Total Cost of Care Program is another point of great pride for us at Accretive Health. In this groundbreaking program, we help care providers identify and reach out to the sickest patients they serve and coordinate their care and services provided to them in ways that help improve their health care and reduce the need for costly emergency room visits.

For example, by connecting social workers with home-bound patients or patients who are vision impaired, we can create safer living environments that reduce accidents. For patients with insufficient social networks and those with memory problems, we coordinate transportation to pharmacies so those patients don't get sicker.

I sincerely hope to have an opportunity to talk today in more detail about this very important part of our work.

The final comment I would like to make is perhaps the most important. Accretive Health is a company that believes our mission is to help patients and strengthen the financial viability of the not-for-profit hospitals we serve. We take seriously the allegations that have been raised by the attorney general and appreciate the opportunity to have this dialog and set the record straight.

As a company, we firmly believe that even one unsatisfied patient is one too many. Let me be clear. Many of the allegations we've heard this morning and in the press are deeply troubling, and if they are true, they would be flatly inconsistent with Accretive Health policies, our training and our values. To any patient who experienced any interaction with us or with our Fairview colleagues that lacked compassion and professionalism, we sincerely apologize.

Senator FRANKEN. Thank you. You have to wrap up.

Mr. KAZARIAN. Again, we thank you, Senator, for inviting us to have this dialog, and I look forward to your questions.

[The prepared statement of Mr. Kazarian follows:]

PREPARED STATEMENT OF GREGORY KAZARIAN

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 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.

[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.

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 8 years of research and dialogue to define a set of practices 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

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[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 CFR § 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).

[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).

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?

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 5 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 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 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.

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[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.

[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).

[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).

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.**

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 e-mail 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.

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

[10] *See generally* Compliance Review at Volt. 2.

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 2 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 8 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.

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, 7 to 10 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.

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 received, 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

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[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).

[13] *Id.*

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 unsupported [14]—allegations that Fairview and Accretive Health violated the Emergency Medical Treatment and Labor Act ("EMTALA").[15] In fact, practices at 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.

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 hospitals [16] and more than 40 primary care clinics.

The attorney general's office has alleged that Accretive Health gained "breathtaking" control over Fairview and its employees, [17] but this is not true. The parties' contracts defined their relationship as a "collaborative" one, [18] 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.

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

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

[15] *See* Compliance Review at Volt. 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 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).

[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 Volt. 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.

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 30 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, 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 1 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 e-mail 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 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.

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[22] Compliance Review at Volt. 4 PP. 7–8.
[23] *Id.* at 11.

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 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 e-mail, 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 e-mail is misleading. From the full text of this e-mail, 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]
- 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 60 percent.
- The attorney general's office cites an e-mail chain among employees discussing a patient's financial situation, stating that the employees "discuss[ed] the condition of the patient's disease and tr[ied] to figure out if her cancer was terminal or simply disabling" and otherwise "discuss[ed] her cancer."[32] This e-mail 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

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[24] Compliance Review at Volt. 2, PP. 16–17.
[25] Compliance Review at Volt. 2, p. 16.
[26] Compliance Review at Volt. 2, p. 14.
[27] Compliance Review at Volt. 2, p. 19.
[28] Compliance Review at Volt. 2, Ex. 93.
[29] Compliance Review at Volt. 2, p. 15.
[30] Compliance Review at Volt. 2, Ex. 80.
[31] Compliance Review at Volt. 2, p. 20.
[32] Compliance Review at Volt. 4, p. 13.

third-party coverage.[33] In fact, the e-mail 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, but fails to present accurate or complete facts:

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 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.

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.

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[33] Compliance Review at Volt. 4, Ex. 14.

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

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.

Senator FRANKEN. Thank you so much, both of you, Mr. Mooty and Mr. Kazarian.

Mr. Mooty, I understand that you are in the process of transitioning to become Fairview's interim CEO, so you may not know every detail of the day-to-day workings of the hospital or what happened. But as chairman of the board, I hope you can answer a few questions, and if there's something you need to check on, I hope that you'll followup with me.

Fairview has been around for over 100 years, right?

Mr. MOOTY. That's correct.

Senator FRANKEN. As far as you know, in those 100 years, has Fairview ever had problems like those that we're discussing today?

Mr. MOOTY. I think as the attorney general referenced, back in 2005, when the agreements were entered into before, that Fairview was part of the group that had had challenges and issues with the attorney general at that time.

Senator FRANKEN. OK, thank you.

I was very disturbed, Mr. Mooty, by the allegations that Accretive was badgering patients in Fairview's emergency room, and in the neonatal intensive care unit they asked for pre-payment and to collect on debts. What was your first reaction to these allegations?

Mr. MOOTY. I think all of us within Fairview love our culture and our commitment to our patients, and any time both our patients and our employees are not in a comfortable situation, that's just very disconcerting.

Senator FRANKEN. If these allegations turn out to be true, would they violate any part of Accretive's contract with Fairview?

Mr. MOOTY. I'm not the legal expert to know exactly as to what the violations would do. My guess is that in many respects if what has been reported is actual and truth, that would require an issue as it relates to any agreement or any activity with Accretive.

Senator FRANKEN. OK, thank you.

Mr. Mooty, the attorney general's report discusses what she calls a culture clash between Accretive and Fairview. She cites e-mails in which Fairview physicians express their discomfort with certain activities. Did Fairview perceive a culture clash between Fairview and Accretive? What steps did Fairview take to address these concerns at the time, and did Fairview staff address them directly with Accretive?

Mr. MOOTY. My understanding is that staff did elevate concerns to their appropriate managerial reports, and that that was passed along. As to how high that was passed along is still something that we're needing to try to dive into and gain greater understanding of.

But there's no doubt that there was a culture change and an uncomfortableness that both went to our employee group as well as to our patients, and that's a troubling situation.

Senator FRANKEN. Mr. Mooty, can you tell me what steps Fairview has taken to protect patients from inappropriate debt collections? How have Fairview's procedures changed since Fairview be-

came aware of the attorney general's investigation and the alleged activities of Accretive? And in Fairview's view, what is the responsible way or the Minnesota way, if you will, to collect payment from patients?

Mr. MOOTY. I think first and foremost is to make sure that whatever our procedures are, is that it's within the rules and laws of the State. In that respect, it's vitally important that we uphold those laws as we go forward.

As it relates to changes, we have now taken all of that collection in-house and we have dedicated our team to new training and to new approaches and new scripting to make sure that we are upholding that as we go forward. I will do my darndest as far as what is needed to make sure that we steward this thing appropriately and guide it to a point where our patients feel that we are being both good stewards and managers of our resources, but also providing exceptional quality care.

Senator FRANKEN. Thank you.

Mr. Kazarian, in its response to my letter, Accretive said that,

> "While the revenue cycle employees in the call center working to collect payments from patients typically refer to themselves as 'patient financial advisors' or 'debt recovery specialists,' these employees also may have, from time to time, identified themselves as 'financial counselors'."

Now, all these terms, "patient financial advisor," "debt recovery specialist," "financial counselor," seem misleading to one degree or another. Shouldn't the people in the call center disclose at the outset that they are debt collectors calling to collect a debt?

Mr. KAZARIAN. Senator, there are two aspects of work in that call center, and I'm in full agreement with you with respect to those people who are collecting on aged debt, debt that is in default, which is the way the Fair Debt Collection Practices Act defines it.

In health care billing——

Senator FRANKEN. Maybe we should talk about changing.

[Laughter.]

Mr. KAZARIAN. Yes, and we might. You know, I've spent 7 years of my life in this company working on these issues that I talked about in my opening statement, and we are——

Senator FRANKEN. Well, how does Accretive determine when a debt is in default?

Mr. KAZARIAN. Actually, Accretive doesn't do that. The hospital policies will typically dictate that. In most instances, it will be deemed in default at anywhere from 120 to 180 days after the date of statement of service. And the unique issue that you have, the reason that we——

Senator FRANKEN. You're saying the hospital does it, but don't you, on all revenue cycle issues, don't you control what the hospital does? That's what it says in your SEC filing.

Mr. KAZARIAN. No, Senator, that's not accurate. I can get to the reconciliation of the SEC filing if you'd like to. But what our contracts all provide is that we will operate in a manner consistent with the hospital's policies and procedures in all the areas that affect the services we provide. So if the hospital says that a debt is in default and to be referred to followup, that's what we adhere to.

Senator FRANKEN. OK. It just seems like it's a legal technicality. Most people think of debt as money that they owe to be collected.

Mr. KAZARIAN. Yes, I understand that, Senator. And that's why I'd like to talk a minute about an area where I think that there's more thought to be provided.

Senator FRANKEN. Sure.

Mr. KAZARIAN. In health care, we have this unique situation where the patient who is receiving the care, absent some dialog with somebody, doesn't know what they're going to owe. So if you have—when my son went to the emergency room and then got his knee surgery, we didn't know what our deductible was, what our co-insurance share might be, and unless somebody sits down and talks to you about how Blue Cross is going to handle that care, what they're going to charge, you don't know——

Senator FRANKEN. I think I was talking more about the call centers.

Mr. KAZARIAN. In the call center, there is a concept in health care called "early out vendors," or pre-collect, and what that is talking about is those financial advisors. These are people—if I send that balance and call a patient and say you've been referred to debt collection 30 days after you've received the statement, then Fairview and hospitals all across Minnesota are going to get complaints that that's been escalated prematurely. "Why did you send me for debt collection? I just had questions that I didn't understand the bill."

So the reason the scripts and the language is different for earlier debt than later debt is because we recognize the first thing patients want to do, and I think your bill actually contemplates it, is understand that the amount that you think is due is an amount I understand. Once we agree on that, then we can talk about how to take care of it. So that's the reason for the different language around a call that's early where the obligation might not be understood.

Senator FRANKEN. I understand. I was referring to calls that were a little bit later in the cycle, but let me move on.

Mr. Kazarian, in your letter to me you say that revenue cycle employees "revenue cycle employees work to communicate with patients with the greatest possible compassion."

Now, I have to say one of the most disturbing documents I've seen in this investigation is an e-mail from an Accretive revenue cycle employee who describes patients as deadbeats and plebeians and who said—and these are his words—that he,

> "really takes the approach of being stern and calling people out for being stupid because if they keep hearing it, they may eventually realize their stupidity and possibly feel just a hint of guilt for being such a schmuck."

And this is the part of the e-mail that I can quote in an open hearing. Believe it or not, most of what he says in the e-mail, or a lot of what he says in the e-mail is even worse.

Now, obviously, what was written here doesn't square with anyone's notion of compassion, so I have several questions about this e-mail. First, when and how did you become aware of this e-mail?

Mr. KAZARIAN. I became aware of it in gathering documents that we'd been asked to gather in response to what was a collaborative dialog we were trying to engage in with the attorney general's of-

fice. She'd asked for us to voluntarily produce some documents, and we were in that process.

Senator FRANKEN. OK. Well, if you really didn't get it until then, what did Accretive do to make sure that its employees were following its policies about communicating with patients?

Mr. KAZARIAN. First let me deal with one issue with respect to that e-mail and that associate. That language, that attitude does not square with our values, it is not consistent with our values, and that employee was terminated within 24 hours of us discovering that e-mail. So let me just, for everybody here, make it clear that is not who we are and that's not what we do.

What do we do to make sure to detect somebody like that? We have a—all of our collectors, we do a quality scoring of two calls every day that we listen to, and not just for compliance with law but for tone, for conduct, for professionalism. If an associate does not reflect our company's values, they will not work in our call center. That's how we listen for it, we troll for it.

All of our calls are digitally recorded. A second feedback loop is that if there's ever a patient complaint—it may come to the hospital, it may come to the Better Business Bureau, it may come from any source—if there's ever a patient complaint, we can listen to that call. It's digitally recorded, and we can determine whether or not they've acted with the care and compassion we expect.

Senator FRANKEN. So I take it that you had listened twice a day to this employee?

Mr. KAZARIAN. We'd listened twice a day to this employee. That tone and attitude hadn't been reflected. Then we took it a step further, Senator, and after we discovered this e-mail I asked our internal audit team to listen to another large group of calls for that employee to make sure that that terrible, offensive attitude hadn't crept into his exchange with patients on the phone, with the idea that if there was anybody that I needed to affirmatively reach out to as an officer of our company, I wanted to do that.

Senator FRANKEN. Doesn't an e-mail like this make you concerned about the culture in the call center? I mean, if an employee works in a setting where he thinks it's OK to send an e-mail like this to his co-workers, doesn't that kind of mean you have a real problem on your hands?

Mr. KAZARIAN. It could, and we looked very closely at that issue. What I was somewhat comforted by was that the employee who received the e-mail, you could tell by the response, was taken aback and wasn't engaging. It wasn't as if this was an exchange. It was, in fact—you could see in the tone somebody who didn't want to engage in this exchange.

We spend a lot of time at that call center. We have records we've shared with the Department of Commerce that indicate that callers and collectors that don't reflect our values can no longer stay with our company, and we'll keep working at that every day. We listen to those calls and we believe in our people.

Senator FRANKEN. Mr. Kazarian, it seems like Accretive often tries to pass blame off to Fairview. For example, in your written testimony you say that Accretive, "did not control Fairview or its employees," and you say similar things throughout your response to my letter, things that would lead most readers to believe that

Accretive did not have full responsibility for Fairview's revenue cycle.

But in reality, isn't it the case that Accretive did assume full responsibility for the management and cost of Fairview's cycle, revenue cycle?

Mr. KAZARIAN. Senator, we work in our work in a partnership model. At the end of the day, both practically and contractually, if there is any disagreement with any aspect of the revenue cycle work, the final authority sits with Fairview.

Now, having said that, I'm concerned if we've left you with that impression. We viewed our work with Fairview as collaborative. We saw it as a shared set of responsibilities. I think what we were trying to simply assure people is that in doing that practical work together every day, we are guided by Fairview's values, and if at any point in time there is an inconsistency between Fairview's value and a particular practice we might be recommending, Fairview's policy and Fairview's values will dictate what we do.

Senator FRANKEN. It just seems that time and time again, both in your written testimony and in your letter to me, that you kind of pass off responsibility to Fairview employees and that you don't take full responsibility for Fairview's revenue cycle, and that's concerning to me because Accretive has said in its SEC filings, in no uncertain terms, that Accretive, "assumes full responsibility for the management and cost of a customer's revenue cycle." Accretive says that it has, "the right to control and direct hospital staffs." It says that, "we directly manage our customers' employees engaged in revenue cycle activities." It even says you can fire the employees. It says this in your SEC filing.

It seems to me that Accretive is saying one thing in the SEC filings, that it does assume full responsibility, and that Accretive is saying pretty much the opposite thing in the documents that I got from you and in your written testimony today, that Fairview is responsible, and I just don't get it.

Mr. KAZARIAN. Senator, at Fairview, as I've said, Fairview wrote these partnership principles into our agreement. We honored them. We were happy to provide for them. There is language that says we have direct financial responsibility, and that is the case. It is the case that if the cost of providing revenue cycle services to Fairview rose beyond what they had been previously, Accretive Health was fully responsible for those costs.

Senator FRANKEN. Well, it's not just—I'm sorry to interrupt you there. It says in the filing "assumes full responsibility for the management," not just the cost.

Mr. KAZARIAN. And the only way I can reconcile that, Senator, is the filings are written in a general template form. They speak to a broad array of agreements. We have 26 agreements that are carefully negotiated over a period of time, and different clients have different objectives in terms of how they want our revenue cycle services to be governed in their agreement.

The best way I can reconcile what you read in our agreement with Fairview and what you read there is that it would seem to me the SEC filing is written more broadly, and that in the Fairview agreement our specific relationship with respect to Fairview is set out there.

Senator FRANKEN. OK. I would just remind you that you're a public company. The SEC filings are there for a reason, so that investors who are investing in Accretive can know what rules it's operating under, and they seem greatly at odds with what happened, with what you wrote to me in response to my questions when I asked, "Did Accretive employees do this?" "No, it was Fairview, et cetera." So let's move on.

In your letter to me, you say that financial counseling was optional for patients. I take that to mean that the patient could choose whether or not to have a conversation with a financial counselor. Is that right?

Mr. KAZARIAN. Correct.

Senator FRANKEN. But the script Accretive gave to employees to use when collecting payment made it look like those conversations were anything but optional. For example, one script teaches employees how to overcome objections from patients. So my question is how are patients supposed to know that these conversations were optional if nobody indicated in any way that they were optional?

Mr. KAZARIAN. I don't know the specific scripting that you're referring to, and there's a lot of scripting in different scenarios. But what I would say to you is that at the top of every one of our scripts around patient care is a bold legend in red at Fairview that says not only are patients never to be denied service for non-payment, they're never to be given the impression that service would be denied for non-payment. The role of these conversations is to help patients find a way to resolve their contractual obligations, but more importantly to educate them about these responsibilities. The information below is to be understood only in that context.

So, Senator, again, I said in my opening statement we will strive to be better every day, but what we believed we communicated in our training is that balance of issues.

Senator FRANKEN. I understand that that disclaimer was there, or you say it was there. The scripts that I saw that were produced by the AG's office do not have any disclaimers to the patients. I mean, there was no way that the patients were told that the conversation was optional in the scripts.

So how do you explain that? I mean, in other words, it's one thing to put something instructing in red bold, OK, this is our policy, but then to give your employees a script that doesn't have a disclaimer saying, "by the way, you don't have to have this conversation with me right now"—how is a patient supposed to know that this is an optional conversation?

Mr. KAZARIAN. Senator, I think the patient should affirmatively be given that information, and I will look at our scripting and I will make sure that that affirmative language is explicit in multiple ways across the scripting. I take your point, which is that it is the absolute intent that these conversations are had at a time when patients are ready to receive them, and if we can make our scripts better, then we'll get at that work tomorrow.

Senator FRANKEN. OK. Thank you very much.

Mr. Kazarian, I'm concerned that Accretive's employees had access to more protected health information than they needed in order to perform their duties. In Accretive's response to my letter,

Accretive says they developed a software tool to restrict its employees' access to just a handful of data points. These included things like the patient's name and contact information, the person financially responsible for the patient's care, the date of service, and a general description of the diagnosis code. It seems to me that that would be all that Accretive employees would need in order to collect debts or do that part of the job.

But Accretive's response to my letter says that Accretive did not even begin to implement this software until 8 months into the contract with Fairview, that the tool was not even operational until February 2011, which was about a year into the contract, and even that some revenue cycle employees continued to have access to Fairview's complete patient files for a full year after that.

Now, that begs four questions. First, why did Accretive wait until 8 months into its contract to begin limiting its employees' access to protected health information?

Mr. KAZARIAN. That's perhaps a bit of a misperception. We had a comprehensive plan to assure that employees working with Fairview only had access to that health information minimally necessary to do their job. I believe that the portion of our response you're referring to relates to activities in the Kalamazoo collection center. The Kalamazoo collection center didn't start serving Fairview patients until, I believe, August or September 2010. So that was part of the lag.

And then you had a mechanism—you had to decide how you were going to have people access that information. Because the legacy system—I think it was called PADS—at Fairview didn't allow for the parsing of data as precisely as we would have wanted, we had to build a custom, if you will, frame to receive that information. So that's the—without getting too into the weeds about the technology of it——

Senator FRANKEN. Sure.

Mr. KAZARIAN [continuing]. Senator, that's my understanding of that sequence.

Senator FRANKEN. Thank you. Well, then, why did some revenue cycle employees continue to have full access to patients' protected health information even after the restrictions were put in place?

Mr. KAZARIAN. So I'll bifurcate in that answer between people who were doing the work at Fairview on the claim denial and followup work, those people that were trying to overturn the denials on pre-existing conditions, those people who were trying to overcome the denials from a payer who said that the procedure lacked medical necessity.

I think it's clear that those individuals doing that work have a necessary reason for access to health information, because they use it to advocate to get the claim paid. So that's one group of people that had that access authorized by Fairview, and I don't think there's any disagreement that that particular access was appropriate.

In the call center, the approach that was taken was that patients who were calling and wanted more information about their case—I don't believe this charge or I wasn't at the facility on that day, or I thought it was already paid—there's two ways to approach that. One is to push the patient back to the hospital. "I'm sorry,

you'll have to followup directly with the hospital." Working with Fairview, we made the judgment that it would be appropriate to have two or three managers in the Kalamazoo call center with discrete access so that they could handle that escalated patient question and be more responsive.

You've asked about things we can think about in the future, and there's an open question as to whether having that escalation, the information necessary to handle that patient query is appropriate. It's permitted today, and that's the discrete purpose for which that would have been used.

Senator FRANKEN. OK. It doesn't seem like it's actually necessary if all that they're disputing is when the procedure was done and what it was. That is the discrete information, the minimum necessary information that anyone would need, and I don't understand why they would need access to all their health care information prior to that. I don't quite understand the response.

But related to that, do you believe that Accretive complied with HIPAA's minimum necessary requirement which says that covered entities have to restrict their employees' access to protected health information to only that which is needed for the employees to perform their job?

Mr. KAZARIAN. Yes, Senator, I do. We had very clear procedures and authorization mechanisms to make sure that if our employees were being provided access to patient health information, it was that amount minimally necessary to do their work.

Senator FRANKEN. OK. Matthew Doyle was a revenue cycle employee, and an unencrypted laptop containing sensitive information about 23,000 Minnesota patients was stolen from his car. And I don't understand why Mr. Doyle had all that information. The law says that Accretive may give its employees, and you just said it does, only the minimum amount of data necessary for them to do their jobs.

Why did Mr. Doyle, a revenue cycle employee, have all these data?

Mr. KAZARIAN. There were two discrete sets of information that Mr. Doyle had at the time that his laptop was stolen from his vehicle. The first was the information relative to the work he was doing in claims, claim followup, disability applications and processing, and the nature of that work in the revenue cycle.

The other was a discrete data file that he had in connection with his work coming up to speed in our area, in our work in the Quality and Total Cost of Care Program.

Senator FRANKEN. He didn't work in that, though, did he?

Mr. KAZARIAN. No, he did not, sir.

Senator FRANKEN. So he would only need that information if he did work in that. I mean, he was in revenue cycle, and you said in your letter back to me for my questions, you said that you gave him that material because he was interested in learning about the QTCC model that you do, but he wasn't an employee for QTCC. I mean, he wasn't—knowing this information isn't required unless you actually have that job. And here, this information was left in a laptop in plain view, and there was a smash and grab as you refer to it or as it's been referred to, at Seven Corners. He was not a QTCC employee. He was a revenue cycle employee.

OK, let me move on to the next question.

Accretive says it has a policy of encrypting all laptops, and that seems like it's a common-sense policy to me. Right now the law does not expressly require encryption of all protected health information that is contained on laptops and other portable media that are vulnerable to theft. For example, in 2011 you had nine laptops stolen.

Do you think the law should be updated to require that practice? It is, after all, a practice that Accretive says it has in place now.

Mr. KAZARIAN. I think that that's an appropriate change to consider. I would tell you that one of the things that drives people in the health care services arena to that standard is that when you apply encryption and you do it, you fit within the safe harbor of the high-tech act under HIPAA. So I'll leave it to you and your colleagues to decide whether it sits better sort of with that regulatory incentive rather than as a matter of law. But one way or another, it is an important standard to drive anybody that is receiving this information to.

Senator FRANKEN. Thank you, Mr. Kazarian.

Mr. Kazarian, the attorney general alleges that patients were charged for the predicted patient share of the service, but that these predictions sometimes were inaccurate. The attorney general also alleges that Accretive delayed refunding over-payments. In one of the exhibits I saw, an excerpt from a registration handbook, Accretive instructs employees not to notify patients when they're talking to them that they have a credit on their account. Instead, it tells them to say nothing about the credit.

Why would Accretive instruct financial counselors not to let the patients know if they had credits on their accounts?

Mr. KAZARIAN. Two answers to that, Senator. First, what ought to be happening is that any patient balance, any patient refund that's due ought to be remitted and transferred in a check within 30 days of its determination. So the process ought to be that if there's any patient refund due to a patient, that patient ought to receive that patient refund within 30 days.

The reason you wouldn't engage in that at the time of service is because you would have to coordinate those two processes, and there are times when that identification of a possible balance isn't an actual balance. So we'd be passing paper back and forth.

We found if you focus your energy on getting payments, refunds that are due, and putting that check in the mail, it's the most straightforward way to make sure that the patient knows you refunded that particular amount without the confusion in an already confusing environment.

Senator FRANKEN. If they hadn't received a refund after 30 days, would you then tell them?

Mr. KAZARIAN. That's a—let me take a minute to think about that. I think it's a good idea.

Senator FRANKEN. Well, I'm afraid you're going to have to think about that a little later because we've run out of time for this panel. But I want to thank you, Mr. Kazarian and Mr. Mooty, for your testimony and for coming today and answering questions. Thank you very much.

I now call the next panel.

Thank you.

Mr. KAZARIAN. Thank you for your interest, Senator.

Senator FRANKEN. Thank you, gentlemen.

Now I'd like to introduce our third panel of witnesses, Tom Fuller from New Brighton, and Deb Waldin from Edina. Both Mr. Fuller and Ms. Waldin are former Fairview patients.

Ms. Waldin and Mr. Fuller, thank you so much for participating in this hearing and for sharing your stories. I know that it is not necessarily an easy thing to do.

My main goal here is to figure out whether existing law is adequate to protect Minnesotans like you when you go to the hospital. I also have a lot of questions about the evidence. That's why I asked Accretive and Fairview and the attorney general so many questions about the exhibits, the reports, and the legal filings.

But it's really important that we not lose sight of the human element of this, so I'd like to hear about your experiences with Accretive and Fairview. So I'd just like to ask you some questions.

Ms. Waldin, I'll start with you. I understand that you visited Fairview's emergency room in July 2011. Why did you go to the emergency room that day?

DEB WALDIN, FORMER FAIRVIEW PATIENT, EDINA, MN

I started experiencing some pain in my side that within an hour just went off the charts with pain. So I had a friend take me to the emergency room at Fairview Southdale. She dropped me off, and I stood in line waiting for triage. I was in so much pain that I marched to the front of the line and said I need help here, I need some help right now.

And he got a wheelchair, he put me in a wheelchair to the side, and I waited there for maybe 10 minutes. And then someone came and took me into the room in the ER. I was put on a gurney. By that time I was just in debilitating pain. I was in a little ball in a fetal position wishing I could die. This ultimately ended up being a kidney stone, which if anyone has experienced that, is terrible pain.

Senator FRANKEN. When you say you're in pain, doctors sometimes use a scale of 1 to 10. On a scale of 1 to 10, what were you experiencing?

Ms. WALDIN. I wouldn't be exaggerating if I said a 12.

Senator FRANKEN. OK.

Ms. WALDIN. It was bad.

Senator FRANKEN. Now, had you been given any pain medications?

Ms. WALDIN. No.

Senator FRANKEN. Anything to relieve the pain before you were approached by a billing employee?

Ms. WALDIN. No. They started me on a morphine drip afterwards, but I had not seen a doctor yet or had any kind of pain meds.

Senator FRANKEN. OK. So you're writhing in pain on the gurney, and you're approached by a financial counselor. Was anyone with you when you were asked for payment, or were you alone?

Ms. WALDIN. No, I was alone.

Senator FRANKEN. How did you feel when the man came to your cot and asked for the payment? Did you feel vulnerable? Did you feel scared? How did you feel?

Ms. WALDIN. Well, yes. I saw out of the corner of my eye, I saw this little guy wheeling a podium with maybe a computer or something on it. I wasn't sure. And I was just having such pain, it was hard to process what he was saying, but I do recall he said I needed to pay him between $700 and $800, and I think it was like $750 or something. And I couldn't believe he was asking me this at the foot of my bed as I'm laying there, and I said I have insurance, I don't know what you're talking about.

And to be clear, I didn't have any debt with Fairview. I didn't owe them any money. I had no debt with them. And he was asking for this money right then as I'm laying there, and I just ultimately told him to get out of the room and go away, and he did.

Senator FRANKEN. OK. Now, as best you can recall, understanding you were in a great deal of pain, had you been seen by a doctor at that point?

Ms. WALDIN. I don't believe I had been.

Senator FRANKEN. OK.

Ms. WALDIN. It seemed like a long time that I was waiting for a doctor. But a long time when you're in that kind of pain may not be that long. I'm not sure.

Senator FRANKEN. Did you have medical insurance?

Ms. WALDIN. Absolutely, yes.

Senator FRANKEN. Would you have paid your bill even if you had not been approached in this vulnerable state?

Ms. WALDIN. Oh, I did pay my bill. Yes.

Senator FRANKEN. OK, you did pay it when you were back at home.

Ms. WALDIN. Yes, yes.

Senator FRANKEN. Do you think there's a better way to collect payment from patients than the way you were treated in the hospital? In other words, do you think trying to collect from patients while they're in pain in the emergency room is a bad policy?

Ms. WALDIN. Yes, I think it's a very bad policy.

Senator FRANKEN. Did you complain to anybody about the way you were treated?

Ms. WALDIN. Yes, I did. A couple of days later I called Fairview and talked to maybe some patient representative. I'm not sure who it was. And she didn't really have an answer for me. It sounded like she didn't know what I was saying almost, and I didn't get any—nothing happened from that. She just kind of poo-pooed it. And then Fairview sends out a survey, at least to me, maybe a week or two later to fill out your experience, and without a doubt the doctors and nurses were fabulous, and I want to make that really clear, that they were wonderful to me.

Senator FRANKEN. So you were satisfied with the care that you got from the doctors and nurses?

Ms. WALDIN. Oh, absolutely. Once I got that, absolutely. But I did write on that survey that this man had come in and approached me under my circumstances that I thought was just terrible.

Senator FRANKEN. I think that is very important, that you were very satisfied with the doctors and nurses at Fairview.

Ms. WALDIN. Absolutely. I think they're getting a bad rap, the whole Fairview is. The doctors and nurses were great.

Senator FRANKEN. Thank you. Thank you very much, Ms. Waldin.

Mr. Fuller, I'd like to ask you similar questions. Can you tell us about what happened when you visited Fairview Hospital in November 2011?

JOHN THOMAS "TOM" FULLER, FORMER FAIRVIEW PATIENT, NEW BRIGHTON, MN

Mr. FULLER. I had been going to the hospital there for 3 years, never any problems. I had a lung transplant in January 2011, and I had many complications throughout the year. When I went in for this procedure in November 2011, I still really wasn't totally with it, and my wife had been taking care of all the financial things, and she was there every time I was at the hospital.

On that day, I checked in at the front desk, and they always do all the check-in right there, put the little bracelet on your wrist and sign the waiver. But this particular time the person at the front desk said that so-and-so will be checking you in. I thought it was awful weird because for 3 years nothing like that had ever happened.

As I was being guided back down a hallway, my wife got up to join me, as she always has, and the nurse says, "No, no, you'll be OK, you don't need to be in there." And they took me into a small little office, about 10 square feet it seemed like. The gentleman checked me in as usual, printed off some papers, signed the waiver forms that are protocol, and then the last thing he did is he put another piece of paper in front of me which was a bill for $500-and-some.

I said, what's this? He said, well, you need to pay up on your outstanding balance. And I said, outstanding balance? I said we paid over $10,000 in this year, and we had gotten a bill the past week, and our balance due was $380. And we were unaware of any past due amount, and he—I just felt badgered and I just got extremely upset.

Finally he said, well, I'll take a check or a credit card, however you want to pay it, and I said I have no intention of paying you anything right now, I'm going in for a procedure.

On the bill he wrote Accretive's name and a number and another name for a person to talk to. I went out of the room and everybody in that waiting room knew what happened in that room. I was shaking. I was furious. Just nobody at that point should be going through that. My wife, she called the guy on the paper. We got home and she called him back, and they went through it, and he kind of agreed that one of the charges on there wasn't correct. But I finished my procedure and went home.

Senator FRANKEN. Now, you had undergone a lung transplant.

Mr. FULLER. A lung transplant, yes.

Senator FRANKEN. So you were vulnerable. I mean, you were weak at this point, right?

Mr. FULLER. I had many side reactions all year long from the medications.

Senator FRANKEN. And I understand they knew about your condition, obviously, from your medical records, so they should have been aware that you were in a compromised state.

Mr. FULLER. Oh, definitely.

Senator FRANKEN. I understand you had visited Fairview many times before, but about how many times?

Mr. FULLER. Starting October 2008, probably leading up to the transplant, I'd bet you 50, 60 times a year.

Senator FRANKEN. Had anyone ever demanded that you provide a credit card to pay a bill when you came for a scheduled procedure before this visit?

Mr. FULLER. Never.

Senator FRANKEN. No.

Mr. FULLER. We had payment plans, and we stayed on top of it. We were never late with a payment. We made a payment plan for a certain amount that in a bad month, if we couldn't pay the whole bill off, we had a cushion to fall back on. But we paid the bills every month, and to our knowledge we were satisfied. We only owed $380.

Senator FRANKEN. Now, I understand you had asked for your wife to come with you. Why was that?

Mr. FULLER. Because of the state of mind of where I was at the whole year, I needed a second set of ears with me at most times.

And they said that she didn't need to come in.

Senator FRANKEN. OK. How did you feel during this, when you were taken into this back room and pressed for a payment? Did you feel like you were being shaken down?

Mr. FULLER. I was outraged. I was shaking. I was just totally upset.

Senator FRANKEN. Did you feel like the conversation with the financial counselor was optional? In other words, did he tell you that you didn't have to have that conversation?

Mr. FULLER. No. I was told to come back to this back room, and he went through the normal spiel of checking in, and without losing a breath he put the bill down and he started asking me for money.

Senator FRANKEN. Setting aside your experience with debt collections, how was your experience with Fairview? Were you satisfied with the care that you received from the nurses and from the doctors?

Mr. FULLER. I can't express enough the care that I received there, doctors and nurses, coordinators, food service people, housekeeping. I spent many weeks off and on in the hospital, and that's what really bothers me, because it's a great facility. The people there are fantastic, caring, and the people that had to talk to you, like on the phone, you knew that they didn't want to be saying what they were saying.

Senator FRANKEN. How are you doing now? How are you feeling? I mean, this lung transplant, I can't imagine. You were going in for the replacement of a trachea tube or something like that that day?

Mr. FULLER. No, it was a feeding tube.

Senator FRANKEN. A feeding tube. I'm sorry, a feeding tube. Of course.

Mr. FULLER. Not a trache at all.

Senator FRANKEN. Yes. And how are you doing?

Mr. FULLER. I'm doing better.

Senator FRANKEN. Good, good.

Well, thank you both very much, Mr. Fuller and Ms. Waldin. Thank you for being here today and being willing to testify. You are now excused.

Ms. WALDIN. Thank you, Senator.

Mr. FULLER. Thank you.

Senator FRANKEN. Would the last panel come forward, please?

I'd like to introduce our fourth and last panel of witnesses.

Jean Ross has been a registered bedside nurse for nearly 40 years and is a member of the Minnesota Nurses Association. She was a nurse at Fairview Health Services and now is co-president of National Nurses United.

Michele Goodwin is the Everett Fraser Professor in Law at the University of Minnesota and holds joint appointments at the University of Minnesota Medical School and the University of Minnesota School of Public Health. Professor Goodwin is a prolific scholar who focuses on the role of law in the promotion and regulation of medicine, science, and biotechnology.

And finally, Jessica Curtis is the director of Community Catalyst's Hospital Accountability Project, where she advises consumer advocates and policymakers on hospital financial assistance and community benefits programs. Prior to joining Community Catalyst, Ms. Curtis provided legal services to low-income elders at Boston College's Legal Assistance Bureau.

Thank you, Ms. Ross, Professor Goodwin, and Ms. Curtis, for joining us.

Ms. Ross, please go ahead with your testimony, and please do keep it to 5 minutes. Thank you.

STATEMENT OF JEAN ROSS, RN, FORMER NURSE AT FAIRVIEW; CO-PRESIDENT, NATIONAL NURSES ASSOCIATION; MEMBER, MINNESOTA NURSES ASSOCIATION, ST. PAUL, MN

Ms. ROSS. Senator Franken, thank you for holding this important hearing on behalf of patients, family members, and nurses at Fairview and all over the country. My name is Jean Ross, and I am a registered nurse.

In December 2009, I was elected co-president of National Nurses United and currently still hold this position. Previously I worked as an RN for Fairview Southdale Hospital in Edina, MN for over 35 years. The following is my personal account of two different incidents involving the Fairview healthcare system in the past 2 years that affected my family and me.

In 2010, my infant grandchild was very ill over one weekend. On a Friday and then again on Saturday night, I accompanied my daughter and the baby for several trips to the emergency room. This was at Fairview Ridges Hospital in Burnsville, where he was eventually diagnosed with encephalitis or meningitis and was then transferred to Minneapolis Children's Hospital.

Our time at Ridges was made especially jarring, however, by the actions of some ancillary personnel who had nothing to do with the care of our young family member. My daughter was extremely worried. She had many questions, but she was holding up pretty well, until I left to use the restroom.

When I returned, she was holding the baby and sobbing. I assumed she must have received some very bad news about the baby's condition. Instead, I learned that while I, the nurse and doctor were out of the room, a woman had come in and asked if my daughter was willing to pay all or any part of her bill now. My daughter told her, no, she could not.

As background, my daughter and her husband are among many families hit hard with medical bills and changes to insurance coverage. She certainly did not need reminders of her financial position while under the stress of worrying about the condition of her youngest child.

Now fast-forward to February of this year. My same daughter has just delivered her third child at Fairview Ridges. Within 24 hours, a Fairview representative visits in her room with the goal to extract some or all of the payment for the bill. According to my daughter, this woman was at least apologetic. She even confessed "this is the least favorite part of my job."

Senator Franken, I spent much of my time at Fairview Southdale working in the ER. While there, I witnessed no such behavior. This kind of—I call it ruthless corporate behavior, just wouldn't have been allowed.

A nurse's main focus is to advocate for patients and families. We urge patients to put other worries aside and to concentrate exclusively on healing. They certainly don't need the added burden of being pressed for payment while they are being treated. Every nurse wants to be proud of the work we do. We expect policies that allow us to do our job properly. We want to be able to speak well of the place that employs us.

Programs or policies that encourage or require bill collection while a patient is being treated are, I believe, unethical and don't belong in any health care setting. It does not reflect well on any institution, and I'm very disappointed in the system that employed me for so many years.

I am even more aggravated at an overall health care system that doesn't allow universal access to all who are vulnerable and which drives providers to this misguided and disgraceful behavior. This is exactly why our trusted and proven system of Medicare should be expanded so every man, woman and child could be included in Medicare for all.

I thank you for your time.

[The prepared statement of Ms. Ross follows:]

PREPARED STATEMENT OF JEAN ROSS, RN

SENATOR FRANKEN, MEMBERS OF THIS HEARING COMMITTEE: Thank you for holding this important hearing, on behalf of patients, family members and nurses at Fairview and all over the country.

My name is Jean Ross, and I am a Registered Nurse. In December 2009 I was elected co-president of National Nurses United, and currently still hold the position. Previously, I worked as an RN for Fairview Southdale Hospital in Edina, MN for over 35 years.

The following is my personal account of two different incidents involving the Fairview health care system in the past 2 years that affected my family and me.

In 2010, my infant grandchild was very ill over one weekend. On a Friday and then again on Saturday night, I accompanied my daughter and the baby for separate trips to the Emergency Room at Fairview Ridges Hospital in Burnsville, where he was eventually diagnosed with encephalitis (or meningitis) and was then transferred to Minneapolis Children's Hospital.

Our time at Ridges was made especially jarring however, by the actions of ancillary personnel who had nothing to do with the care of our young family member.

My daughter was extremely worried and had many questions but was holding up well—until I left to use the rest room. When I returned she was holding the baby and sobbing. I assumed she must have received some bad news about the baby's condition. Instead, I learned that while I, the nurse and doctor were out of the room, a woman had come in and asked if my daughter was willing to pay all or any part of her bill now. My daughter told her no, she could not. As background, my daughter and her husband are among many families hit hard with medical bills and changes to insurance coverage. She certainly did not need reminders of her financial position while under the stress of worrying about the condition of her youngest child.

Now fast forward to February of this year. My same daughter has just delivered her third child at Fairview Ridges. Within 24 hours, a Fairview representative visits my daughter's room with a goal to extract "some or all" of the payment for the bill. According to my daughter, this woman was at least apologetic, even confessing "this was the least favorite part of her job."

Senator Franken, I spent much of my time at Fairview Southdale working in the ER. While there I witnessed no such behavior. This kind of ruthless, corporate behavior simply would not have been allowed. Nurses' main focus is to advocate for patients and families. We urge patients to put other worries aside and to concentrate exclusively on healing. They certainly do not need the added burden of being pressed for payment while they are being treated.

Every nurse wants to be proud of the work we do, and we expect policies that allow us to do our job properly. We want to be able to speak well of the place that employs us.

Programs or policies that encourage or require bill collection while a patient is being treated are, I believe, unethical and do not belong in any health care setting. It does not reflect well on any institution, and I am very disappointed in the system that employed me for so many years. I am even more aggravated at an overall health care system that does not allow universal access to all who are vulnerable, and that drives providers to this misguided and disgraceful behavior.

I thank you all for your time.

Senator FRANKEN. Thank you very much. We'll handle that last part in a different hearing, I think.

[Laughter.]

Ms. ROSS. Just a hint.

Senator FRANKEN. Professor Goodwin, your testimony, please.

STATEMENT OF MICHELE GOODWIN, EVERETT FRASER PROFESSOR IN LAW, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MN

Ms. GOODWIN. My testimony today covers two components. Hopefully we'll get to the second. The first is to explain why, as a matter of law and policy, Members of Congress should be concerned about contemporary debt collection practices at some U.S. hospitals; and the second is to share with you a set of recommendations that can help move forward your inquiry beyond investigation, the investigation stage, to exploring meaningful options to improve patient access to health care, reduce if not eliminate nefarious collection practices, and shore up a commitment to patient privacy.

And I do commend you, Senator Franken, for chairing this hearing and for moving forward in your efforts regarding consumer protection against overreaching debt collection practices.

The allegations outlined by Ms. Swanson's office are worthy of your sustained attention because they outline a disconcerting pattern of coercion, exploitation, fraud, near extortion, quid pro quo emergency medicine, indifference to patient privacy, and abuse of patients. These activities were allegedly carried out under contractual relationships that incentivized such conduct. These types of practices are not protected by law. Indeed, these practices are an egregious disregard of laws championed by Congress.

Specifically, the Emergency Medical Treatment and Active Labor Act, EMTALA; the Fair Debt Collection Practices Act, the FDCPA; and the Health Insurance and Portability Accountability Act, otherwise known as HIPAA, are intended to protect patients when they are at their most vulnerable. These laws are intended to ensure patient privacy, access to medicine during emergencies, as well as to provide not a mild but a very strong check against fraudulent overreaching and duress-inducing debt collection practices.

The FDCPA was enacted in 1978 specifically to guard against the type of activities that have been described today. When Congress enacted this law, the following was noted in section 802:

> "There is an abundant evidence of the use of abusive, deceptive, and unfair debt collection practices by many debt collectors. Abusive debt collection practices contribute to a number of personal bankruptcies, to marital instability, to the loss of jobs, and to invasion of individual privacy."

Nearly 35 years later, this law is treated as a relic rather than a living, robust feature of our Nation's promise to its consumers. The FDCPA specifically prohibits the types of practices that have been alleged by the attorney general's office.

If the findings are correct from the attorney general's office, we have a very clear violation of Federal law. I'll point you to Section 805 of the FDCPA. In sub-section A it states that that subsection prohibits collection agents from communicating with any consumer at, "any unusual time or place, or time or place known or which should be known to be inconvenient to the consumer." Certainly, emergency rooms with people with feeding tubes in and the other kinds of situations that we've heard about today are certainly inconvenient and not the appropriate time or place.

My submitted testimony goes further.

I would point you to the EMTALA. The Minnesota Attorney General's report outlined a range of nefarious practices, including hospitals embedding debt collectors among their staff, including in emergency rooms. If this is true, hospitals deploying such tactics may have violated EMTALA if the practices resulted in turning away patients in need of emergency care.

To explain, in 1986 Congress enacted EMTALA to ensure public access to emergency services regardless of the ability to pay. What we know is that the legacy that preceded EMTALA was one that was really quite a scar on our Nation's history. It included turning away pregnant women who gave birth on the side of roads. Sometimes people died. We know that there's been a history in this country where African-Americans have literally died on the steps of hospitals.

I would just simply close with also pointing out to you that what we've heard today, and certainly what has come through in your

line of questioning, shows a clear disregard for HIPAA as well, and patient privacy, being located on laptops that have been stolen and that were not to be privy to individuals who had clearly more patient information than they needed for their debt collection practices.

I have recommendations that are submitted as part of the written testimony.

[The prepared statement of Ms. Goodwin follows:]

PREPARED STATEMENT OF MICHELE GOODWIN

WHEN FEDERAL LAW IS UNDERMINED: THE CASE OF PATIENT HARASSMENT AT U.S. HOSPITALS

Chairman Harkin, Ranking Member Enzi, Senator Franken and members of the U.S. Senate HELP Committee, my name is Michele Goodwin. I am the Everett Fraser Professor of Law at the University of Minnesota, where I also hold joint faculty appointments at the Medical School and the School of Public Health. My prior credentials include the directorship of one of the Nation's top 10-ranked health law programs, as well as serving as the Chair of the American Association of Law School's Section on Health Care Law. My work has been reviewed in or featured by the New England Journal of Medicine, the Journal of the American Medical Association, and Nature, among numerous other periodicals. I speak with you today not only in my capacity as a law professor, but also as a trained bioethicist.

I come before you this morning to provide testimony about patients' access to care and privacy. Specifically, this testimony responds to the urgency of your hearing. That is, are Federal laws protecting patients? I commend your leadership for holding this very important hearing and accepting my testimony.

My talk today covers two major components. The first is to explain why, as a matter of law and policy, Members of Congress should be concerned about contemporary debt collection practices at some U.S. hospitals. The second is to share with you a set of recommendations that can help to move your inquiry beyond the investigation stage to the exploration of meaningful options to improve patient access to health care, reduce if not eliminate nefarious collection practices, and shore up a commitment to patient privacy. I commend Senator Franken's efforts to provide more consumer protections against overreaching collection practices, including the increased use of warrants and the seizure of bank accounts to collect debt.

During the past several months, the Minnesota attorney general, Lori Swanson, has investigated Accretive Health, Inc.'s debt collection practices and their contractual relationship with Fairview hospitals, located in Minnesota. From that investigation, disturbing allegations have emerged that bring into question the effectiveness of current Federal laws to secure patient privacy and access to care. To be clear, the use of debt collection organizations to recoup hospital expenses is not a new phenomenon, nor does that on its face violate Federal law. Hospitals by law may utilize debt collection organizations to recover overdue, unpaid fees. For hospitals, if they are to collect on patient debt (just over $39 billion in uncompensated care in 2010), determining what information can reasonably be shared with debt collection agencies is a very important issue.

However, the allegations outlined by Ms. Swanson's office are worthy of your sustained attention, because they outline a disconcerting pattern of coercion, exploitation, fraud, near-extortion, quid pro quo emergency medicine, indifference to patient privacy, and abuse of patients. These activities were carried out under a contractual relationship that incentivized such conduct. These practices are not protected by law. Indeed, these practices are an egregious disregard of laws championed by Congress.

The tactics that you have heard about today and some that are described in this testimony, may be unscrupulous, but are they illegal? If there is some illegal practice occurring, what is it? Are these tactics (stalking at hospitals or embedding as medical personnel) permissible if a patient refuses to pay medical bills or simply lacks the financial resources to do so? In the Minnesota case, several Federal laws appear to have been violated.

Specifically, the Emergency Medical Treatment and Active Labor Act (EMTALA), the Fair Debt Collection Practices Act (FDCPA), and the Health Insurance and Portability Accountability Act (HIPAA), are intended to protect patients when they are most vulnerable. These laws are intended to ensure patient privacy, access to medi-

cine during emergencies, as well as to provide not a mild, but a very strong check against fraudulent, overreaching, and duress-inducing debt collection practices.

The FDCPA,[1] enacted in 1978, specifically guards against the latter activities. When Congress enacted this law, the following was noted in § 802. Congressional findings point out:

(a) There is abundant evidence of the use of abusive, deceptive, and unfair debt collection practices by many debt collectors. Abusive debt collection practices contribute to the number of personal bankruptcies, to marital instability, to the loss of jobs, and to invasions of individual privacy.

(b) Existing laws and procedures for redressing these injuries are inadequate to protect consumers.

(c) Means other than misrepresentation or other abusive debt collection practices are available for the effective collection of debts.

(d) Abusive debt collection practices are carried on to a substantial extent in interstate commerce and through means and instrumentalities of such commerce. Even where abusive debt collection practices are purely intrastate in character, they nevertheless directly affect interstate commerce.

(e) It is the purpose of this title to eliminate abusive debt collection practices by debt collectors, to insure that those debt collectors who refrain from using abusive debt collection practices are not competitively disadvantaged, and to promote consistent State action to protect consumers against debt collection abuses.

Nearly 35 years later, this law is treated as a relic rather than a living robust feature of our Nation's promise to its consumers. The FDCPA specifically prohibits the type of practices that Ms. Swanson's investigation reveals to be common amongst Accretive employees. For example, the law prohibits misrepresentation and deceit. According to the attorney general's investigation, Accretive employees were embedded amongst Fairview hospital's staff. Accretive employees hid in hospital waiting rooms and even stalked patients in the convalescing rooms to collect payments before and after treatments. These bed-side practices highlight desperate hospital tactics to collect money and recoup losses. But, the tactics are particularly troubling because they occur when patients are most vulnerable: seeking emergency care for a range of conditions, which may be life-threatening. The cases highlighted by the attorney general's office detail clandestine debt collection schemes that not only misrepresent hospital staff, but likely produce a deterrent effect on individuals seeking treatment.

If these findings are correct, they reveal clear violations of Federal law. Federal law obligates collection agents to reveal their identity and the purpose(s) of their communication with consumers.

Accretive and Fairview hospital's failure to properly disclose collection agents' identities and the purposes of their communication with patients violates Federal law. I refer you to § 805 of the FDCPA, which specifically addresses communication in connection with debt collection.

Subsection (a) prohibits collection agents from communicating with any consumer "at any unusual time or place or a time or place known or which should be known to be inconvenient to the consumer." Interfering with patients' emergency care through a barrage of questions and attempts to exact moneys before treatment at hospitals indicates a pernicious pattern of violation that rises to the level of brazen disregard of Federal law. The purpose of the FDCPA was to shield consumers from the unfettered reaches of debt collection agents by limiting location, method, and hours by which consumers could be contacted. However, this type of debt collection practice—in person harassment at the point of service—exemplifies the worst type of patient-chasing.

Section 807, subsection (5), speaks to these concerns as it prohibits collection agencies from "threat[ening] to take any action that cannot legally be taken or that is not intended to be taken," which is important in this particular context as much of these activities are reported to have occurred during emergency visits to hospitals.

The Minnesota attorney general's report[2] outlined a range of nefarious practices,[3] including hospitals "embedding" debt collectors among their staff, including in emer-

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[1] See, *http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre27.pdf*.

[2] See, Compliance Review of Fairview Health Services' Management Contracts with Accretive Health, Inc. at *http://www.ag.state.mn.us/PDF/PressReleases/ComplianceReview/Volt.%201.pdf*. (Volumes 1–6 can be found here: *http://www.ag.state.mn.us/*)

[3] See, Compliance Review of Fairview Health Services' Management Contracts with Accretive Health, Inc Volume Two-Culture Wars at *http://www.ag.state.mn.us/PDF/PressReleases/ComplianceReview/Volt.%202.pdf*.

gency rooms. If this is true, hospitals deploying such tactics may have violated EMTALA if the practices resulted in turning away patients in need of emergency care. To explain, in 1986, Congress enacted EMTALA "to ensure public access to emergency services regardless of ability to pay." Specifically,

> Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.[4]

Indeed, the very purpose of this law is to ensure that patients in emergency situations are not turned away, sent off, or refused treatment. The legacy preceding EMTALA's enactment involved "patient dumping," a term used to describe the denial of emergency care to individuals because of their insurance status (or lack thereof), poverty, or even racial and gender status. Some patients died as a result of "dumping" or their conditions worsened. Quite relevantly, such decisions were neither medically nor ethically justifiable. Pregnant women were dumped if their pregnancies were perceived as complicated, often requiring them to deliver in compromised and unsanitary conditions, including in their cars while en route to other hospitals located miles away. This was particularly problematic in rural communities. Sick children without health insurance were dumped if their parents—working class Americans—lacked health coverage. And, years ago, black patients died on the steps of hospitals that refused to treat "colored" people. This is a shameful legacy, but EMTALA provided hope, backed by law for a new era. EMTALA was a bold congressional effort to ensure care for sick Americans and others when at their most vulnerable.

EMTALA was inspired by a noble, American vision. That is, Our commitment to patient access and the flourishing of human development cannot be subordinated or conditioned on money. The law specifies that hospitals may not start any payment processes or billing until after the patient has been stabilized to such a degree that working out billing will not detract from, interfere with, or compromise the patient's health care.

When collection agencies systemically and brazenly interfere with patients' efforts to seek and receive emergency care at hospitals, the law becomes more illusory than real. By this, I mean to impress upon you that the law must be more than what is scribed in order to effectuate real meaning and achieve congressional goals. Harassment at hospitals at the time of service, before service and after service symbolically and substantially interferes with and undermines the spirit of this legislation. EMTALA was not intended to provide a new opportunity for bill collection at the point of emergency care. Specifically, legislators sought to prohibit money chasing in exchange for medical care. The law does not tolerate a medical quid pro quo in this regard.

Just briefly, before outlining a few recommendations, I want to turn your attention to HIPAA,[5] a Federal law that protects patient privacy and restricts certain uses of patient information without their consent. Under HIPAA, hospitals are subject to the "Privacy Rule," which forbids data sharing or disclosures about "individuals' health information." Again, the attorney general's office found significant and systemic breaches of patient privacy. Among their findings were examples of collection agencies having direct access to full patient files, which include dates of birth, social security information, health information, and other sensitive data. When concerns were raised about these direct violations of Federal law, the concerns were dismissed. The immediate focus of this hearing relates to patient access and health, but an extended concern must include identity theft and data mining.

I urge you to evaluate these issues as matters of concern that extend beyond Minnesota.

PART II: RECOMMENDATIONS

How might we move forward? The problems outlined today concerns not only formal law, but also public policy and ethics. The laws highlighted in my testimony are likely regularly trespassed due to poor enforcement and accountability mechanisms at the local and Federal levels.

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[4] See, Emergency Medical Treatment & Labor Act (EMTALA), at *http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/*.

[5] See, *http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html*.

The important question here today, is what do we prioritize: patient health or corporate profit at all costs? That you sponsor this hearing is evidence of your aspiration that there must be dignity in the delivery of medicine.

As described above, debt collection harassment at hospitals is an illegal practice. However, the protections for patients are rather thin and there are no real disincentives to reduce such behavior. Hospitals have every incentive to engage in aggressive and sometimes illegal debt collection practices, because they desire to recoup losses, but also there are so very few disincentives. The damages awarded to aggrieved patients are minimal. Indeed, the potential recovery of $1,000 for a successful claim under the FDCPA is so minimal that patients may be less-inclined to pursue these matters because recovery is so limited.

There is a significant problem with proportionality given the significant trauma that a family or individual may endure from egregious debt collection practices and the revenue these industries generate. To better discourage unfair debt collection practices there are a few matters that should be considered.

First, aggrieved consumers deserve a recovery that is more than symbolic; $1,000 does not provide the type of award that meets inflation standards. Medical costs have skyrocketed since the enactment of the FDCPA. The maximum statutory damages reflect the original 1977 version of the law. Further, even though that penalty by current standards might be about $4,000, even that is not a sufficient remedy for the consumer, nor is it an adequate penalty for the debt collectors. A more reasonable cap is $15,000. This is not to suggest that all awards would be this amount, but it does provide room for the more egregious cases, an incentive for consumers to "inform" on companies, and a sufficient deterrent to firms that violate the law.

Second, the FDCPA seemingly gives an out to the agency/company that hires debt collectors who engage in "unfair" or egregious debt collection practices. Fining the medical groups and hospitals that knowingly contract with companies that break the law would be a means of joining the liability. Joint and vicarious liability is a well-established concept in tort law and it provides particular traction in these cases.

Third, introducing criminal sanctions in this domain is well worth considering. As described above, the incentives and disincentives are ill aligned in matters such as those under your review. In the worst case scenario, a company may be subject to a $1,000 penalty, which will be paid to an aggrieved consumer, but the punishment is symbolic and more illusory than real. Criminal sanctions are appropriate in instances where the proportion of harm is consistent with the level of breach. In other words, where the conduct could reasonably be understood to result in substantial humiliation, emotional distress, and reckless violation of Federal laws, a criminal sanction could be reasonable. There are two approaches you might consider: (a) every violation of the FDCPA might result in a fixed penalty payable to the State or Federal Government; (b) each penalty might incur a different level fine depending on the scope and nature of the violation. Here intent, the degree of harm, and prior infractions might be relevant.

Fourth, registration and de-licensure are worth considering. In other words, the threat of losing the privilege to do business in a State should be considered to address repeat offenders. In thinking about creating new consumer protection norms, new norms must be fostered.

Fifth, when considering how these matters should be addressed on the front end, I urge you to evaluate hospital information-sharing on the front end. There are problematic information asymmetries between patients and hospitals. For example, patients are expected (required) to disclose billing information, ranging from their places of employment, insurance, and contact information for themselves as well as close relatives. Historically, this has been perceived as important for the delivery of medicine. The testimony today and Ms. Swanson's investigation indicate that hospital information collection also has another purpose, including debt collection. Yet, hospitals do not provide clear, detailed information regarding their collection practices, who they use to collect the debts, how those practices may affect the patient, or how the patient's sensitive personal information may be shared with third party collection agents. This is an information gap that can be filled. It will empower patients and may help hospitals in building trust with their patients.

In closing, these issues are relatable to all Americans. Each of us has experienced the fear, anxiety, and concern for a loved one's health if not our own while at an emergency room. That should be the last place in which social goods are distributed based on status.

Thank you for providing me the opportunity to present this testimony. It is an honor to participate in this process and I look forward to your questions (*mgoodwin@umn.edu* © Michele Goodwin).

Senator FRANKEN. Yes, all the written testimony is part of the record.

Thank you, Professor Goodwin.

Ms. Curtis.

STATEMENT OF JESSICA L. CURTIS, J.D., DIRECTOR, HOSPITAL ACCOUNTABILITY PROJECT, COMMUNITY CATALYST, BOSTON, MA

Ms. CURTIS. Good morning, Senator Franken. I'm grateful for the opportunity to testify today. My name is Jessica Curtis, and I direct the Hospital Accountability Project at Community Catalyst for a national non-profit consumer advocacy organization that focuses on health issues. The project works with hospitals, community groups, and policymakers to improve access to care and protect patients to the greatest extent possible for medical debt arising from hospital bills. We track public policies and have developed standards and model legislation that hospitals and policymakers alike can use to make billing collections fair for patients.

I think it's worth noting that in 2011, one in five people in the United States reported that their family had difficulty paying a medical bill, and 1 in 10 reported having a medical bill that they could not pay at all. Insurance coverage alone is no protection against medical debt. About 76 percent of those with medical debt reported having had health insurance when they acquired it.

Today I hope to provide some context by looking at what makes medical debt unique, the role hospital billing and collections policies have played in its proliferation, and what can be done to address these problems.

First, medical debt can be distinguished from other types of consumer debt. As many have noted, with very few exceptions, patients attempting to access health care services do so out of medical necessity. Illness and injury are unpredictable and involuntary, and the stakes for patients are very high. Delaying care could result in disability or even death.

A patient seeking care in a hospital's emergency room is in no position to bargain for a better deal and in that sense starts from a very different place than a person walking into a big-box store to purchase a flat-screen television. Even with perfectly transparent prices, which we do not have in health care today, patients do not know in advance what their diagnosis and treatment options will be or whether complications, which are not always preventable, will occur.

The long-term effects of medical debt can be devastating. Over 60 percent of all bankruptcies can be traced back to medical debt or illness. Others have linked medical crises to home foreclosures. As family finances shrink, low- and middle-income families resort to using credit cards to pay down medical bills, but this strategy leaves them susceptible to high interest rates and lower credit scores. And medical debt has been shown to have a chilling effect on patients' willingness or perceived ability to seek care in a timely way. To keep costs down, the uninsured and underinsured forego care more frequently than people with better coverage.

So how do hospital billing and collections policies contribute to medical debt? First we have to recognize that there are good public

policy reasons to look to hospitals to promote care, their mission, tax status, public subsidies, social and corporate responsibility; and, quite simply, for America's 50 million uninsured, hospital charges are simply out of reach.

But too often, hospitals have been cited for aggressive billing and collection strategies, like failing to screen or notify patients about public programs or their own financial assistance policies before using more aggressive tactics to collect; deciding to offer financial assistance or payment plans based on a patient's propensity to pay rather than their ability to pay; using credit scores to determine a patient's access to lines of credit; placing liens on patient homes or garnishing wages; and over-charging the uninsured and under-insured for care.

These complaints are common, the impact is devastating, and quite frankly, we have been here before. In the early 2000s, backlash against aggressive collection tactics prompted hospital groups to issue voluntary billing and collection standards. Clearly, more is needed to protect patients from hospital bills they simply cannot pay.

So we recommend a three-pronged strategy that I'll just quickly cover. The first is we need to clarify the roles that hospitals have on billing and collection. And right now, there's a ready-made tool to protect patients as far as non-profit hospitals go. Section 9007 of the Affordable Care Act put limitations on what hospitals can do to collect on patient bills and the timing with which they have to inform patients about these options.

Second, we need to expand coverage to care.

And third, I do believe that we need to expand the debt collection protections that are available to patients.

Thank you.

[The prepared statement of Ms. Curtis follows:]

PREPARED STATEMENT OF JESSICA L. CURTIS, J.D.

Good morning, Chairman Harkin, Ranking Member Enzi, and distinguished Senators. I am grateful for the opportunity to testify before you today.

My name is Jessica Curtis. I direct the Hospital Accountability Project at Community Catalyst, a national non-profit consumer advocacy organization that has been giving consumers a voice in health and health care since 1997. My organization works to promote pragmatic, consumer-friendly solutions to the obstacles many low- and middle-income people face in staying healthy and accessing the care they need. Medical debt is one such obstacle, and we have been a leading consumer voice investigating its causes and pushing for rational policy solutions for many years.

Through the Hospital Accountability Project, we work with hospital leaders, community groups, public health organizations, and policymakers to improve access to care and protect patients to the greatest extent possible from medical debt arising from hospital bills. Out of this work, we have developed standards and model legislation that hospitals and policymakers can use to craft institutional and public policies, respectively, that make the billing and collections process fair, clear, and transparent for patients. We also track and inform developments in State and Federal policy related to hospital financial assistance, billing and collections.

My comments today will aim to provide some context for medical debt by answering: What is medical debt, and how is it unique? In what ways does it impact patients' access to care and financial well-being? Finally, what can be done to address these problems and protect families from its harmful effects?

INTRODUCTION

First, though, I'd like to start with a story. In April 2008, the *Wall Street Journal* drew national attention to the story of Texas resident Lisa Kelly, a former school bus driver whose battle with leukemia found her facing an unlikely adversary: the

business department of the M.D. Anderson Cancer Center, a non-profit hospital affiliated with the University of Texas and the country's premier specialty hospital for cancer treatment and research at the time.[1] When her doctor referred her to M.D. Anderson, Mrs. Kelly tried to schedule an appointment only to be told that the hospital did not accept her insurance.[2] From the hospital's perspective, she was uninsured and would have to present a certified check for $45,000 in order to make her initial appointment.[3] Mrs. Kelly managed to meet that deadline and see a hospital oncologist, who wanted to admit her immediately. But the hospital's business office told her that she would need to pay another $60,000 up front in order to be admitted, despite the fact that she and her husband were unable to meet that demand.[4]

When Lisa Kelly's story went public, it became clear that her experience was the result of a policy to demand up front payment from uninsured and underinsured patients implemented by M.D. Anderson's business office to reduce the hospital's unpaid patient bills, or bad debt.[5] The policy led to interruptions in Mrs. Kelly's care and severely impacted her family's long-term financial future. At the time of the article, the family was making monthly payments of $2,000 to M.D. Anderson in order to pay off the $145,000 they accrued in medical bills from Mrs. Kelly's treatment.[6]

What happened to Lisa Kelly—the discovery that the insurance policy she could afford was inadequate to cover the costs of her care; repeat encounters with a hospital business office demanding money she did not have; the crushing debt she acquired due to a diagnosis she could neither predict nor control—is part of a larger phenomenon that is being relived daily in hospitals and medical offices around the Nation. Similar stories have emerged from North Carolina to California. The question is, what can be done?

MEDICAL DEBT: A SPECIAL CASE

Medical debt is simply "money owed for any type of medical service or product" to a provider or third-party agent, such as a collection agency.[7] Medical debt arises when providers classify the money a patient owes for health care services as bad debt—that is, payment for services that a hospital expected to receive but was unable to collect.[8] As this definition suggests, classifying a patient's account as bad debt almost certainly means that the provider or its collection agency has pursued the bill through the collections process.

Medical debt is the outcome of a unique type of consumer transaction— Medical debt can be distinguished from other types of consumer debt in several ways. First, consider the circumstances under which it arises. With very few exceptions, patients—or, health care "consumers"—attempting to access health care services do so out of medical necessity. Illness and injury are unpredictable and involuntary. In addition, the stakes for patients are very high: the decision not to seek medical care due to lack of insurance or potential cost could result in disability or death. A patient seeking care in a hospital's emergency room is in no position to bargain for a better deal, and in that sense starts from a very different place than a person walking into a big-box store to purchase a flat-screen TV. Second, patients have no way of knowing the cost of treatment in advance, making medical care—especially hospital care—very different from normal consumer transactions. Even with perfectly transparent prices, patients do not know in advance what their diagnosis and treatment options will entail, or whether complications (which are not always preventable) will occur.

Medical debt is a widespread problem—The number of Americans struggling to pay medical bills is startlingly high. In the first half of 2011, one in five people

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[1] Barbara Martinez, "Cash Before Chemo: Hospitals Get Tough," *The Wall Street Journal*, April 28, 2008, at A1. For M.D. Anderson Cancer Center's national ranking, see "America's Best Hospitals 2008," *U.S. News and World Report* (2008).

[2] Martinez, *supra* note 1.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] Statement of Mark Rukavina before the U.S. House of Representatives Committee on Financial Services, Subcommittee on Financial Institutions and Consumer Credit, on "Use of Credit Information Beyond Lending: Issues and Reform Proposals," May 12, 2010.

[8] See American Institute of Certified Public Accountants, *Audit and Accounting Guide: Health Care Organizations* (2006); American Hospital Association, *American Hospital Association Uncompensated Hospital Care Cost Fact Sheet*, October 2006; Catholic Hospital Association, *A Guide for Planning and Reporting Community Benefit*, 2006. Bad debt should be contrasted with charity care, or financial assistance, that is written off due to a patient's inability to pay.

in the United States reported that their family had difficulty paying a medical bill.[9] One in four reported they were in a family paying a medical bill off over time; remarkably, 1 in 10 reported they or a family member were currently responsible for a medical bill they could not pay at all.[10] Families with children and adults under the age of 65 have been hit particularly hard, with a disproportionate burden falling on low-income, Hispanic and black families.[11]

Medical debt is a threat to physical and financial health—For patients, the long-term effects of having a medical bill sent through the collections process can be particularly devastating. First, medical debt plays a significant role in driving families deeper into economic distress. One well-known study posited that over 60 percent of all bankruptcies could be traced back to medical debt or illness.[12] A 2007 preliminary study of home foreclosures in four States cited medical crises as a contributor to half of home foreclosures.[13] As family finances shrink, many more low- and middle-income families resort to using credit cards to pay down medical debt.[14] However, this strategy leaves them susceptible to high interest rates and can lead to lowered credit scores.[15] In August 2011, the *New York Times* reported that 20 percent of clients seeking financial counseling from Atlanta-based CredAbility, a national non-profit credit counseling agency, cited medical debt as the primary reason they were seeking bankruptcy—up from 12 to 13 percent the previous 2 years.[16]

Second, medical debt—or the threat of it—can have a chilling effect on patients' willingness or perceived ability to seek care in a timely way. Skipping recommended followup care, not filling prescriptions, and delaying physician or specialist care when medical problems arise are all commonly reported behaviors among families carrying credit card debt.[17] In families that lost insurance coverage due to unemployment, just under three-quarters report using one of these strategies to keep costs down.[18] And in one national survey, about 1 in 10 Americans living with a serious illness, medical condition, injury or disability "report being turned away by a doctor or hospital for financial or insurance reasons at some time during the past 12 months when they tried to receive care."[19]

WHAT CAUSES MEDICAL DEBT? LESSONS FROM THE STATES

Three main factors contribute to medical debt: lack of comprehensive coverage; provider practices to collect on debts that range from the inappropriate to egregious; and a lack of strong public policies and oversight. The result is that too many Americans fall through gaping holes in the very same safety net on which they, of necessity, must rely.

Lack of affordable health coverage—Approximately 50 million people living in America lack health insurance.[20] A recent report by the Department of Health and Human Services (HHS) found that hospital charges are simply out of reach for many of these uninsured families, with most families able to afford only 12 percent

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[9] Robin A. Cohen, Renee M. Gindi, Whitney K. Kirzinger. *Financial Burden of Medical Care: Early Release of Estimates from the National Health Interview Survey, January–June 2011*. Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention, March 2012.

[10] *Id*.

[11] *Id*.

[12] David U. Himmelstein, Elizabeth Warren, Deborah Thorne, & Steffie Woolhandler, *Illness and Injury As Contributors to Bankruptcy*, Health Affairs Web Exclusive, February 2, 2005 [hereinafter Himmelstein, et al.].

[13] Christopher Robertson, Richard Egelhof, & Michael Hoke, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, Harvard Law School, August 2007.

[14] One survey report found that medical bills and unemployment were among the leading contributors to credit card debt for low- and middle-income families, with 55 percent of survey respondents with poor credit citing medical debt as a contributing factor. Amy Traub and Catherine Ruetschlin, *The Plastic Safety Net: Findings from the 2012 National Survey on Credit Card Debt of Low- and Middle-Income Households*, Demos, May 22, 2012.

[15] *Id*.

[16] Ann Carrns, "Medical Debt Cited More often in Bankruptcies," *New York Times*, August 8, 2011.

[17] See *Plastic Safety Net, supra* note 14, at Table 7.

[18] Michelle M. Doty, Sara R. Collins, Ruth Robertson, and Tracy Garber. *Realizing Health Reform's Potential: When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help*. The Commonwealth Fund, August 2011.

[19] NPR/Robert Wood Johnson Foundation/Harvard School of Public Health, *Poll: Sick in America Summary*, Released May 2012.

[20] *Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey*. Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, September 2011.

of the cost of a hospital stay.[21] Even uninsured families with relatively higher incomes (over 400 percent of the Federal Poverty Level) could afford only 37 percent of the stay.[22]

Another 29 million people living in America are underinsured.[23] This is due in part to rising out-of-pocket expenses—higher premiums, higher co-pays and coinsurance, and higher deductibles—as well as a rise in plans that either limit benefits or cap coverage.[24]

Uninsured and underinsured patients are more susceptible to medical debt. When compared to people with adequate coverage, both groups forego care due to costs at rates that are twice as high for the underinsured and three times as high for the uninsured.[25] And the uninsured and underinsured struggle with medical debt at higher rates than those with better coverage.[26] For many, skimpy coverage is just as bad as no coverage. About 76 percent of those in medical debt reported having health insurance when they acquired the debt.[27]

Despite obligations to provide access to care, many hospitals are using or authorizing billing and collection tactics that contribute to medical debt—Through our work on the Hospital Accountability Project, Community Catalyst has found that hospitals play a significant role in promoting access to care and avoiding medical debt. There are good public policy reasons to look to hospitals to promote care, including:

- *Mission*. Hospitals often base their organizational missions on core values that expressly articulate a community-focused approach, irrespective of an individual's ability to pay or any external legal obligation to do so.
- *Tax Status*. By filing for tax-exempt status, non-profit hospitals have covenanted with the public to provide financial assistance and other forms of community benefit in exchange for the highly valuable Federal, State, and local tax breaks and other benefits they receive as a result of that tax-exempt status.
- *Public subsidies*. Many hospitals receive Disproportionate Share Hospital (DSH) payments and money from other public funds that indirectly subsidizes a significant portion of their costs for providing uncompensated care.
- *Social and corporate responsibility*. All hospitals, non-profit and for-profit alike, have a social responsibility to provide some amount of financial assistance since health care is an "essential service"—particularly in areas where there are few acute care providers.

But in many places, hospitals' financial assistance, billing and collections policies have been shown to be inadequate, inappropriate, or even harmful. Hospitals have been cited for:

- Failing to screen patients for eligibility for public programs or the hospital's own financial assistance policy prior to engaging in more aggressive collection activity[28];
- Failing to notify patients of the availability of these programs, and even denying that they offer free care[29];
- Deciding to offer financial assistance or payment plans based on a patient's propensity to pay, rather than ability to pay;
- Using credit scores to determine a patient's access to lines of credit;

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[21] *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills*, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, May 2011.

[22] *Id*.

[23] See Schoen, C., Doty, M., Robertson, R., and Collins, S. *Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent*. Health Affairs vol. 30 no. 9 (1762–71), September 2011.

[24] Examples of such plans include hospital-only plans, plans that do not cover prescription drugs or mental health services or cap coverage for these services, or those that set lifetime or annual caps on what the plan will pay.

[25] Schoen, et al., *Affordable Care Act Reforms . . . Underinsured, supra* note 23.

[26] To give one summarizing statistic, 52 percent of the underinsured and 58 percent of the uninsured report medical debt or problems paying medical bills, compared to 27 percent of those with insurance. Id.

[27] Himmelstein, et al., *supra* note 12.

[28] In a random national survey of 99 nonprofit hospitals conducted in 2009, researchers found that fewer than half of hospitals surveyed (42) provided charity care application forms; only a quarter (26) gave information about eligibility criteria; and just over a third (34) offered information about charity care in languages other than English. C. Pryor, et al. *Best-Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs*?, The Access Project and Community Catalyst, May 2010. See also, *e.g*., Ames Alexander, Karen Garloch & Joseph Neff, *Prognosis: Profits*, Charlotte Observer and Raleigh News & Observer, April 22–26, 2012; Nina Bernstein, *Hospital Flout Charity Aid Law*, *New York Times*, February 12, 2012.

[29] *Id*.

• Requiring significant up-front payments before providing treatment [30];
• Mounting extremely aggressive collection practices, including placing liens on patients' property or garnishing their wages;
• Selling off patient accounts to third party lenders that charge exorbitant interest rates [31]; and
• Overcharging the un- and underinsured for care.[32]

These practices all create obstacles for patients seeking access to care. In Community Catalyst's work with State and local partners, these complaints are common, and the impact on patients is devastating.

What makes these practices even more abhorrent is that they are not necessary for hospitals to remain financially viable. Treating patients fairly and having clear, transparent, and strong policies for financial assistance and billing makes good business sense. In a September 2008 outlook report, Fitch Ratings commented on the apparent correlation between stability in hospitals' median operating margins and some consumer-friendly practices, such as developing strategies to better identify Medicaid-eligible patients and revisiting financial assistance policies.[33] Increasingly, industry experts are advising hospitals to implement best practices for financial assistance, billing and collection.[34] And in many States, low-income patients who currently qualify for hospital financial assistance programs will be newly eligible for Medicaid, subsidies, or other coverage when Affordable Care Act reforms take full effect in 2014. In Massachusetts, for example, hospitals were able to help the State identify and "flip" patients who received safety-net services into public coverage programs after State-level reforms.[35] This sped up enrollment significantly, giving patients more immediate access to comprehensive benefits, which "trickled down" to the hospitals through higher reimbursements.

But government oversight of hospital practices has often been weak or inconsistent—State laws and regulations, like hospital practice, also vary tremendously. For example, California, Maine and Rhode Island have set minimum eligibility standards for hospital financial assistance tied to family income. In Pennsylvania, State regulators have limited what information hospitals can require of patients to determine eligibility for financial help as a condition of receiving certain public subsidies. In Minnesota, prior to pursuing legal action or garnishing a patient, hospitals must verify the debt, confirm that all appropriate insurance companies were billed, offer the patient a payment plan, and offer the patient any cost reduction available under the hospital's charity care policy.[36] In California, hospitals and their affiliates are barred from garnishing a "financially qualified" patient's wages or placing a lien on his or her primary residence in order to collect a debt.[37]

Still, most States lack adequate protections for individuals who cannot afford to pay for their care. Some, such as North Carolina, have no laws on the books that expressly regulate medical debt collection. There, a major public hospital system was found to routinely use liens to collect debts on very low-income patients' homes. But even when State laws are strong, oversight and enforcement of these protections can be ad hoc or non-existent. As a result, compliance with existing laws can decay. For patients, this means that the protections available to them vary greatly depending on where they live and the individual policies of the hospitals in their area.

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[30] Jessica Silver-Greenberg, *Debt Collector Faulted for Tough Tactics at Hospitals*, *New York Times*, April 24, 2012.

[31] Brian Grow and Robert Berner, *Fresh Pain for the Uninsured*, Business Week, November 21, 2007.

[32] Hospitals charge self-pay patients, including the uninsured and underinsured, 2.5 times the rates insurers paid and three times the hospital's Medicare-allowable costs for the same services. Gerard F. Anderson, *From "Soak the Rich" to "Soak the Poor": Recent Trends in Hospital Pricing*, 26 Health Affairs 3 (2007).

[33] *2008 Median Ratios for Nonprofit Hospitals and Health Care Systems*, Fitch Ratings, September 25, 2008.

[34] See, *e.g.*, Ron Shinkman, *Five Much Better Ways to Collect Patient Debt*, FierceHealthFinance, May 8, 2012; *Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape*, PricewaterhouseCoopers' Health Research Institute, 2005; Catholic Hospital Association, *A Guide for Planning and Reporting Community Benefit*, 2006.

[35] Stan Dorn, et al., *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, State Health Access Reform Evaluation, The Urban Institute and Robert Wood Johnson Foundation, November 2009.

[36] Pursuant to a binding agreement between the Minnesota attorney general and the Minnesota Hospital Association.

[37] Calif. Health & Safety Code § 127425(f).

RECOMMENDATIONS FOR PREVENTING AND ADDRESSING MEDICAL DEBT

We have discussed the ways in which medical debt is unique, its impact on families, and the factors that have contributed to its proliferation. Accordingly, special rules need to be in place to protect patients. We suggest a three-pronged Federal solution, as follows.

(1) Prevent medical debt by implementing the coverage expansions found in the Affordable Care Act

The growing problem of medical debt lends an additional perspective to how America's health care system fails many uninsured and underinsured people precisely when they need to rely on it most. But an exclusive reliance on the hospital safety net is neither financially sustainable over time; nor is it a suitable replacement for comprehensive health benefits in terms of guaranteeing access to care. Expanding access to care therefore requires making affordable, comprehensive coverage a reality for the millions of Americans who are currently un- or underinsured, and implementing the coverage provisions found in the Affordable Care Act is the best strategy for making affordable coverage a reality.

(2) Implement rules that clarify hospitals' obligations to observe fair billing and collections practices

Even with full implementation of the Affordable Care Act, some Americans will remain uninsured or underinsured, or suffer a medical catastrophe that could otherwise destroy their financial security. The second remedy for addressing medical debt is to put adequate protections in place by regulating and monitoring hospital billing and collections practices.

Section 9007 of the Affordable Care Act includes new requirements for tax-exempt hospitals that would curb some of the worst practices noted above.[38] First, Section 9007 requires tax-exempt hospitals to have a written financial assistance policy that includes eligibility and application requirements and outlines the steps the hospital will take to notify the public that financial help may be available. Second, it requires these hospitals to make a "reasonable effort" to qualify patients for financial assistance prior to engaging in "extraordinary collection actions." Third, patients who qualify for financial assistance may only be charged the amounts generally billed to an insured patient, ending the industry's standard practice of price-gouging the uninsured and underinsured. Fourth, it requires hospitals to undertake a regular community health needs assessment and develop strategies to address some of the unmet needs.

These requirements are already in effect for tax-exempt hospitals. As recent media stories have demonstrated, however, they have not yet had an impact on the behaviors of some of these hospitals. Part of this may be due to the fact that we have yet to see implementing regulations from the Department of the Treasury that will further define what behaviors are acceptable under the statute. We believe strong regulations are necessary to fully protect consumers from medical debt, as Congress intended, and we strongly urge members of this committee to weigh in with the Department accordingly.

While we believe that strong regulations and oversight pursuant to Section 9007 of the Affordable Care Act are the best way to improve hospital behavior, we recognize Section 9007's limitations. It applies only to tax-exempt hospitals (though for-profits often adopt industry norms) and works primarily by addressing the "upstream" behaviors of providers that contribute to medical debt. Because the statute leaves the scope and breadth of their financial assistance policies up to hospitals' discretion, uninsured and underinsured patients may still find themselves excluded from many of the protections offered by Section 9007. What can be done to protect people from the downstream behaviors that providers and collection agents are using?

(3) Expand consumer protections against aggressive collection practices by initial creditors, such as hospitals, and debt collectors

The third remedy for alleviating medical debt is to expand consumer protections available to patients. We recommend that this committee investigate opportunities to expand Federal debt collection laws that would increase transparency by placing

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[38] Section 9007 of the Patient Protection and Affordable Care Act, Public Law 111–148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (2010). For a fuller discussion of Section 9007, see Corey S. Davis, Jessica Curtis, & Anna Dunbar-Hester, *Leveraging the Patient Protection and Affordable Care Act's Nonprofit Hospital Requirements to Expand Access and Improve Health in Low-Income Communities*, Clearinghouse Review, January–February 2012; and *Protecting Consumers, Encouraging Community Dialogue: Reform's New Requirements for Non-Profit Hospitals*, Community Catalyst.

debt collectors on the hook for providing people with the information they need to understand their rights and take appropriate action. Patients who qualify for financial assistance or are eligible for public programs such as Medicaid should be exempted from debt collection activity. In general, hospital debts should not be referred to collections or reported to credit bureaus until the patient is screened for financial assistance or public programs. In no case should a hospital engage in or authorize collection lawsuits, garnishing wages, freezing bank accounts, body attachments or capiases, or placing liens on patients' homes or cars without the express approval of its governing board. Practices such as selling patient debts to third parties or charging interest on outstanding patient debts should be prohibited outright. Medical collections actions—again, because of the unique circumstances under which the debts arise—are not predictive of creditworthiness, yet they appear on credit reports even after a medical debt has been settled. Each of these practices creates tremendous hardship for families, with long-lasting effects that spill over into the financial well-being of whole communities.

Finally, policymakers should continue to support transparency initiatives, such as the Internal Revenue Service Form 990, Schedule H, that require hospitals to report the practices they use or authorize agents to take in order to collect patient debt. By giving communities access to detailed information about local hospitals' practices, these initiatives offer an important check on hospital practices that contribute to medical debt.[39]

CONCLUSION

In conclusion, medical debt has an increasingly profound effect on families, even those with private insurance coverage and middle-class incomes. But behind the data lies the human element involved in every case of medical debt: in hospital rooms and medical offices around the Nation, families facing the specter of medical debt are forced to choose between placing their loved ones' lives or the family's financial future at risk.

We have been here before. Concerns about aggressive collections tactics that impact patient access to care surfaced as recently as the early 2000s. At that time, the response from the hospital industry was to publish and update voluntary standards. While such standards are welcomed, they are clearly not enough to staunch the wide range of behaviors and tactics currently being used to collect debts that many Americans simply cannot pay.

One thing is clear: hospitals that make a practice of healing patients' bodies while bankrupting them—or authorize third parties to do the same on their behalf—have missed the mark. They run the risk of compromising individual and public health; eroding individual, community, and national economic security; and destabilizing their own financial well-being by ignoring industry best practices. Those are risks that we can ill-afford to take.

On behalf of the 79 million people who are uninsured or underinsured in America today, I thank you for the opportunity to testify and welcome your questions.

Senator FRANKEN. Thank you, Ms. Curtis.

Ms. Ross, thank you so much for your testimony. As an emergency room nurse with decades of experience, what do you believe is the most important role of a nurse?

Ms. ROSS. Our main role is, always has been, to advocate for the patients, and that's what I find so disturbing. Aside from the fact that it interferes with the patient's care, the nurse is the person that's coordinating your care when you're a patient, and I have had dietary people, if a curtain is pulled, ask is it OK to go in a room now and talk to that patient. That's not even in the emergency room. That's up on the unit.

I have had people from medical records or the triage area in the emergency room, let's say someone had to be rushed back because they were having trouble breathing or having chest pain, even

[39] However, the Internal Revenue Service has buckled under pressure from some within the hospital sector and made these reporting requirements optional in the past. See *Letter to the Honorable Timothy Geithner, Secretary, U.S. Department of the Treasury, re: Internal Revenue Service Announcement 2011–37* ("*Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010*"), Community Catalyst, June 20, 2011.

those people need that information. It might just be a phone number, an address, et cetera, but they know enough to ask me or the doctor is this an OK time now, is that patient stable enough.

To have a stranger come in without my knowledge as coordinating that patient's care, or the doctor's, is not just an interference; it's unethical.

Senator FRANKEN. Nurses are often the providers who spend the most time with the patients in the hospital. In national polls, nursing often is rated as one of the most trusted professions.

As their nurse, would you allow patients to be badgered for payment?

Ms. ROSS. I would not. I think it's unconscionable. This is not the time or the place, and—well, as I said earlier, I can appreciate that they have to collect moneys in order to do what they do, but this is not the time or place. And over all the years that I worked at a Fairview facility, this was not done.

Senator FRANKEN. When you say it's not the place, you're saying the emergency room.

Ms. ROSS. No, I'm not just saying the emergency room. I think any point of care when you're hospitalized, you do not need that extra burden, that stressor. It shoots your cortisol level way up. We don't need that. That's not part of healing.

Senator FRANKEN. Ms. Ross, the attorney general's report says that maintaining the privacy of patients' health information is critical, because otherwise patients would not have candid conversations with health care providers.

Did you find that to be the case in your years as a nurse? What could go wrong if you don't have all the information?

Ms. ROSS. If I don't have all the information?

Well, obviously, a person, a patient is a complex human being. You need all that information. I am a little disturbed, and I noticed this too when I started reading the consent for treatment forms, because I read them for my parents, who are elderly now too, and I did notice that over the years the Fairview consent for treatment form had changed.

When I was last in with my father, I asked who this third party might be that needed this excess information. I am used to, obviously, you give it to other people, other physicians who handle your care, and to insurance companies who would have to process your bill. I asked, who is this third party, and I was told those poor people at the desk, they don't know. What the lady said to me was, quite frankly, ma'am, nobody has ever asked that question, and if you don't want to sign OK to this, you just put your initials there and say no, so we did say no. But it came obviously after I started reading about what's going on here. I believe that's the third party they're talking about, and I do not understand why that pertinent medical information needs to be given to a third entity.

Senator FRANKEN. And if people don't trust that their information is going to be secure, they'll be less likely to give out personal information——

Ms. ROSS. Exactly.

Senator FRANKEN [continuing]. That you as a nurse and the doctors may need to know what medications that person is on, what conditions they have——

Ms. ROSS. Exactly.

Senator FRANKEN [continuing]. So that you don't prescribe, the doctor doesn't prescribe medicine that will interact badly with others.

Ms. ROSS. Exactly.

Senator FRANKEN. Ms. Curtis, in your written testimony, you explain that medical debt is different from other types of debt, that people don't typically choose to rack up medical debt, and they definitely don't choose to get sick.

Can you talk more about the special nature of medical debt and how devastating it can be for a family to deal with debt collectors while they're trying to heal?

Ms. CURTIS. Sure, and I can say probably the best way to talk about this is to talk about some of the patients that we've come across in our work across the country.

Just to bring it to light, I think really what's happening is that patients are being forced to choose between their family's financial future and their health, and that's a choice that I don't think people should have to make, but frequently they do.

One of the patients that we have worked with, for example, in Florida, she's the woman who went into the emergency room for care. She was asked to take care of her bill at the moment. When she said she wasn't able to, she was asked if she had a credit card. So because she wanted to seek care, she put the bill on her credit card. The charge was $4,000, and it took care of her immediate problem. She was able to see the doctor, she was able to get treatment.

But as a result of having that bill on the credit card, she ended up falling behind on her mortgage and is now in a very different situation where her financial health is in danger as well.

Another story that I know has made the news recently in New York was a woman, a graphic designer who for most of her life had been insured and employed but was hit hard by the recession. She went into one of New York's premiere non-profit hospitals and was asked immediately to pay up-front for care. She had, I think, a benign tumor on her liver.

She did that. She raided her savings account and paid $17,000 right away. What ended up happening to her, however, was, of course, that didn't take care of the entire charge. And so she was landed with an $88,000 bill. She tried to work out a payment plan, was unable to do so, and ended up in court with the hospital. There, a judge recommended that the hospital accept her offer to make a $100 per month payment plan, and she has said she'll be paying that bill for the rest of her life.

In these situations, when people hear these stories, they're carrying that information and that knowledge with them the next time that they or their family requires additional help.

Senator FRANKEN. How do you think our Federal debt collection laws should reflect the special circumstances around medical debt?

Ms. CURTIS. Well, one of the things that my organization has been working on is to really back up from the point where a debt becomes bad debt and we're in the position where people are collecting. Hospitals, to my knowledge, are mostly exempted from the Federal Debt Collection Protection Act. They are a creditor, and

they're allowed to do a lot in order to collect on their own debt. And again, we recognize that hospitals need to receive payment for services rendered, but we have become increasingly aware of and troubled by the same kinds of practices that we've heard alleged here in the Fairview and Accretive Health cases happening in hospitals across the country.

What's troubling is that the protection that's now in the Affordable Care Act and applies to non-profit hospitals just applies to those hospitals. It's still very much predicated on what the hospital's own financial assistance policy is, and all of the protections in it which would require hospitals to limit what they charge patients for care, and the steps that they take to screen a patient before they engage in extraordinary collection actions, again all of those depend on their own financial assistance policy, and that's up to their discretion.

So what we have is a situation where some hospitals have higher burdens placed on them, new higher burdens placed on them to be thoughtful about how they collect on bills, but not all hospitals in the United States have that. And then again, those protections differ as you move down the line and the account proceeds forward and becomes past due.

Senator FRANKEN. Thank you.

Professor Goodwin and Ms. Curtis, as you both know and as we've heard in our testimony today, tax-exempt or charity hospitals in Minnesota don't pay Federal or State income taxes, property taxes or sales taxes, and they can sell tax-exempt bonds. These benefits are worth billions of dollars nationally. In return, tax-exempt hospitals are required to provide a benefit to the community.

Could that create a conflict of interest and potentially undermine the mission of a charitable hospital when it contracts out its revenue cycle management services to a for-profit and publicly traded firm? It seems to me that non-profit hospitals have to carefully manage their for-profit contractors, particularly in the area of debt collection, to make sure the public's interests are being served. Would you agree?

Ms. CURTIS. Sure, I would definitely agree. I think this is one of the reasons why the Internal Revenue Service has begun to ask non-profit hospitals to report what collection actions they or an authorized agent have undertaken, and it's very specific questions. Those questions were added for tax year 2010, but they were made optional for that tax year. This is the first year, tax year 2011, that hospitals will have to report that information, and I think it's just for the reason that you're saying, there is an inherent conflict of interest here.

Senator FRANKEN. Professor.

Ms. GOODWIN. I absolutely agree with you. Historically, the reason why, in fact, we allowed hospitals and other organizations to have a charitable status is because we had sick people, and we know when there are sick people who are untreated, just as you mentioned earlier, it can become a public health nightmare. So we want people who cannot afford treatment to be able to get treatment, and in exchange for that we allow for tax exemption status for hospitals. But there is a conflict of interest that does arise

clearly when hospitals perform in more illusory than real ways with regard to providing charitable care.

Senator FRANKEN. It just seems to me that there is a responsibility that the charity hospital has and that it can't allow its relationship with a for-profit entity to compromise that mission.

Ms. GOODWIN. I think that's absolutely right, and I think this has become a very complicated issue not only in the State of Minnesota but throughout the country, as well. There are also some very significant information asymmetries that take place so that individuals who need care and they seek emergency treatment believe and, in fact, Federal law provides for them to be able to get that care. Poor people who believe that they're being treated at a charitable hospital believe that they will be treated charitably. It's unfortunate when they arrive at our hospitals that we are providing tax exemption status for and Minnesota taxpayers are paying for when they're not getting that kind of quality of care.

I think we're all sensitive to the fact that this is a real challenge, how hospitals will recoup debt. That we all know about. But it's the manner and place in which this all happens that I think makes this hearing incredibly important.

Senator FRANKEN. I think that's the case. Hospitals are in a crunch and they have to be able to collect debt, and I think everyone agrees with that. What's important is how you do it, and when and where.

Professor Goodwin, as you know, the Fair Debt Collection Practices Act is intended to protect consumers from unscrupulous debt collectors. However, the law doesn't cover all collection activities. Accretive has argued that the Fair Debt Collection Practices Act did not cover their revenue cycle employees working at Fairview. Do you agree with that assessment?

Ms. GOODWIN. I disagree with that assessment. I think if you look at the law, the intent behind the law, and as I pointed out specific sections of the law, Accretive would certainly have been covered by this and that their behavior certainly stands, in my opinion, as a violation of the law. I've read through all the volumes that have been presented, written by the Minnesota Attorney General, and there are specific violations that are pointed out both in terms of communication, how they communicated, when they communicated, deceptive practices in terms of what they did not disclose to the individuals who were seeking treatment at the hospitals to inform them that they actually were debt collection agents, that they served a dual purpose and role.

There were violations by the manner in which they sought payment from patients at bedside and in ways that even my law students, non-law students, if I were talking to high school students and I showed them the statute and said here's the conduct that's been alleged, has there been a violation, a high school student would say yes.

Senator FRANKEN. It sounds like you're saying that the law is clear enough to hold bad actors accountable?

Ms. GOODWIN. Certainly that's true, but I also would say that there are ways in which the laws can be strengthened. I think that on the face of the law itself, as I've read some today and you have the other in my written testimony, there were clear violations of

what the attorney general's office has amassed, and if their investigation holds to be true, clear violations of the law.

That said, what concerns me is that for consumers, there really isn't the opportunity to be incentivized to even complain about this. At best, a consumer who wants to file under the FDCPA may, at most, recover $1,000. That's negligible. There's no significant disincentive for a company that's going to bring in tens of millions, if not hundreds of millions in revenue per year, to do anything otherwise if, at best, they're going to pay off $1,000 to a consumer who complains.

Senator FRANKEN. In addition to the FDCPA, let's talk about privacy laws. Based on the evidence we've heard today, do you believe our Federal health policy, privacy policy, that those laws should be strengthened to protect patients' privacy? And if so, how?

Ms. GOODWIN. One of the issues that arose today involves the snatch and grab of the laptops, one in Seven Corners, and I suppose that there have been a number of others, I think up to nine that have been snatched and grabbed. And in these laptops, the data that—first of all, there's been too much data that's been provided. But in addition, there's data that has not been encrypted.

I think that we can do more to strengthen HIPAA to provide for the advancements in technology that perhaps were not predicted at the time of HIPAA's passing.

Senator FRANKEN. Thank you.

This question is for all the witnesses, so anyone, chime in.

One of the key things we've been struggling with all day is that hospitals need a way to collect from patients that is fair and reasonable and that doesn't interfere with patients getting the care that they need. Where do we strike that balance? Is there a responsible way for hospitals to collect on their debts without compromising the quality care of patients, and are there additional changes to Federal law that you would recommend to achieve that balance?

Ms. CURTIS. I'll start. I think that those are exactly the right tensions to point out. But the truth is that there are ways that hospitals can collect on these debts without going bankrupt. Hospitals do this all the time.

Part of the issue that does come up is really timing and place. What struck me from the testimony today was that it did not seem in the questions the patients were being asked about ability to pay or whether they would like to pay, I didn't hear at that moment a question about are you concerned that you will not have an ability to pay. The hospitals that we've worked with that have done this really well will ask those questions up front, if a patient is uninsured, if they're under-insured, if they express some difficulty about paying.

In some places, if they are eligible for other kinds of programs, food stamps, Medicaid, Medicare, there can be some form of presumptive eligibility put in place for financial help under the hospital's policy.

That's a starting place, to think about in the hospital how are they communicating, what are the policies, what do they say about time and place, how are those being communicated to staff and re-

inforced to staff within the hospital through regular trainings. There are ways that that can happen.

Then again, moving down the line, I do think that there are debt collection activities, because of the way that medical debt is unique, that should not be allowed for patients who are below certain income thresholds, for example, who have qualified for charity care, who have set up a payment plan and they're at the max already. There are debt collection practices that I think should be outlawed as well, if you're looking at garnishing patients' wages or putting a lien on their primary residence.

Those are things that have very significant consequences, and right now the burden is really on patients to advocate for themselves in these situations. I think the burden needs to shift to be more on hospitals. If they're going to engage in some of these activities, they need to ratchet up the internal controls that they're using before they move forward.

Ms. GOODWIN. I would agree with that.

Two things that I'd like to point out. The first is that we not lose sight of the Nuremberg Code or the Tuskegee experiments. These sort of anchoring moments in history that teach us about the ethical conduct that is expected of the medical community, whether we're talking about researchers, doctors, nurses, or hospitals. There are four principles that we learn and that are guided from those moments in history that we all continue to be shocked by.

They are beneficence, and that is about first do no harm, that hospitals are about giving care. The second is about patient autonomy and that being a priority. Social justice is also important, and informed consent. I think one of the things that one hears through this investigation is how so many of those basic practices, what we expect dating back to Nuremberg, were just simply not taken seriously at all by Fairview in their relationship with Accretive Health Care.

In terms of thinking about the ways in which the law can move forward, one of the things that we haven't talked about is the use of criminal law, and I would commend you to consider the work of Professor Song Richardson. She's a person who has collaborated with me about the ways in which we need to take a much more serious look at the ways in which health laws are violated, and research codes are violated, and the criminal law provides a very strong stick to check against behavior such as this, and I think we need to move in that direction.

Two more things that I would suggest, and that is we really do need better information sharing with patients because there are information asymmetries, and what patients need to know about are the ways in which hospitals go about collecting their money and why it's important that hospitals are in the shape that they are when they're looking to recoup losses. That's not really information that is shared with patients. They're expected to sign on the dotted line, but in terms of good quality information, it's simply not there.

One other point would be to take a very serious look at hospitals and their charitable status. We need to consider joint and severable liability here, which is not a new concept in the law, but it is to say that when hospitals understand that they're working with par-

ties that do badly, they too can get in trouble, not just the companies that they're working with.

Senator FRANKEN. Thank you.

Ms. Ross.

Ms. ROSS. I would have to say, echoing what Michele Goodwin just said here, I was struck when Mr. Mooty and Mr. Kazarian were speaking, especially Mr. Kazarian, about the types of things he said his company is supposed to do. And what struck me is you have this supposedly beneficent community facility. Hospitals are there for the community, they're supposed to be. And you have professionals who know their duty is first do no harm. You have social workers. You have people who could perform all of those duties that he was talking about in his for-profit business.

So people who clearly understand HIPAA and know what they can and cannot share, who clearly would safeguard that information because they are health care professionals, caregivers in that institution, the hospital in which they work clearly understands that, why on earth would you farm that out to another company? That does not make sense to me.

What he talked about in the form of helping patients I was really glad to hear, because patients do not have a clue. They are farmed out to talk to their insurance people. It depends on who you get that day, whether you get a real person on the phone. They can talk to the hospital personnel. The hospital usually says go talk to your insurance person.

If they had some sort of coordinator within that hospital facility that could do that, that would be more ideal, I would think, than farming it out to someone else.

Senator FRANKEN. I truly believe that Accretive did that service, too, and that they did, as Mr. Kazarian said, that they helped patients find insurance. But again, we're talking about balance, and we're talking about the right way and the right time.

Ms. ROSS. And it's yet again another party to give that protected information to when it doesn't need to be.

Senator FRANKEN. Exactly.

Well, thank you all for all your testimony today. You're now excused.

Ms. GOODWIN. Thank you very much.

Ms. ROSS. Thank you.

Senator FRANKEN. I want to thank all the witnesses today.

In closing, I also want to thank the Chairman and Ranking Members of the Senate HELP Committee, Senators Harkin and Enzi, for allowing this hearing to take place.

I'd like to also take this opportunity to once again thank each of the witnesses who testified here today.

We have a health care system that is among the most expensive per patient in the world. I visited many hospitals across Minnesota, and as far as I'm concerned, we deliver some of the best health care, if not the best health care, in this country. That is in no small part because of extraordinary hospitals like Fairview and Mayo and others.

Many hospitals are operating on smaller and smaller margins, and they need help to survive financially so they can serve their communities. A company like Accretive offers itself as a solution,

a way for hospitals to get revenues that are owed to them. I get it.

But it really seems like something went wrong here. Accretive cites in its response letter to me some very positive e-mails and comment cards and letters from Fairview patients expressing their gratitude for the help that they received in finding insurance and other ways to pay for their care, and I will read the first two.

"She was incredibly helpful," "INCREDIBLY HELPFUL" in all caps, "and provided me peace of mind," "PEACE OF MIND" in all caps.

Next one.

> "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."

I think that's just great, and Ms. Ross I think spoke right at the end about the folks that do that.

Here's the thing about that. I think that should be the norm. This is Minnesota. People in Minnesota are good at their jobs, and we are nothing if not nice.

[Laughter.]

Senator FRANKEN. I would expect Minnesota health care employees to do a great job in very difficult circumstances, and these are very difficult circumstances. When people come to a hospital, it's usually a very stressful situation, even in the most blessed occasions, the birth of a baby. Even that can be very stressful. And very often, hospital visits are made in more trying circumstances. You go to a hospital when you're sick or when you've been hurt and when you're at your most vulnerable.

And the revenue cycle folks that were doing these jobs for Fairview had to exercise a lot of judgment. These jobs require not just sensitivity but also the ability to make distinctions, distinctions about when and how and where it is proper to ask a patient for money.

It seems to me that there is a right way and a wrong way, and a right time and a wrong time to do these things. And to help your employees get it right means creating the right culture. We are all human beings, and human beings are not perfect. But leadership in the industry isn't just about providing the right software and the right processes. It's about providing thoughtful guidance. It's about creating a culture where people err on the side of compassion.

Minnesotans should be able to receive the health care they need when they need it, and when you or someone you love is sick or hurt, you shouldn't have to spend time worrying about some of the details we've been talking about here today, such as whether you or your loved one is being badgered for pre-payment when they're writhing in pain, or whether that sensitive information you're giving to your doctor or nurse might not stay private.

So I'm going to continue to look into these issues. This hearing is just a beginning, not the end of my investigation. I'm going to think about everything I've heard here today. I'm going to look into whether we can do more to strengthen our laws, our Federal laws to protect patients.

I'd also like to submit four statements for the record. These are from the Minnesota Hospital Association, the Teamsters, the Minnesota Nurses Association, and the PCD Foundation.

[The information referred to can be found in additional material.]

Senator FRANKEN. We will hold the record open for 1 week for submission of questions for the witnesses and other materials.

This hearing is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF NINA BUGBEE, RN, PRESIDENT, TEAMSTERS LOCAL UNION 332, FLINT, MI

Thank you for the opportunity to provide testimony to the U.S. Senate HELP Committee Field Hearing, "Ensuring Patients' Access to Care and Privacy: Are Federal Laws Protecting Patients?" I am President of Teamsters Local Union 332 in Flint, MI. We represent RNs, LPNs and technical workers at Ascension's Genesys Regional Medical Center in Grand Blanc, MI. I practiced as an RN for 14 years before going to work at my local union. I am also a member of the Michigan State Board of Nursing.

Genesys is owned by Ascension Health, the largest non-profit hospital chain in the United States, and the 2nd-largest health system in the country. Ascension Health, based in St. Louis, is also the largest customer of Accretive Health (providing 41 percent of its revenues) and is Accretive's 6th-largest shareholder.

Our members who work at Ascension Genesys have reported many troubling practices since the hospital contracted with Accretive in 2004. Our members report that collection practices have become much more aggressive, and that they are told "not to leave money on the table."

We have not just collected anecdotal stories here and there. We conducted a survey of our members who work at Ascension Genesys, and the survey results are quite concerning.

The surveys tell us that the Ascension Genesys Emergency Department (ER) was re-configured to put a major focus on getting bills paid. Administrative Assistants had their titles changed to "Financial Administrative Assistant" (FAA). More and more pressure is applied by management to collect co-pays and prior balances. Eighty-five percent of ER staff who responded to our survey reported that patients are made to think at registration that they must pay before receiving care, and that they must pay any past due bills before receiving care. According to our surveys, at registration patients are asked to take care of any balance by "cash, check or credit card" before they're seen by a doctor. If a patient does not have insurance or has past balances, a bill collector, or "financial counselor" (FC), is called in.

The surveys also tell us that ER patients with insurance have to turn over their insurance card and driver's license at registration, and they do not get them back until they go to the discharge desk when they leave and pay their co-pay. This policy "created a lot of tension between registration staff and the department supervisor. Many employees felt uncomfortable," reported one survey respondent.

From one survey, we received an example of how Ascension Genesys treated one of its own. Kelly Rivera-Craine, an RN at Genesys, brought her husband to the ER in July 2009 for kidney pain and nausea. Because all of the rooms were occupied, her husband was put on a stretcher in the hallway, in front of the nurse's station. While waiting to be seen by a doctor or nurse, a financial counselor approached her about a previous bill owed by her husband for $23,228.19. She asked Kelly's husband how he would like to settle it, even though he could not speak at the time because he was vomiting and in an extreme amount of pain. Only after Kelly asked the woman if there was somewhere private they could talk, was she brought into an office. If it were not for Kelly's suggestion, the counselor would have continued to discuss the outstanding bill with Kelly's ill husband in the middle of the public hallway. This information could have been heard by other patients and employees. I am appalled, as were Kelly and her husband, that the hospital would send a "financial counselor" (bill collector) to patients when they are in their most vulnerable state, as well as doing so in an inappropriate setting.

Another example of hunting down patients while they are acutely ill comes from another survey. A Genesys RN was in the hospital herself with trouble breathing, and a FC entered her room to ask her to pay a past due balance of $25. This occurred when doctors and nurses were in her room, so the bill collector could easily have overheard confidential medical information.

Many surveys we received report that bill collectors enter patient rooms where they would be able to overhear medical information. Eighty-five percent of ER staff who responded to our survey reported that bill collectors attempt to discuss payment in inappropriate places. The financial advisors "always see [patients] in patients' rooms or the hallway," one respondent noted.

Other surveys tell us that patients being seen in the ER for trauma are asked for payment while being treated. One survey reported an example from 2 weeks ago of a suicidal patient who was tracked down in the ER by a bill collector while being treated.

One Genesys employee stated in her survey,

> "I have been personally told by patients and their families, and have witnessed on several occasions, a patient's upset at being approached about money owed at a time when they feel the most vulnerable. I have walked into a patient's room after the FC had left, and the patient would be in tears, after a discussion of their prior balances. When a patient is ill or in pain, it is not the best time, or the best place, to prey on their vulnerable state to collect money. Judging by the complaints I have heard from Genesys patients and their families, they do not see Genesys employees as being compassionate. Since working at Genesys, I have heard comments made by long-time employees about how Genesys has changed in recent years."

A former FAA reported on her survey,

> "I was an FAA at Genesys for 7 years. It was part of my job to communicate with Accretive regarding self-pays and prior balances on past due accounts. Accretive is able to go into ADT [the hospital's billing/patient management software] and access all past and present visits to verify any prior balances. They are also able to view emergency contact information, previous insurance, chief complaints, previous admissions, and any payments made by the patient in the past. Often Accretive would enter the patient's room before the patient is treated by a physician. During very high patient load, some patients may have to be placed in a hallway. Accretive will approach our patients anyways."

Another Genesys employee told us in her survey,

> "I have seen notes in ADT that are pretty graphic, about patients' jobs and money they earn, or information that was given to the patient about how to get money for their injury—such as one patient who was injured at someone's home. They instructed the patient to go after the homeowner's insurance, to help pay the hospital bill."

Another survey responder told us of her sister being aggressively pushed for payment at Ascension Genesys at the time her husband was being seen in the ER. She didn't have the money to pay the bill right then and there, and she was made to feel "she couldn't leave without paying—this was a very embarrassing situation for them."

The surveys also tell us that Accretive staff do not clearly identify themselves. "They all wear Genesys badges," one Genesys employee reported on her survey. The "badges don't identify them as Accretive." Another employee reported on her survey,

> "Accretive employees dress in business casual clothing and wear a name badge with a Genesys logo, confusing patients into thinking they're employed with the hospital. They enter the room and say they are with "Financial Services."

The surveys also report that Accretive supervises Genesys' financial administrative assistants, as well as their supervisors.

The surveys told us as well that scripts are provided for staff to use in collecting payments. Attached is one example of a set of scripts distributed to FAAs. There are 10 different scenarios given, with answers to possible patient responses. Each is designed to get as much money out of patients as possible, as quickly as possible.

Some other examples of aggressive collection tactics include outpatient surgery, where patients are called at home before the procedure and asked to bring payment with them. Patients with past-due balances have been told that they cannot undergo additional procedures. From another survey, a Genesys RN told us that she hadn't paid an ER bill because it had never been sent to her. When she went to have an MRI at Genesys on a later date, she was told she couldn't have it done until she paid her bill. They "gave me a very hard time," she reported. Another hospital employee gave a similar report—even though she had insurance, she was told she couldn't have her MRI unless she paid $500 up front.

I understand that you are investigating Accretive Health's practices in hospitals, but I urge you to also investigate the roles of these huge Fortune 500-sized nonprofit hospital chains as well. It is the choice of hospital systems like Ascension Health to contract with Accretive. The hospital is the paying client, and Accretive is certainly acting on its customers' agenda. A $15 billion company like Ascension is obviously calling the shots with its contractors. And in Ascension's case, using Accretive helps them bring in revenues twofold:

First, Ascension directly benefits from Accretive's strong-arm tactics to push patients to pay bills while in the hospital. Ascension is Accretive's biggest customer, comprising 41 percent of its revenue stream. And second, Ascension benefits from Accretive's own profits, as Ascension is Accretive's 6th-largest shareholder. With these kinds of incentives, it's no wonder that we have been hearing all these horror stories about Accretive. But I would certainly hope that we are not going to overlook

the role and responsibility of the hospitals, especially those, like Ascension, that are allowed to use a non-profit tax status. It's another sneaky way for a non-profit to claim profits in the health care industry.

There is another particularly disturbing aspect to this situation, aside from the unethical treatment of patients. Based on our survey of Genesys employees, medical coders have been asked to change coding practices. Another new practice that occurred when Ascension Genesys brought in Accretive is that Accretive staff started to directly supervise the work of the medical coders. This is not allowed under our collective bargaining agreement, so we pushed back and the practice was discontinued. However, the coders tell us that their supervisors are now being supervised by Accretive staff. So Accretive is essentially running the coding department.

Some of our survey responders reported that they've been asked to change how they code for Medicare billing purposes. One coding department employee stated, "I've certainly had ethical and moral questions about the process." I believe this should be investigated further, considering that in December 2009, Genesys agreed to pay $669,413 plus interest and $97,500 in attorney fees in a settlement with the U.S. Department of Justice over claims of Medicare overcharging. In May 2010, Genesys agreed to another settlement with the DOJ, for over $931,000, for allegedly submitting false claims to Medicare.

Non-profit hospitals, in exchange for tax-exempt status, are supposed to have missions that will benefit their communities, have fair billing and collection practices, reinvest surplus funds in ways that benefit their communities, and to remain accountable to their communities. Instead, for decades, we have seen non-profit hospitals across the country hoard money, defraud Medicare, overcharge and intimidate patients without insurance, and violate the purposes of their tax exemptions.

Ascension Health has a venture capital arm of its operations. It is building hospitals in the Cayman Islands, likely for "medical tourism." It pays Accretive Health to shake down patients for money. It has been fined multiple times for questionable Medicare billing practices. And they're not the only non-profit hospital system that does this.

The behavior of Accretive Health should be investigated, but the responsibility for treating—and billing—patients ethically lies at the feet of our Nation's hospitals and especially large hospital chains such as Ascension Health.

I thank you for considering my testimony.

ATTACHMENT

HEALTH CARE REGISTRATION FORMS, CHECKLISTS, & GUIDELINES*

Role-Playing Scenarios: Asking for the Money

Scenario 1	How to ask for the money
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I can't pay today.
Registrar	When will you be able to pay?
Patient	Next Friday.
Registrar	Is this your next payday?
Patient	Yes. I will be in after 3p.m.
Registrar	On next Friday, will you be paying the balance in full?
Patient	I can only pay half then and the balance in 2 weeks when I get paid again.
Registrar	I will make a note on your account to this effect and will see you next Friday.

Scenario 2	When the patient says "I will make payments"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I will make payments.
Registrar	The hospital doesn't carry accounts and requests that the account be paid today.

Scenario 2	When the patient says "I will make payments"
Patient	My husband has been off work for 3 months, and I don't know how we can pay it.
Registrar	Please call the financial counselor to talk about your situation.

Scenario 3	When the patient says "I don't have my purse or wallet"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I don't have my wallet/purse.
Registrar	How were you going to pay if you had your wallet/purse?
Patient	By check.
Registrar	Will you be sending a check as soon as you get home? Here is a self-addressed envelope for your convenience.
Patient	Yes. I can send one out then.
Registrar	Will that be for the entire balance?
Patient	Yes.
Registrar	Thank you for your cooperation and have a nice day!

Scenario 4	When the patient says "I'm disabled"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I am disabled.
Registrar	Where are you disabled from?
Patient	XYZ Company.
Registrar	JWhen do you receive disability benefits?
Patient	Every 2 weeks.
Registrar	Are you able to pay today?
Patient	I can only pay $20.00 today and the balance from my next check.
Registrar	When will you get your next check?
Patient	On the 17th of this month.
Registrar	I will make a note on the account that you will be paying the rest of the amount on the 17th.

Scenario 5	When the patient says "This is Ridiculous"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	This is ridiculous!
Registrar	Why is that? This is a business that needs money to keep it going. When do you plan on paying this account?
Patient	I have no money today.
Registrar	When do you get paid?
Patient	Next week, on Friday.
Registrar	Will you be paying the entire balance then?
Patient	I wish!
Registrar	Does that mean you'll make a partial payment?
Patient	I have so many bills and very little money to go around.
Registrar	Please call the financial counselor to talk about your financial situation.

Scenario 6	When the patient says "I was in an auto accident"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I was involved in an auto accident.
Registrar	The hospi1al holds you responsible for the bill. When you receive the bill from the hospital, forward it to the responsible party or his or her insurance company as soon as possible.
Patient	But it was not my fault.
Registrar	We will note the account to that effect, so that this situation will be known to anyone else working the account. But we still have to hold you responsible because the hospital is not a party to the case. Just send the bill to the party who was at fault.

Scenario 7	When the patient says "I have no money/no job"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I have no money and no job.
Registrar	Do you receive unemployment benefits?
Patient	Yes I do-every two weeks.
Registrar	Please call the financial counselor so that something can be worked out regarding your situation.

Scenario 8	When the patient says "I have insurance but a high deductible"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I have insurance, but it never pays anything since I have a $1,000 deductible.
Registrar	It would be to your advantage for the hospital to bill for this service to your insurance company. It will go against your high deductible.
Patient	Here is my insurance card.
Registrar	Would you like to put the balance on your credit card?
Patient	(after a little hesitation) OK. Here is my Discover card.
Registrar	Thank you for your payment. And remember to have your insurance billed each time you have medical services done.

Scenario 9	When the patient says "I have $20 to put down"
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	I have a $20 bill to put down on it.
Registrar	Thank you and here is your receipt. When will you be paying the balance?
Patient	I get paid on the 20th and should be able to pay the balance then.
Registrar	I will note the account for this arrangement. If by chance you cannot pay the balance on the 20th, please call the office.

Scenario 10	When the patient says ''Just charge it''
Registrar	The charge is X dollars. Wi11 that be cash, check, or credit card?
Patient	Just charge it.
Registrar	What credit card do you want to use?
Patient	Put it on my account!
Registrar	We have no revolving accounts here. The hospital requests that the account be paid today.
Patient	(getting out checkbook) How much is that again?

Courtesy of Mary Rutan Hospital, Bellefontaine, OH.

PREPARED STATEMENT OF LAURENCE J. MASSA, PRESIDENT, MINNESOTA HOSPITAL ASSOCIATION, ST. PAUL, MN

Senator Franken, thank you for the opportunity to submit written testimony to you. I am Lawrence Massa, president of the Minnesota Hospital Association. We represent 145 Minnesota hospitals and 17 health systems in the State.

We are proud of the 113,000 health care professionals who provide exceptional care to our patients 24 hours a day, 7 days a week. That commitment to our patients continuously lands Minnesota in the top rankings for patient safety and quality of care, according to Health Grades, US News & World Report, Thompson Reuters, and the Commonwealth Fund—among others.

The most important point I want to make today is that the standard for Minnesota hospitals is patient care above all. The conversation about billing should never get in the way of patient care.

How hospitals have that conversation about billing is very important, and there are three important aspects to this conversation that I would like to discuss:

1. Our regulatory requirements under EMTALA—the Federal Emergency Medical Treatment and Active Labor Act;
2. Our transparency and responsiveness to patients on billing questions; and
3. Our commitment to assist patients who are uninsured or underinsured.

1. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to conduct a medical screening examination and determine whether an emergency medical condition exists before asking for reimbursement in the Emergency Department. A patient with a life-threatening illness, a person involved in a car crash or a person with severe pain, for example, needs medical attention and care.

Minnesota hospitals routinely take care of patients without regard for the cost of a procedure or concern about payment. Our obligation is clear: we treat a person with a medical emergency.

2. Last year, Minnesota hospitals had 10 million outpatient visits. Minnesota hospitals provided in-patient care to nearly 600,000 people. It's important to draw a distinction between emergencies and admitting a patient where there is not an emergency or when outpatient procedures are scheduled in advance.

The fact is an increasing number of employers are asking employees to shoulder a greater burden of their health care costs with high-deductible insurance plans. As this occurs more and more often, consumers are taking note of how much health care costs, and communication between the hospital and patient helps people plan for health care.

Hospitals are continuously surveying patients on their experience. This is part of the goal of the Triple Aim we all strive for in health care today—the improved health of the population, a great patient experience and the affordability of care. Further, under the Affordable Care Act, patient satisfaction is an increasingly important factor in determining a portion of reimbursement from Medicare under its new value-based purchasing program. This is something Minnesota hospitals support.

I was the CEO of Rice Memorial Hospital in Willmar for 15 years. I know from my own experience as well as my travels around the State with our members over the past 3 years that patients increasingly want to know up-front how much a procedure is going to cost. Patients sometimes decide to defer or delay elective procedures because of that cost estimate.

As a result, we are as transparent and responsive to our patients as possible and provide this information when asked—and at the appropriate times.

3. Uncompensated care costs are growing rapidly, and our hospitals are increasingly assisting individuals without insurance. In 2010, there were more than 1.6 million visits to our hospital's emergency rooms. There are 128 24-hour emergency rooms in the State. All of Minnesota's hospital emergency rooms treat anyone who enters, regardless of their ability to pay.

In many cases, Minnesota hospitals provide care to patients who do not have health insurance. As you know, the emergency room is sometimes the only place for care for people without insurance. In 2010, Minnesota hospitals provided $311 million in uncompensated care—including charity care and bad debt. In addition, we provide care below cost to patients covered by government programs such as Medicare and Medicaid as a result of payments below the cost of care.

When patients do not have insurance, hospitals often assist patients to see if they qualify for Medical Assistance or other public programs. In addition, every hospital has financial assistance/charity care programs for those patients that fall through the cracks of eligibility for public programs. These evaluations need to occur at the time the patient is seen so that adequate eligibility information may be collected. Getting patients enrolled in these programs is critical to ensuring followup care and care coordination.

In fact, our hospitals are going to great lengths to see to it that patients who are eligible for programs get the assistance they need to enroll. For example:

Allina Health's long-standing "Med-Eligible" program provides services to any patient admitted from the ER who does not have insurance. Twenty-six staff members serve Allina hospitals. These specialists meet with patients, assuring them it is a free service to see if they are eligible for any government or hospital programs. If a patient is receiving treatment, the specialist will simply tell the patient that they should take care of himself or herself, and that they're here for them and will sit down with them at the appropriate time. They find that many patients are panicking about how to pay for tests.

The Med-Eligible program specialists offer assistance with applications for Medical Assistance or a hospital financial assistance program. They advocate for the patient. The Med-Eligible program helps 1,300 patients each month, and in the course of a year may have only 10 to 15 people who don't want the help.

These specialists also help patients with other, non-hospital needs. They assist in getting patients to a clinic appointment and making sure they have what they need to make the appointment. They also assist with access to community services, including transportation and food shelves.

Ultimately, the hospital gets paid as a result of enrolling a patient in a government program, but that is not Allina's first priority. I share this example with you because it is the right way to engage a patient in a conversation about payment. And it is an example of what hospitals are doing to reduce uncompensated care.

Finally, there are standards and policies in place on how hospitals interact with a patient on billing and payment—both in Minnesota and nationally.

Most Minnesota hospitals use internal staff for initial billing and followup. However, some do contract with an outside law firm or a vendor to collect unpaid bills. In 2005, an agreement with the attorney general set in place a high level of care for how patients are to be handled when a hospital is collecting on a debt. The hospital CEO, the hospital board, and other senior hospital executives must actively oversee the activities of hospital debt collection agencies and approve of any debt collection actions taken by the debt collectors. The debt collector must provide detailed information to patients about their debt and payment history and the hospital's charity care policy. They must charge a flat fee for their services, meaning they do not earn a commission on debt they recover.

The agreements with the attorney general were renewed in 2007 for an additional 5 years and are in the process of being renewed again for an additional 5 years. The attorney general's office is sending new agreements in coming months to hospitals. The MHA board of directors unanimously passed a resolution at its May 18 meeting recommending that our member hospitals sign the agreements.

The requirements of the agreements between Minnesota hospitals and the attorney general are also similar to those standards adopted by Congress as part of the Affordable Care Act. The ACA created a new Section 501(r) of the Internal Revenue Code that includes standards of conduct for non-profit hospitals that are very much in line with what Minnesota hospitals have been doing since 2005.

In my visits around the State with our member hospitals recently, I can say these situations you've heard about are rare and not the standard. Minnesota hospitals are dedicated to providing exceptional patient care and quality every time.

ACCRETIVE HEALTH,
CHICAGO, IL 60611,
June 6, 2012.

Hon. AL FRANKEN,
U.S. Senate,
Washington, DC 20510.

DEAR SENATOR FRANKEN: On behalf of Accretive Health and its thousands of employees in Minnesota and around the country, I want to thank you again for the opportunity to appear at last week's hearing to speak about our company's work and the other critically important issues you raised. I write today to correct the record with respect to one issue.

At last week's hearing, Attorney General Swanson stated in her testimony that Accretive Health and North Memorial Health Care worked together to create and "basically backdate" a Business Associate Agreement ("BAA"). The attorney general is mistaken.

In connection with the Accretive Health/North Memorial March 21, 2011 Revenue Cycle Management Agreement ("RCM"), both parties contemplated, and the contract required, the execution of a Business Associate Agreement ("BAA"). The parties believed they executed a BAA prior to or at the time services commenced and, in accord with ordinary and customary practice, acted at all times consistent with the terms of the BAA, meeting all the requirements of HIPAA and HITECH. In October 2011, the parties could not locate the executed copy of the BAA. Accordingly, a replacement BAA was signed in October 2011. The replacement BAA was *not* backdated. The only reference to a past date—consistent with the requirements and execution date of the RCM contract—was making the replacement BAA *effective* March 21, 2011 so that it would accurately reflect the period during which RCM services were provided. Accretive Health voluntarily produced documents related to this issue to the attorney general's office, and also explained this chronology to Attorney General Swanson in March 2012. In addition, it is our understanding that North Memorial also produced documents related to this issue and explained the BAA chronology to the attorney general's office in April and again in May 2012.

Thank you again for the opportunity to be a part of last week's proceedings.

Sincerely,

GREG KAZARIAN.

MINNESOTA NURSES ASSOCIATION (MNA),
ST. PAUL, MN 55102,
May 30, 2012.

Hon. AL FRANKEN,
60 East Plato Blvd., Suite 220,
Saint Paul, MN 55107.

The Minnesota Nurses Association would like to thank Senator Franken for holding this hearing today and to again, applaud Attorney General Swanson for pursuing the investigation into Accretive Health's debt collection tactics.

The Code of Ethics for Nurses directs patients be treated with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status. Requiring payment while patients lay in pain, is not compassion. We know how financial stress can impact a patient's compliance with health care directives and can create negative health outcomes. We also promote, advocate and strive to protect the health, safety and right of the patients. The unethical practice of demanding bill payment for services not rendered is precisely why nurses are needed on the front lines of patient advocacy. From a legal aspect, we also question if Accretive is violating Federal EMTALA laws. Further investigation is warranted and we would be eager to help Senator Franken and Attorney General Swanson in every way possible to make sure this cut-throat debt collection behavior is abolished in Minnesota.

Accretive Health's mission statements seem contradictory from their actions. For example, on their Web site, one reads this corporation is ". . . a built-for-purpose company with the sole focus of providing end to end revenue cycle execution for providers." Its stated mission is "to strengthen the financial stability of health care providers through excellence, best people, and leading technology there by increasing health care access for all." We have to wonder how chasing people out of the emergency room by demanding up front payment increases access to health care? Their claims to increase access to care by bringing increased discipline to the revenue cycle, but services rendered are far different from demanded up front payment.

Most concerning for the future of health care, we notice that Accretive claims they have signed an "inaugural deal" to help providers become Accountable Care Organizations—a lynchpin of the Affordable Care Act. As ACOs find their place in our health care system, we should be wary of Accretive's past practices and *best* practices.

The members of the Minnesota Nurses Association have long been advocates for a single-payer health care system. This example of ruthless "profits before patients" behavior is just one more reason why our Nation should consider pursuing a payer system that is not dependent upon free-market whims, that too frequently leaves patients behind, and not at the forefront where they should be.

From our press release on May 8, MNA president Linda Hamilton, RN, stated:

> "On behalf of our 20,000 nurses, I want to thank Lori Swanson for ignoring political pressure and corporate influence and continuing to stand up for the patients we care for. What Accretive is doing seems to be the epitome of the 'profits-before-patients' type of health care delivery that needs to stop, and we're grateful Attorney General Swanson is having none of it."

Thank you again Senator Franken and Attorney General Swanson and we stand ready to help in any way possible.

Sincerely,

LINDA HAMILTON, RN, BSN,
President, Minnesota Nurses Association.

MAY 25, 2012.

Hon. AL FRANKEN,
60 East Plato Blvd, Suite 220,
Saint Paul, MN 55107.

Re: Statement for Field Hearing on Ensuring Patients' Access to Care and Privacy

DEAR SENATOR FRANKEN: Patient advocates for rare disorders are deeply concerned about protecting the personal health information of these vulnerable patients. While we support the concept of using technology and electronic medical record sharing to facilitate coordination of care, patient education and scientific collaboration, we are increasingly alarmed at the ease of access to personal medical information by entities that either do not intend to abide by existing regulation or who fall outside of the current regulatory structure and whose primary interest is not patient welfare.

Specifically we are concerned that, because many people affected by rare disorders have extraordinary health care needs, they may be targeted in data collection efforts designed to identify "outliers" and restrict access to needed care and services. Additionally, the sense of isolation experienced by those with rare disorders makes them especially vulnerable to opportunities to share what should be protected health data on public forums, particularly social networking platforms, run by entities exempt from HIPAA statutes. This data then becomes a valuable commodity for individuals and entities with no regulatory requirement to protect patient privacy. Also, numerous non-profit "advocacy" groups have entered the data collection fray, many of which are in reality nothing more than industry-sponsored direct-to-patient marketing and recruitment initiatives that allow companies to collect data voluntarily provided by patients, while avoiding compliance with regulatory requirements. It is increasingly difficult to distinguish between legitimate and predatory initiatives, a situation that potentially puts patients at great risk for misuse of their personal data.

As representatives of patient advocacy organizations who work on behalf of patients with extraordinary healthcare and research needs, we question the value of imposing additional regulation that would interfere with achieving patient care goals. However, we are aware that personal health information has become a valuable commodity and believe that regulation must ensure that the value derived from this commodity actually goes to benefit the patients to whom these data ultimately belong. To that end, we support regulatory efforts that have as their objective improving patient care and access to services and research.

Sincerely,

MICHELE MANION, *Executive Director*,
Primary Ciliary Dyskinesia (PCD) Foundation.

CYNTHIA LE MONS, *Executive Director,*
National Urea Cycle Disorders Foundation (NUCDF).

RESPONSE TO QUESTIONS OF SENATOR FRANKEN BY LORI SWANSON, MICHAEL ROTHMAN, CHARLES MOOTY, GREGORY KAZARIAN, JEAN ROSS, RN, MICHELE GOODWIN, AND JESSICA L. CURTIS, J.D.

LORI SWANSON

Question 1. As you know, under Federal law, a hospital that wishes to qualify for non-profit status must meet the "community benefit standard." In other words, hospitals are eligible for non-profit status only if they promote the health of a broad class of individuals in the community. Do you believe that the current Federal requirements on non-profit hospitals are sufficient?

Answer 1. Non-profit charitable hospitals receive significant benefits from taxpayers in the form of tax exemptions. They may qualify for exemptions from sales, income, and property taxes and may issue tax-exempt bonds. In exchange, charitable hospitals are expected to fulfill a charitable purpose and act in a manner consistent with their charitable duties and mission.

In 2005, the Office of the Minnesota attorney general entered into an agreement with every hospital in Minnesota. The agreement (hereinafter "Hospital Agreement") was renewed in 2007 for a 5-year term. Prior to the Hospital Agreement in 2005, charitable hospitals in Minnesota—like elsewhere in the country—charged significantly more to uninsured patients than they charged to managed care companies or the government for the same services. Under the Hospital Agreement, Minnesota hospitals agreed to charge no more for uninsured treatment than they charged to the private third-party payer that delivered the most revenue to the hospital (which is typically the insurer that negotiates the highest discounts). In addition, the Hospital Agreement requires hospitals to adhere to certain collection standards. Under the Hospital Agreement, hospitals must adopt charity care policies and communicate those policies clearly to eligible patients. The agreement also requires hospitals to comply with certain elevated standards concerning debt collection, and requires a hospital's board of directors to annually review the practices of any third-party collection agencies, as well as the hospital's own internal collection practices. The hospitals must have a "zero tolerance" policy against abusive, harassing, or oppressive collection practices, whether by their own employees or by outside collectors.

The Hospital Agreement contains industry-leading standards. Congress should consider adopting the substantive provisions as law so that patients throughout the country will receive these benefits and protections.

Question 2. If patients' protected health information is not secure, what would be the effect on our healthcare system, including on patients' willingness to have candid conversations with their healthcare providers?

Answer 2. The doctor-patient relationship is predicated on trust. Medical privacy is a bedrock principle of the doctor-patient relationship. Confidentiality is important to encourage a full and frank exchange of information between patients and their doctors. If patients are worried about whether their medical information will be given to a debt collector or otherwise kept private, they may be less willing to seek treatment. This would be detrimental not just to the particular patient, but to the public as a whole as it relates to illnesses like communicable diseases, mental health, and treatment of chronic health conditions. Untreated communicable diseases and mental health problems can impact public health and safety, and untreated chronic health conditions can increase costs to be borne by taxpayers.

Question 3. You filed a complaint under Minnesota's debt collection statute instead of under the Fair Debt Collection Practices Act (FDCPA). Are there any weaknesses or loopholes in the FDCPA that make it difficult for Attorneys General to enforce? And do you have any suggestions for improving the statute?

Answer 3. Minnesota's debt collection law (Chapter 332 of the Minnesota statutes) incorporates the substantive provisions of the Federal Fair Debt Collection Practices Act ("FDCPA") and applies to collectors who collect "accounts, bills, or other indebtedness." Not every State, however, has adopted the substantive provisions of the FDCPA. State attorneys general do not currently have authority to directly bring an enforcement action under the FDCPA. That authority is left primarily to the Federal Trade Commission and individual consumers. Congress should consider giving State attorneys general the same authority to bring a claim under the FDCPA as the Federal Trade Commission. Congress should also increase the fines available to the Government and consumers under the FDCPA. Beyond the medical debt collection area, Congress should update the FDCPA to provide more protections to consumers who are hounded by debt buyers for "zombie debt" or money they do not owe.

Question 4. In your compliance report, you discuss Accretive's use of incentives—including public recognition, prizes, and monetary bonuses—to encourage Fairview employees to increase the amount of money they collected from patients. What effect did these incentives have on the culture at Fairview?

Answer 4. We found a culture clash between the mission of the charitable hospital and Accretive's "numbers driven" culture.

A hospital emergency room is and should be a solemn place. It is a place where parents lose children, children lose parents, and spouses lose each other. It is a place of medical trauma and emotional suffering. Charitable hospitals more broadly should be sanctuaries to treat the sick, the injured, and the infirm.

By contrast, Accretive's management contract unduly incentivized Accretive to ignore the culture, mission, and duties of the charitable hospital, and the charitable hospital was unable to restrain Accretive. Accretive assumed day-to-day management responsibility for the hospital employees who perform registration, admissions, and collections functions. Accretive used "chalk talks" to enforce collection quotas among hospital registration and admission staff, including in the ER. It gave hospital emergency room and registration staff prizes for meeting their collection quotas. Accretive managers promised to wear clown outfits or costumes if hospital employees met their collection quotas. The company's tactics failed to reflect proper compassion and concern for the dignity and well-being of patients.

MICHAEL ROTHMAN

JUNE 20, 2012.

Hon. AL FRANKEN,
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC 20510.

DEAR SENATOR FRANKEN: I write in response to your June 12, 2012 request concerning the three questions for the record following your May 12, 2012 Committee on Health, Education, Labor, and Pensions field hearing in St. Paul. I appreciate the opportunity to provide the answers to your questions below.

Question 1. I understand that your Commission conducted an investigation into Accretive's call center in Kalamazoo, MI. The attorney general's report says that your examiners listened to recordings of calls between the debt collectors and patients and that the debt collectors were using private health information in those calls. How was private health information used in those calls? If you cannot discuss specifics about this case, please explain how debt collectors could potentially use private health information in an inappropriate or illegal manner while attempting to collect debts?

Answer 1. While I would like to provide specific details on the record at this time, the details relating to an ongoing investigation in the Accretive matter are classified as confidential until the investigation is no longer active under Minnesota Statutes Section 13.39.

With respect to the second part of the question, over the past year and a half and as a general proposition, consumers' financial information and other personal information such as health information can be at risk because of inadvertent or intentional improper access to this consumer information. Investigations conducted by the Department of Commerce have revealed that consumers' personal information has been inappropriately compromised and in some instances stolen during the course of collection activity by individual collectors. While Minnesota law prohibits a collector from using consumers' personal information for anything other than the collection activity, there are instances when this has not taken place. Thus, it is always a concern that identity theft, improper tactics, and other types of fraud may occur. If the Department of Commerce becomes aware of any such activity through individual complaints or other means, our staff works to carefully determine the merit of these complaints. When warranted, the Department's review may move to the stage of a formal, comprehensive investigation.

Question 2. Please describe the key differences between Minnesota's debt collection statute and the Fair Debt Collection Practices Act.

Answer 2. Our staff prepared an outline of differences between Minnesota's debt collection statute and the Fair Debt Collection Practices Act (FDCPA), which I have attached as Exhibits A and B. Exhibit A is a brief discussion of Minnesota law relative to the Fair Debt Collection Practices Act (FDCPA). Exhibit B is a chart that compares both laws section by section. Please note that Exhibit B contains relevant

information from the statutes, not necessarily the exact language or entire text of the provisions. Please reference the statutes for exact language as necessary.

Question 3. In your view—and based on your work on this case and others—are there areas of Federal debt collection law that need to be updated or improved to protect patients in Minnesota and throughout the country?

Answer 3. During the May 30, 2012 Committee on Health, Education, Labor, and Pensions field hearing, two Minnesota consumers testified to experiences they had where they were asked for prepayment before receiving treatment while at the hospital. Additionally, there have been news reports that consumers had been asked to pay debts while they or a family member were about to undergo treatment. With respect to these instances, it appears that section 1692c(a)(1) of the FDCPA offers consumers the following protection from communications at any unusual time or place or a time or place known or which should be known to be inconvenient to the consumer:

(a) Communication with the consumer generally

Without the prior consent of the consumer given directly to the debt collector or the express permission of a court of competent jurisdiction, a debt collector may not communicate with a consumer in connection with the collection of any debt—

> (1) at any unusual time or place or a time or place known or which should be known to be inconvenient to the consumer. In the absence of knowledge of circumstances to the contrary, a debt collector shall assume that the convenient time for communicating with a consumer is after 8 o'clock antemeridian and before 9 o'clock postmeridian, local time at the consumer's location;

As a suggestion, you may wish to consider strengthening this provision to clearly address issues of concern that were raised during the May 30, 2012 field hearing. For example, Minnesota law addresses this issue to some extent. Minnesota Statutes section 332.37(14) (2012) states that,

> "No collection agency or collector shall . . . in collection letters or publication, or in any communication, oral or written, imply or suggest that health care services will be withheld in an emergency situation."

Thank you for the opportunity to respond to your questions. Please let me know if I can be of further assistance to you.

Sincerely,

MIKE ROTHMAN,
Commissioner.

EXHIBIT A

Date: June 19, 2012

To: The Honorable Al Franken

From: The Minnesota Department of Commerce

Re: Comparison of Minn. Stat. Ch. 332 and the FDCPA (Exhibit A)

ISSUE

Identify key differences between Minnesota's debt collection statute and the Federal Fair Debt Collection Practices Act.

SHORT ANSWER

The most significant differences included in the Minnesota debt collection statute are:

- the methodology of licensing and registering debt collectors and debt collection agencies,
- the ability of the Commissioner of Commerce ("commissioner") to take action in relation to such licenses and registrations,
- supplemental debt collection conduct prohibitions, and
- additional protective measures.

INTRODUCTION

The Minnesota debt collection statute, Minn. Stat. §332.31 *et. seq*. (2012) ("Minnesota statute"), and the Federal Fair Debt Collection Practices Act, 15 U.S.C.A. §1692a *et. seq*. ("Federal FDCPA") contain the same general approach in relation to debt collection in an attempt to protect consumers and facilitate fair competition

amongst debt collectors. Both statutes prescribe behavior requirements and dictate prohibited conduct for debt collectors, as well as provide consequences and penalties for violations. The Federal FDCPA grants regulatory authority for debt collection to the Federal Trade Commission ("FTC"), and the Minnesota statute grants like authority to the commissioner. The crucial difference, however, is the method utilized to attain the objective of fair debt collection. The Minnesota statute includes a system of registration and licensure for both debt collection agencies and individual debt collectors. Further, the Minnesota statute affords protection to consumers through various prohibited conduct provisions in addition to those in the Federal FDCPA, and includes several additional protective measures.

In general, the Minnesota statute offers an approach that is focused on prevention of unfair debt collection practices with an emphasis on requiring financial responsibility, transparency to ensure accountability and compliance, and availability of information to facilitate effective enforcement of regulations.

DISCUSSION

I. Methodology

A. Generally

A comparison of the Federal FDCPA and the Minnesota statute reveals similar objectives, language and approach on a broad level. Both regulatory schemes endeavor to protect consumers and promote fair competition among debt collectors. The Minnesota statute, however, is distinct from the Federal FDCPA in several respects. First, the Minnesota statute distinguishes between debt collection agencies and individual debt collectors, wherein a debt collector is a person acting under the authority of a debt collector. This distinction is necessary to effectuate Minnesota's system of licensing and registration, as discussed below. The Federal FDCPA, on the other hand, regulates the activities of agencies and collectors more generally as "debt collectors." 15 U.S.C.A. §1692a(6).

In addition, the Federal FDCPA is more detailed in structure as it divides required conduct and prohibited behavior into separate sections, whereas the Minnesota statute more generally includes all prohibited practices into one section. The Federal FDCPA goes into more depth than the Minnesota statute in relation to some of these practices, including: acquisition of location information, communication with consumers and third parties, furnishing deceptive forms, exclusions and exemptions from the chapter, exceptions for certain bad check enforcement programs, and more. It is important to note, however, that the Minnesota statute incorporates any violation of the Federal FDCPA as a violation of the Minnesota statute in its Prohibited Practices section. Minn. Stat. §332.37(12).

B. Licensing and Registration

A critical difference between the Federal FDCPA and the Minnesota statute is Minnesota's system of licensing and registration. The Federal FDCPA does not require debt collectors to obtain licenses or register with any government entity before conducting debt collection activity. Rather, the FTC has authority to enforce compliance of the FDCPA unless authority is specifically committed to another government agency. 15 U.S.C.A. §1692*l*(a). Likewise, the FDCPA grants the Bureau of Consumer Financial Protection the authority to prescribe rules with respect to debt collection. 15 U.S.C.A. §1692*l*(d). Further, the FDCPA stipulates that persons are subject to State debt collection laws except to the extent that State laws are inconsistent with the FDCPA. 15 U.S.C.A. §1692n. Inconsistency, however, does not include protection afforded to consumers that is greater than the protection in the FDCPA. *Id*. Thus, the Minnesota statute works to implement an additional level of protection to Minnesota consumers in relation to fair debt collection.

Minnesota Statutes sections 332.33–.355 ("the license provisions") comprise the debt collection licensure and registration component of the Minnesota statute. Minnesota Statutes Section 332.33, Subdivision 1 requires any person to apply for and obtain a collection agency license from the commissioner before conducting business as a collection agency or engaging in the business of collecting claims for others. In addition, any person acting under the authority of a collection agency as a collector must be registered with the commissioner. *Id*. Thus, a collection agency must register with the State all individual employees who perform the duties of a debt collector. Minn. Stat. §332.33 Subd. 5a. The penalty for violating the license and registration requirements, and for carrying on business after the revocation, suspension, or expiration of a license or registration, is a misdemeanor. Minn. Stat. §332.33 Subd. 2. This penalty is unique to the Minnesota statute, as the Federal FDCPA lacks a license and registration requirement and imposes civil liability for violations of the statute in the form of damages. 15 U.S.C.A. §1692k.

The Minnesota statute's license provisions specify detailed requirements for the process of obtaining, using and renewing debt collection licenses and registrations. This includes term limits, application and renewal fees, display and notice requirements and more. Minn. Stat. §332.33 Subd. 3–8. In addition, the license provisions prescribe the commissioner's method for granting and rejecting license and registration applicants. Minn. Stat. §332.33 Subd. 4–5. As a further method of protection, Minnesota Statutes section 332.33, subdivision 8 requires each licensed collection agency to establish screening procedures for debt collector applicants prior to submitting applicants to the commissioner for registration. The commissioner has the authority to review such procedures. *Id*. Likewise, licensed collection agencies must notify the commissioner of any employee termination within 10 days of termination if it is based on a violation of the Minnesota statute. Minn. Stat. §332.385.

As previously discussed, the Minnesota statute differentiates between debt collection agencies and individual debt collectors, Minn. Stat. §332.31, whereas the Federal FDCPA does not, 15 U.S.C.A. §1692a(6). The Minnesota statute grants the commissioner authority "to take action against any collection agency for any violations of debt collection laws by its debt collectors." Minn. Stat. §332.355. Likewise, the commissioner "may also take action against the debt collectors themselves for these same violations." *Id*. This in effect creates an incentive for collection agencies to employ responsible debt collectors, as well as an incentive for debt collectors to comply with debt collection laws, for either or both may be liable for violations. Overall, the Minnesota system of debt collection licensing and registration provides an additional level of protection for consumers and facilitates fair competition among debt collectors generally. The license provisions also provide a more direct route for the commissioner to support, regulate and take action in regards to debt collection in Minnesota.

II. Prohibited Practices

Both the Minnesota statute and Federal FDCPA include a list of conduct that is prohibited for debt collectors and/or debt collection agencies. Many of the provisions are similar and effectively the same; however there are many provisions that are unique to both. One important inclusion in the Minnesota statute's Prohibited Practice's section's provision that no collection agency or collector shall "violate any of the provisions of the Fair Debt Collection Practices Act of 1977, Public Law 95–109, while attempting to collect on any account, bill or other indebtedness." Minn. Stat. §332.37(12). Therefore, though certain provisions appearing in the Federal FDCPA do not have an equivalent provision in the Minnesota statute, it follows that the violation of Federal FDCPA provisions implies a violation of the Minnesota statute as well.

Several notable provisions appear in the Minnesota statute's Prohibited Practices section that establish additional protections for consumers beyond the protection afforded by the Federal FDCPA. A full account of these provisions is included in Appendix A under Minnesota Statutes section 332.37. One of the most prominent is Minnesota Statutes section 332.37(14), which provides, no collection agency or collector shall "in any communication imply or suggest that health care services will be withheld in an emergency situation." *Id*. This provision effectuates the objective of protecting consumers from threatening behavior in their most vulnerable moments. Likewise, several provisions in the Minnesota statute attempt to prevent deceptive debt collection behavior. Minnesota Statutes section 332.37(21) requires debt collectors and agencies to provide a disclosure notice that includes a statement that they are properly licensed when initially contacting debtors by mail. Specifically, this statement must be of equal or greater font size than the text of the notice. Minnesota Statutes section 332.37(18) stipulates that collection agencies and debt collectors shall not accept payment without issuing a receipt. This prevents scenarios when debt collectors could unfairly take advantage of debtors who have in fact made payments. Likewise, debt collectors and agencies may not use shame cards or shame automobiles to coerce payment. Minn. Stat. §332.37(7). This goes beyond the Federal FDCPA requirement that mail to debtors may not include language that indicates its purpose for debt collection. 15 U.S.C.A. §1692f(8). Overall, in accordance with the Federal FDCPA, the Minnesota statute provides a greater level of protection for consumers by imposing additional prohibited behaviors on debt collection agencies and collectors.

III. Specific Additional Provisions

Several other important provisions in the Minnesota statute do not appear to have equivalent provisions in the Federal FDCPA. These provisions afford subsequent levels of protection to consumers and/or deterrence for unfair debt collection practices. Minn. Stat. §332.34, for example, requires that each collection agency licensee

must file and maintain a corporate surety bond with the commissioner. Likewise, Minnesota Statutes §332.345 stipulates that payments collected by collectors or collections agencies on behalf of customers must be held by in a separate account in an authorized institution clearly designated for customer funds. Further, Minnesota Statutes §332.35 provides the commissioner shall not issue a license to or register any person, firm, corporation or association who has been convicted of fraud or a felony in the past 5 years for failure to account money collected by them to their clients or customers. This effectively disqualifies such persons or entities from engaging in lawful debt collection activity, and acts as a deterrent, penalty and barrier to re-entry for violators.

The Minnesota statute also grants the commissioner authority in relation to licenses and registrations that appears to go beyond the authority of the FTC under the Federal FDCPA. The commissioner may institute proceedings or impose civil penalties within 2 years if a license or registration relapses, is surrendered, withdrawn, terminated or otherwise becomes ineffective. Minn. Stat. §332.395. In addition, the commissioner may make examinations of collection records in order to enforce the Minnesota statute. Minn. Stat. §332.40 Subd. 1. Licensed collection agencies are required to keep such books and records in the place of business in this State. Minn. Stat. §332.42 Subd. 2. The commissioner may also require a licensed agency to submit a verified financial statement for examination to determine whether the collection agency is financially responsible and solvent. Minn. Stat. §332.42, Subd. 1. If upon examination of records the commissioner discovers any violation, the commissioner may revoke or suspend a license or registration. Minn. Stat. §332.Subd. 1. Similarly, in order to determine if a license or registration should be issued, the commissioner may investigate within or without this State as necessary to verify whether any person has violated the Federal FDCPA. Minn. Stat. §332.40 Subd. 2. In addition, the commissioner may use the power of subpoena to effectuate the purpose of any investigation under this section. Minn. Stat. §332.40 Subd. 3.

In general, the additional provisions present in the Minnesota statute where an equivalent provision is not expressly included in the FDCPA, effectively promote greater protection for consumers and fair conduct by debt collectors. The provisions in the Minnesota statute related to the commissioner's authority and violations of this chapter compliment these objectives by providing direct method of remedy and avenue of enforcement. The additional provisions advance the purposes of the Federal FDCPA by further deterring unfair debt collection practice and rectifying damage created by such.

CONCLUSION

The Federal FDCPA and the Minnesota statute both endeavor to ensure adequate consumer protection from unfair debt collection practices and support fair competition among debt collectors. The Minnesota statute supplements the Federal FDCPA through its method of issuing licenses for debt collection agencies and registering individual debt collectors. This allows for a greater measure of regulation and an effective method of enforcement by the commissioner. Specific debt collector prohibited practices in addition to those provided in the Federal FDCPA also promote a greater level of protection for consumers. Additional provisions in the Minnesota statute not found in the Federal FDCPA effectively provide more protection for consumers and facilitate fair debt collection in the State of Minnesota.

EXHIBIT B

Fair Debt Collection Practices Act (Exhibit B)

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
1692a	Definitions ..	(6): Defines ''debt collector'' broadly, does not distinguish between individual collectors and agencies.	332.31	Definitions	Subd. 3: Defines ''collection agency'' as any person (individuals, partnerships, associations or corporations) engaged in business of collection for others; Subd. 6: Defines ''collector'' as a person acting under the authority of a collection agency.

Fair Debt Collection Practices Act (Exhibit B)—Continued

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
1692b	Acquisition of location information.	Allows a debt collector to communicate with persons other than the consumer to acquire location information including place of abode, telephone number and place of employment. The consumer is any natural person obligated or allegedly obligated to pay any debt. (1)–(6) address limits on communication methods employed by debt collectors with parties other than the consumer; collector must identify himself, prohibits communicating more than once without specific request, communication by postcard, statements that the consumer owes debt, and communication with persons other than an attorney if collector possesses knowledge of representation by attorney.			

Fair Debt Collection Practices Act (Exhibit B)—Continued

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
			332.33	Licensing and Registration.	Subd. 1: Requires a person conducting a collection agency or collecting claims in Minnesota to apply for and obtain a collection agency license prior to conducting business; Subd. 1: Also requires a person acting under the authority of a collection agency to register with the commissioner. Subd. 2: Penalty, A person who conducts business as a collection agency before obtaining a license, or acts as a collector without first registering, or carries on with business after revocation, suspension or expiration of a license or registration, is guilty of a misdemeanor. Subd. 3: Term Licenses and registrations expire on June 30. Subd. 4 Permits the commissioner to conduct investigations and require financial documents pertaining to the financial adequacy of license and registration applicants. Subd. 5: Describes the collection agency license issuing procedure. Subd. 5a Requires licensed collection agencies to register all individual employees who act as debt collectors. Subd. 8: Requires collection agencies to establish procedures for screening individual collector applicants prior to submitting registration applications to the commissioner.
			332.3351	Exemption from licensure.	Allows collection agencies exemption from licensure and registration requirements if specified conditions are met.

Fair Debt Collection Practices Act (Exhibit B)—Continued

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
1692c ..	Communication with consumer.	Dictates prohibited behavior for communicating directly with consumers. Consumer for this section includes: consumer's spouse, parent (if minor), guardian, executor or administrator. (a)(1)–(3): Prohibits communication at unusual times or places known to be inconvenient (convenient is 8:00am–9:00pm consumer's local time only), communication directly with consumer if represented by an attorney or at consumer's place of employment.			
	Communication with third parties.	(b): Prohibits debt collector communication with third parties, unless given prior consent directly from the consumer or court of competent jurisdiction, or acting within §1692b. Debt collector may communicate with consumer's attorney, attorney of the creditor, attorney of the debt collector, or consumer reporting agency if permitted by law.			
	Ceasing Communication.	(c): Prohibits further communication if consumer notifies debt collector in writing that consumer refuses to pay the debt or wishes to cease communication. (c): Exceptions include advising consumer that collection efforts are being terminated, and notifying consumer that debt collector or creditor may or intends to invoke specified remedies.			
			§332.34	Bond	Requires collection agencies to file and maintain a corporate surety bond of at least $50,000, or deposit cash deemed acceptable by commissioner in lieu of a bond.
			§332.35	Prior conviction or judgment as disqualification.	Registration and licenses shall not be issued to any person, firm, corporation, association or any of its officers if convicted of fraud, felony or had judgment against them for failure to account collections to customers within the past five years.

Fair Debt Collection Practices Act (Exhibit B)—Continued

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
			§332.345	Segregated Accounts.	Requires collectors and collection agencies to deposit payments collected on behalf of customers in an account clearly designated for customer funds in an authorized bank or other institution.
			§332.355	Agency responsibility for collectors.	The commissioner may take action against collection agencies and debt collectors themselves for violations of debt collection laws.
§1692d	Harassment or abuse.	Details prohibited debt collector conduct in connection with the collection of a debt. Generally, may not harass, oppress or abuse any person in connection with collection of debt. A debt collector may not:	§332.37	Prohibited Practices.	Details prohibited conduct for debt collection. No collection agency or collector shall:
		(1) threaten or use violence or criminal means to harm the physical person, reputation or property of any person.	.....	.....	(2) employ sheriffs or other officers in connection with collection unless performing legally authorized duties.
		(2) use obscene or profane language to abuse hearer or reader.	.....	.....	(3) threaten or use methods of collection in violation of Minnesota law.
		(6) telephone calls without meaningful disclosure of identity (except under §1692b).	.....	.....	(4) furnish legal advice or engage in the practice of law or represent that it is competent to do so.
§1692e	False or misleading representations.	Generally, a debt collector may not use any false, deceptive or misleading representation or means in connection with collection of debt. Violations include, but are not limited to:	.....	.....	(6) exercise authority on behalf of creditor to employ lawyer unless specifically authorized to do so.
		(2)(A)–(B) false representation of character, amount or legal status of any debt; and compensation which may be received by debt collector for collection.	.....	.....	(7) use shame cards or shame automobiles.
		(4) representation or implication that nonpayment of debt will result in imprisonment of any person, or seizure of property, unless action is lawful and intended to be taken.	.....	.....	(8) refuse to return any claim or valuable papers to creditor, claimant or forwarder; refuse or fail to account to clients all money collected within 30 days of the last day of the month in which it was collected.
		(6)(A)–(B) false representation or implication that a sale, referral or transfer or interest in a debt shall cause the consumer to lose any claim or defense to payment or become subject to prohibited practices.	.....	.....	(10) use customer's money to conduct agency business.

Fair Debt Collection Practices Act (Exhibit B)—Continued

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
		(7) false representation or implication that consumer committed crime or other conduct in order to disgrace consumer.	.....	.....	(11) act as debt adjuster or prorater unless no charge to the debtor or done under court order.
		(10) false representation or deceptive means to collect or attempt to collect debt or obtain information about consumer.	.....	.....	(12) Violate any of the provisions of the Fair Debt Collection Practices Act of 1977 while attempting to collect on any account, bill or other indebtedness.
		(12) false representation or implication that accounts have been turned over to innocent purchasers for value.	.....	.....	(14) in any communication imply or suggest that health care services will be withheld in an emergency situation.
		(14) use of any business, company, or organization name other than the true name of the debt collector's.	.....	.....	(15) enlist neighbors or third parties to aid with collection of debt when debtor has listed phone number.
		(15) false representation that documents are not legal process forms or do not require action by the consumer.	.....	.....	(16) fail to provide the debtor with full agency name as it appears on its license when attempting to collect a debt.
		(16) false representation or implication that debt collector is a consumer reporting agency.	.....	.....	(17) collect money that is not reported to creditor; fail to return overpayment to debtors.
§1692f	Unfair practices.	Debt collectors may not use unfair or unconscionable means to collect or attempt to collect any debt. The following conduct is a violation:	.....	.....	(18) accept payment without issuing an original receipt to debtor and maintaining a duplicate in records.
		(1) collection of any amount unless expressly authorized by the agreement or permitted by law.	.....	.....	(19) attempt to collect money or charge fees that are not authorized by client agreement.
		(2)–(4) acceptance and deposits of checks or payments, threatening to deposit postdated checks.	.....	.....	(21) when initially contacting by mail, fail to include disclosure notice in equal or larger font size than text of notice. Disclosure must state: "This collection agency is licensed by the Minnesota Department of Commerce."

Fair Debt Collection Practices Act (Exhibit B)—Continued

Federal			Minnesota		
Section	Title	Description	Section	Title	Description
		(5) causing charges to be made to any person for communications by concealment of true purpose of communication. (6) threatening or taking any nonjudicial action to dispossess property if there is no right to it as collateral, present intention to take property, or property is exempt by law. (7) communicating by postcard (8) use any language or symbol on envelopes except debt collectors address or name if such name does not indicate he is in the debt collection business.			
§1692g	Validation of debts.	(a)(1)–(5) within five days after initial communication with consumer in connection with collector of any debt, debt collector shall send consumer written notice. Notice must contain amount of debt, name of creditor to who debt is owed, statement that debtor has 30 days to dispute, and statement that collector will provide consumer with name and address of original creditor if different from current. (c) the failure of a consumer to dispute the validity of a debt may not be construed by the court as an admission of liability. (d) communication in the form of a formal pleading shall not be treated as initial communication for purposes of subsection (a) of this section.			
§1692h	Multiple debts.	If consumer owes multiple debts and makes a single payment to debt collector, collector may not apply payment to any debt which is disputed and shall apply such payment in accordance with consumer's directions.			

CHARLES MOOTY

Thank you Chairman Franken, for the opportunity to provide additional information about Fairview's values with respect to patient privacy and our Community Care programs.

Question 1. Exhibit 6 to Volume 4 of the attorney general's report is a slide from a presentation about Fairview's and Accretive's respective views about laptop thefts. It says that Fairview's perspective was that, "Accretive Health's treatment of laptop theft was fundamentally different than Fairview's values." What are Fairview's values with respect to the privacy of patients' health information? Do you believe those values differ from Accretive's, and, if so, how?

Answer 1. Fairview's values of dignity, integrity, service and compassion extend to all aspects of how we deliver care to our patients, including the protection of patient health information. Fairview takes the responsibility to protect the privacy and security of patient health information seriously. We treat the information we document and receive in providing the best possible care to our patients with dignity and respect. We maintain the confidentiality of patient health information; we collect that information necessary to provide high-quality patient care and access patient health information only when necessary.

As part of Fairview's commitment to the privacy and security of our patient's health information, we require our vendors to secure and protect patient health information. This includes compliance with HIPAA and other legal requirements, including following security and privacy standards, the use of appropriate safeguards to secure the health information of Fairview patients and to use or disclose patient health information only as permitted or required to carry out necessary services.

Question 2. Please describe Fairview's charity care program and policies, including the number of patients served and an explanation as to how and when patients are given information about the program, including its application process and eligibility requirements.

Answer 2. Fairview operates Community Care Programs (charity care) in both the hospital and free-standing clinic settings. These programs enable Fairview to provide quality medical services to the people in our community. There may be many reasons individuals are unable to pay all or part of a medical bill. Fairview's Community Care Programs offer a potential means of assistance to patients needing help paying for all or part of the cost of medical services. These programs are intended to ensure that the financial capability of our patients who need care does not prevent them from seeking or receiving care. In addition to the Community Care Programs, Fairview offers other means of assistance including discounts for uninsured patients and prescription drug assistance for patients experiencing financial hardship.

Fairview's Hospital-Based Community Care Program is available to assist patients who are or may receive care in Fairview hospitals and may not have sufficient insurance or who do not have access to insurance. Fairview's Free Standing Clinics Community Care Program is offered to patients who do not have access to health care coverage. In 2010, Fairview's Hospital Community Care Program provided assistance to patients for more than 22,985 patient visits.

Information about Fairview's Community Care Programs is communicated widely to patients, both prior to receiving services and during the billing process. Information is posted for patients on Fairview's Web site, including the application process and eligibility, and in all clinic and emergency rooms. Brochures are widely available for patients explaining the program and application process. In addition, information about the programs is available on billing statements. Further, information and resources regarding medical assistance and Fairview's Community Care Programs are provided to patients during the registration process.

GREGORY KAZARIAN

Accretive Health appreciates the opportunity to provide additional information about our company and the work we do to help hospitals strengthen their financial stability. We believe our work is critical to helping hospitals adapt to a changing healthcare landscape so that they can continue to provide high-quality healthcare in the communities they serve and better serve their patients.

Please find attached Accretive Health's responses to your supplemental questions. Over the last 7 days, our company and its employees have worked diligently to gather the information necessary to respond to your questions. We have responded below as completely as possible given the timeframe, the records and employees accessible to us, and the pending litigation with the Office of the Minnesota attorney general. The company will continue to investigate these issues over many months in its ongoing litigation and reserves the right to amend these responses at a later date should that be necessary.

Question 1. How many Accretive computers containing protected health information (PHI) have been lost or stolen since the company began providing services to

hospitals and other healthcare systems? For each computer that has been lost or stolen, please describe the incident, including:

a. whether the computer was a laptop or desktop;
b. the date on which the computer was lost or stolen;
c. the location from which the computer was lost or stolen;
d. whether the computer was stolen from an employee's vehicle;
e. the nature and extent of the PHI the computer contained;
f. the number of patients for whom PHI was included on the computer;
g. whether the computer contained PHI from hospitals or healthcare systems other than those at which the computer's custodian worked;
h. the nature of the custodian's employment with Accretive, including whether the custodian was employed exclusively in revenue cycle management operations;
i. the basis on which Accretive believed the custodian needed the PHI contained on the lost or stolen computer to perform his or her job duties; and
j. whether Accretive reported the data breach to its customer.

Answer 1. Accretive Health takes seriously the confidentiality of protected health information ("PHI"). For this reason, Accretive Health policy requires the encryption of each company laptop and desktop computer.

On July 25, 2011, an Accretive Health revenue cycle employee's laptop was stolen from the back seat of a locked rental car. At approximately 8 p.m., the employee entered a restaurant in the Seven Corners area of Minneapolis. When the employee returned to his rental car approximately 20 minutes later, he found that the rear passenger window of the vehicle had been smashed and that his briefcase—containing his laptop—had been stolen. The employee immediately reported the theft to the Minneapolis police department and then notified Accretive Health.

The July 25, 2011 theft is the one and only incident of which Accretive Health is aware involving the loss or theft of a company computer that was not properly encrypted. Following this theft, Accretive Health determined that the stolen laptop was one of approximately 30 laptop computers that was not properly encrypted due to the error of an individual IT employee. That employee was terminated.

Since that time, Accretive Health has added redundancies to its practices to ensure that each company computer is and remains properly encrypted. Multiple IT employees now check each computer to confirm that it is properly encrypted. Accretive Health conducts reviews at least five times each week to confirm that every computer remains properly encrypted. And Accretive Health has recently adopted further protections for PHI by rolling out a new e-mail encryption system and working to implement company-wide use of drive-based encryption, which will bring Accretive Health's systems to higher-than-industry standard.

According to Accretive Health records (which date from May 2008), a total of 24 company computers—all laptops—have been lost or stolen. Four of these were subsequently recovered. According to company records, no desktop computers were lost or stolen during this time period.

Details concerning each lost or stolen laptop are outlined below in Table 1.

Table 1. Twenty-Four Laptops Lost or Stolen Between May 2008 and the Present

Date of incident	Location	Employee's role [1]	Laptop encrypted?
May 7, 2008	Car	Revenue Cycle Management ("RCM")	Yes
Jan. 27, 2009	Unspecified	Medicaid Eligibility Hub	Yes
Feb. 3, 2009	Domestic Dispute	RCM	Yes
Jan. 20, 2010 (recovered)	Unspecified	Human Resources	Yes
June 3, 2010	Car	RCM	Yes
July 15, 2010	Hospital	RCM	Yes
Sept. 16, 2010	Unspecified	Physician Advisory Service ("PAS")	Yes
Oct. 1, 2010 (recovered)	Unspecified	RCM	Yes
Nov. 15, 2010	Car	RCM	Yes
Nov. 17, 2010	Car	PAS	Yes
Jan. 17, 2011	Car	Quality and Total Cost of Care ("QTCC")	Yes
Mar. 31, 2011	Home Garage	QTCC	Yes
July 25, 2011	Car	RCM	No
Sept. 29, 2011	Condo Garage	PAS	Yes
Nov. 7, 2011 (recovered)	Unspecified	IT	Yes
Nov. 11, 2011	Trunk of Car	IT	Yes
Dec. 21, 2011 (recovered)	Unspecified	RCM	Yes
Dec. 23, 2011	Restaurant	PAS	Yes
Dec. 23, 2011	Restaurant	PAS	Yes

Table 1. Twenty-Four Laptops Lost or Stolen Between May 2008 and the Present—Continued

Date of incident	Location	Employee's role [1]	Laptop encrypted?
Jan. 23, 2012	Home	IT	Yes
Jan. 26, 2012	Office	PAS	Yes
Mar. 8, 2012	Home	PAS	Yes
Apr. 12, 2012	Trunk of Car	RCM	Yes
June 8, 2012	Public Transportation	RCM	Yes

[1] *See* Accretive Health's response to question 7, in which we explain the basis for Accretive Health employees' access to PHI.

Aside from the laptop stolen on July 25, 2011, each lost or stolen laptop was encrypted. Although Accretive Health believes that several of the laptops identified in Table 1 may have contained PHI, Accretive Health did not undertake an examination of the backup data for these laptops because Accretive Health's encryption software rendered any PHI inaccessible and unusable as contemplated by the "safe harbor" under HITECH. For this reason, reporting was not required by Federal law. Importantly, Accretive Health has no reason to believe that the loss or theft of any company laptop—including the laptop stolen on July 25, 2011—has resulted in the unauthorized disclosure of PHI to any third party.

Question 2. Have any other Accretive media—such as thumb drives, compact disks, and tablets—containing PHI been lost or stolen? If so, please describe each incident, including the information requested in question 1 and its sub-parts.

Question 3. Have any of Accretive's paper documents containing PHI been lost or stolen? If so, please describe each incident, including the information requested in question 1 and its sub-parts.

Answer 2 and 3. Accretive Health has not identified any reports of any such loss or theft, aside from the reports of lost or stolen laptops summarized in response to question 1.

Question 4. In my April 27, 2012, letter to Accretive, I asked about allegations that Accretive laptops containing PHI had been lost or stolen. In your response to question 10, you wrote this:

> "Context is important: in 2011, Accretive Health had approximately 1,400 laptop and desktop computers in use by its employees." (Emphasis added.)

Later in your letter, in response to Question 11, you wrote this:

> "[The laptop stolen from Mr. Doyle's car] was one of approximately 30 laptops (out of 1,400 laptop and desktop computers) missing Accretive Health's required encryption software." (Emphasis added.)

Then, in your written testimony, you wrote this:

> "[T]he laptop stolen in July 2011 was one of approximately 30—out of more than 1,400—that was not encrypted[.]"

I agree that context is important, but I found this series of responses to be confusing because they conflate laptop computers with desktop computers. These responses also appear to be inconsistent with each other: in your written testimony, you reference 1,400 laptops, whereas, in your response to my letter, you reference 1,400 computers (both laptops and desktops). Please provide the following clarification:

a. How many of the 1,400 computers referenced in your response letter and in your written testimony are laptops?

b. How many of the computers referenced in your response to question 4(a) were found to be unencrypted during the audit conducted after the July 25, 2011 theft of a laptop from Matthew Doyle's car?

c. How many of the 1,400 computers referenced in your response to my letter and in your written testimony are desktops?

d. How many of the computers referenced in your response to question 4(c) were found to be unencrypted during the audit conducted after the July 25, 2011 theft of a laptop from Matthew Doyle's car?

Answer 4. First, we apologize for any confusion on this issue, but we trust the following will address your question. Around the time of the July 25, 2011 laptop theft, Accretive Health had approximately 1,400 laptop and desktop computers in use by its employees. That number may vary at any point in time. In September 2011, Accretive Health had approximately 1,627 total computers in service: approximately 1,152 laptops and approximately 475 desktops. The increase from approxi-

mately 1,400 computers to approximately 1,627 computers was due to (1) Accretive Health bringing additional computers into use as a result of business needs, and (2) an Accretive Health training class for Chicago Career Tech that started in mid-2011 and resulted in Accretive Health bringing approximately 80 computers into use. Accretive Health's policies require encryption of both laptop and desktop computers.

Following the July 25, 2011 laptop theft, Accretive Health performed a review of its laptop and desktop computers to determine whether any other company computers were not properly encrypted. This review revealed that approximately 30 laptops were not properly encrypted. Following this review, Accretive Health's IT staff loaded or re-loaded encryption software onto every company laptop and desktop computer and implemented the redundancies described in response to question 1.

Question 5. Does Accretive employ any policies or practices to restrict employees' access to PHI when the employee moves from one hospital to another or from one set of duties (*e.g.*, QTCC) to another (*e.g.*, RCM)? If so, please describe those policies and practices and explain whether and to what extent they were employed in Matthew Doyle's case.

Answer 5. Yes. Employee access to Accretive Health client hospital IT systems is typically determined according to the client hospital's policies and access protocols. In general, an Accretive Health employee requests access according to these policies and protocols and an individual designated by the client hospital determines whether to grant the Accretive Health employee's request. Client hospitals grant access to Accretive Health employees based on employee job functions and related business requirements.

Accretive Health also controls access to its own IT systems based on employee job functions and business requirements, and performs periodic validations of employee access rights. On a quarterly basis, IT Support requires Accretive Health Site Leads at both client hospitals and Accretive Health Shared Services Facilities (for example, the Kalamazoo call center) to (1) confirm the list of users with access is accurate, and (2) validate that each user's access is appropriate. If an employee is determined to have changed roles or moved to a different site, that employee's access related to the prior role or site is terminated.

On a monthly basis, Accretive Health Site Leads send a Client System Terminate List to hospital clients. This list includes the Accretive Health employees for whom access should have been terminated during the prior month. The list ensures that access rights to hospital IT systems are terminated for those Accretive Health employees who no longer need access.

Accretive Health employees are instructed to regularly review their electronic files and delete any PHI that is no longer necessary for their jobs.

The Accretive Health policies described above were in place prior to the July 25, 2011 laptop theft. As described in Accretive Health's May 11, 2012 response, the employee responsible for the stolen laptop had worked at Fairview. While at Fairview, the employee, seeking to become better acquainted with Accretive Health's QTCC program and acting within the scope of his access rights, downloaded certain QTCC data described in the Minnesota attorney general's report. The employee then transferred to North Memorial and was working at North Memorial at the time of the theft.

Question 6a. On June 2, 2010, a laptop was stolen from Brandon Webb's car. On July 25, 2011, an unencrypted laptop containing PHI was stolen from Matthew Doyle's car. On September 20, 2011, Accretive issued a notice of the breach to Fairview. On October 12, 2011, Accretive issued an advisory to employees, instructing them not to leave laptops in plain view.

Why did Accretive wait until September 20, 2011, to notify Fairview of the July 25, 2011, data breach?

Answer 6a. Accretive Health notified Fairview's chief financial officer, general counsel, and vice president of revenue cycle management of the July 25, 2011 laptop theft 4 days after the theft occurred, on July 29, 2011. In the days and weeks following the theft, there was regular and close contact with Fairview about the theft and the process for addressing the theft. Federal law requires formal notice of a breach of unsecured PHI within 60 days of the discovery of the breach. 45 CFR §164.410. Accretive Health's September 20, 2011 written notice to Fairview was the formal notice required by law.

Question 6b. Why did Accretive wait until October 12, 2011, to advise its employees not to leave laptops in plain view?

Answer 6b. Accretive Health has for years advised its employees as a part of regular training that laptop computers must be secured. The October 12, 2011 "advi-

sory" referenced in Question 6 was a memorandum sent to all employees as an additional reminder following the investigation of the July 25, 2011 theft.

Question 7. Since entering into contracts with the Fairview Hospital System, how many of Accretive's revenue cycle employees have had unrestricted access to patients' PHI? For each employee, please provide the time period for which the employee's access to PHI was unrestricted and please explain the justification for the employee's unrestricted access to PHI.

Answer 7. Accretive Health employees do not have unrestricted access to PHI. As described in response to question 5, Accretive Health employees' access is limited by Fairview and Accretive Health policies.

In order to perform the contracted services for Fairview, certain Accretive Health employees required access to Fairview IT systems, including those containing PHI. Authorization to access Fairview systems occurred according to Fairview's formal access request and review process, which Accretive Health understands is the same process used for all Fairview contractors.

Different Accretive Health employees had access for different purposes:

Revenue Cycle Employees. Between April 2010 and April 2012, Accretive Health Revenue Cycle employees performed a wide variety of tasks for Fairview. These employees—like the more than 1,200 Fairview employees performing Revenue Cycle functions—required access to various Fairview IT systems containing PHI, including Fairview's PASS and EPIC patient accounting systems, Fairview's patient scheduling system, and Fairview's billing editor system.

Revenue Cycle employees with access to Fairview IT systems are described below. (The employee numbers reflect the approximate, total number of Accretive Health Revenue Cycle employees with access to Fairview IT systems over the term of the parties' Revenue Cycle Operations Agreement):

- Approximately 56 Accretive Health employees worked onsite at Fairview hospitals. These employees ensured that patients were registered correctly, determined patient insurance information, contested and challenged payor denials, assessed options for third party coverage in the event the patient was not insured, ensured that insurance claims were accurate and timely, and ensured that the patient was billed accurately.
- Approximately 15 Medicaid Eligibility Hub employees worked offsite with patients and Minnesota counties to ensure that Medicaid applications were processed promptly and properly.
- Approximately 17 IT and other employees worked on- and off-site to analyze, implement, and ensure the functionality of Accretive Health proprietary Revenue Cycle Management tools at Fairview hospitals.
- Approximately 92 Blended Shore Operation employees worked offsite performing a variety of tasks, including resolving credit balances, ensuring payment on low-dollar insurance accounts, and monitoring collections calls for compliance with FDCPA, HIPAA, and company requirements.
- Approximately 18 other employees performed various functions for Fairview, including following up with third party payors and loading hospital and payor contracts onto Accretive Health's IT systems.

Quality and Total Cost of Care Employees. Between April 2010 and June 2012, approximately 31 Accretive Health QTCC employees required access to Fairview IT systems containing PHI, including Fairview's EPIC system, so that they could help Fairview identify and create care plans for those patients who would benefit most from more integrated and intensive care.

Physician Advisory Service Employees. Between May 2010 and April 2012, approximately 116 Accretive Health employees worked offsite performing Medicaid and Medicare compliance consulting services for Northland and Lakes Hospitals. These employees had access to Fairview IT systems, including Fairview's EPIC system.

Financial Clearance Center Employees. Between February 2011 and April 2012, approximately nine Accretive Health FCC employees performed pre-registration and other functions for Fairview. Like the approximately 50 Fairview employees performing similar functions, FCC employees required access to Fairview's EPIC system to ensure that patients were registered correctly.

Medical Financial Solutions Employees. Between July 2010 and February 2011, approximately 28 Accretive Health MFS employees performed pre-collect and dormant collections for Fairview patients. MFS employees required access to Fairview's PASS, EPIC, and WinCollect systems. The purpose of access was to enable MFS employees to verify patient identities and provide patients with requested information, including the date of service and nature of service received.

As explained in our May 11, 2012 response, for a period of time, Fairview's PASS system was the only source of information for MFS employees to answer patient questions about amounts owed. In November 2010, Accretive Health began implementing a software technology tool that limited employee access to: (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 tool became fully operational in February 2011, though approximately 10 employees with managerial responsibilities who handled escalated patient calls or system operations continued to have access to Fairview PASS files until early 2012.

Question 8a. During the field hearing, I asked you whether the scripts that Accretive provided to revenue cycle employees contained a disclaimer to be provided to patients to inform them that conversations with revenue cycle employees were optional. You agreed that patients "should affirmatively be given that information" and you committed to review Accretive's scripts to assess whether disclaimers expressly are provided to patients.

How many versions of scripts has Accretive provided to revenue cycle employees?

Question 8b. Of the scripts referenced in your response to question 8(a), how many instruct revenue cycle employees to disclaim expressly to the patient that the conversation is optional?

Question 8c. Of the scripts referenced in your response to question 8(a), how many instruct revenue cycle employees how to overcome objections from patients?

Question 8d. Will you please provide to my office full copies of the scripts referenced in your responses to questions 8(a)?

Answer 8a, 8b, 8c, and 8d. For decades, hospitals throughout the United States have used scripts to assist employees in interacting with patients. Many of Accretive Health's client hospitals have their own scripts at the time they contract with Accretive Health.

Accretive Health typically works with each client hospital to prepare scripts to fit the individual hospital's policies and needs. Sometimes, Accretive Health and its clients develop scripts based on Accretive Health templates. Just as often, the client's own pre-existing scripts are the starting point. On occasion, Accretive Health or its clients further individualize the scripts over time to account for changes in the clients' policies or to respond to specific issues encountered by Revenue Cycle employees when engaging with patients. As a result, scripts vary from client to client, and also vary over time for the same client. Accretive Health cannot readily determine how many versions of scripts its client hospitals have used over the years. All conversations with patients are at the patient's option and Accretive Health employees are trained as to their client hospitals' obligations under EMTALA.

In its May 11, 2012 response, Accretive Health referenced disclaimer language included in employee scripts used at Fairview. This language provided as follows:

> ***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.

Please find attached as Exhibits 1, 2, 3, and 4 to this response the scripts referenced in Accretive Health's May 11, 2012 response.

As a result of the dialog between your office and Accretive Health senior vice president Greg Kazarian, including at the May 30, 2012 field hearing, Accretive Health has undertaken the process of reviewing and standardizing the scripts used by its client hospitals. Although the scripts will continue to be tailored to clients' specific policies and needs, all recommended scripts will contain certain common elements, including an express disclaimer to inform patients that conversations with Revenue Cycle employees are optional. For example, Accretive Health has drafted the following:

> ***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 ROLE OF THESE CONVERSATIONS WITH PATIENTS IS TO HELP THEM FIND A WAY TO RESOLVE THEIR CONTRACTUAL OBLIGATIONS WITH THE HOSPITAL WHEN POSSIBLE, BUT MORE IMPORTANTLY TO EDUCATE THEM ABOUT THESE RESPONSIBILITIES. THE INFORMATION BELOW IS TO BE UNDERSTOOD ONLY IN THAT CONTEXT.
>
> SPECIFIC GUIDELINES FOR PATIENT INTERACTIONS:
>
> • IN THE EMERGENCY ROOM AND IN LABOR AND DELIVERY, EVERY PATIENT MUST BE SEEN IN COMPLIANCE WITH THE REQUIREMENTS OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT,

42 USC SECTION 1395DD. ACCORDINGLY, NO CONVERSATION WITH A PATIENT ABOUT INSURANCE OR ABILITY TO PAY SHALL OCCUR UNTIL AFTER THE PATIENT HAS HAD A MEDICAL SCREENING EXAM AND ANY NECESSARY STABILIZING TREATMENT.

• ABSOLUTELY NO INPATIENT OR EMERGENCY ROOM PATIENT SHALL BE APPROACHED TO COLLECT PAYMENT FOR A RESIDUAL OR PRIOR BALANCE UNTIL AN APPROPRIATE CLINICIAN HAS (1) SEEN THE PATIENT; (2) EVALUATED THE PATIENT'S CONDITION; (3) CLEARED THE PATIENT FOR CONTACT WITH A REVENUE CYCLE EMPLOYEE; AND (4) IDENTIFIED A MEDICALLY APPROPRIATE TIME FOR THE REVENUE CYCLE EMPLOYEE TO CONTACT THE PATIENT.

• REMEMBER THAT OUR MISSION IS TO ASSIST PATIENTS, WHICH REQUIRES EMPATHY FOR EVERY PATIENT'S MEDICAL CONDITION AS WELL AS HIS OR HER FINANCIAL CONDITION. OUR MISSION IS FULFILLED ONLY BY TREATING EVERY PATIENT IN EVERY SITUATION WITH COMPASSION, DIGNITY, RESPECT, AND PROFESSIONALISM.

• REMEMBER THAT EVERY PATIENT CONVERSATION IS OPTIONAL. PATIENTS ALWAYS HAVE THE RIGHT TO DECLINE TO SPEAK WITH REVENUE CYCLE EMPLOYEES ABOUT THEIR FINANCIAL OBLIGATIONS. EVERY PATIENT MUST BE INFORMED OF THAT RIGHT AT THE *BEGINNING* OF EVERY CONVERSATION. IF A PATIENT SAYS THAT HE OR SHE DOES NOT WANT TO HAVE THE CONVERSATION, THE REVENUE CYCLE EMPLOYEE MUST THANK THE PATIENT FOR HIS OR HER TIME AND IMMEDIATELY END THE CONVERSATION. THE FOLLOWING SCRIPT SHOULD BE USED TO START EVERY CONVERSATION TO ENSURE THAT EVERY PATIENT UNDERSTANDS THAT CONVERSATIONS WITH REVENUE CYCLE EMPLOYEES ARE OPTIONAL:

Mr./Ms._____, my name is_____. I am not a clinician. My job is to educate you about any medical benefits that may be available to cover the cost of your care as well as your personal responsibility for your treatment costs.

You do not have to speak with me. Having a conversation with me about your financial obligations for your care is entirely optional. Whether you choose to speak with me or not will have no impact on the care you receive.

Are you willing to speak with me?

(***STOP***! *DO NOT SAY ANYTHING MORE UNTIL PATIENT RESPONDS)*

If the patient says "no," thank the patient for his or her time and end the conversation.

If the patient says "yes," ask the patient: "Are you comfortable speaking with me now?"

If the patient says "no," thank the patient and indicate that you will find another time to speak with him or her.

Only if the patient says "yes," may you proceed with the conversation.

Accretive Health welcomes any suggestions that you may have concerning this draft language.

Question 9a. The attorney general alleges that Accretive sometimes overcharged patients for the predicted cost of a service and then delayed in issuing refunds to patients. During the field hearing, I asked you about an Accretive patient registration handbook, which instructed employees not to inform patients if they had credits on their accounts. You said all refunds should be remitted to the patients within 30 days.

How does Accretive predict the patient's out-of-pocket cost for a service? In responding to this question, please list all factors that are considered in making this determination.

Answer 9a. As an initial matter, the "patient registration handbook" titled "Registration—Handbook for Prior Balance Collections" does not instruct employees to remain silent about credits. Rather, the handbook provides instructions on when a Revenue Cycle employee should ask a patient about a prior balance during registration. The document instructs:

> If a prior balance exists, the patient hasn't been contacted by hospital staff in the last 30 days, and there are no current payment plans or credit balances then ASK!

But if the patient has a credit balance, the document instructs: Don't ask [about the prior balance], and note on the account.

Additionally, this document was ***not*** used or prepared for Fairview. Under Fairview policy, a refund was not generated until both the PASS and EPIC systems

were reviewed for outstanding patient balances and appropriate distribution decisions were made in accordance with Fairview's financial policies.

To clarify any misconceptions, Accretive Health understands that Fairview endeavored to resolve (either by distributing or refunding) self-pay credits within 30 days of the last insurance remit date. Accretive Health worked to help Fairview achieve this goal when possible. As set forth below, Accretive Health helped improve Fairview's ability to issue prompt and correct refunds.

To the extent possible, and in advance of non-emergency treatment, Fairview patients were provided with estimates of their share of the treatment cost so as to avoid confusion or surprise later. This practice is both common and consistent with the "recommended practices" advocated by the Healthcare Financial Management Association.

Through the use of Accretive Health's software tools, diagnostic codes, including the American Medical Association's Current Procedural Terminology ("CPT") Codes, and hospital pricing information, Revenue Cycle employees could generate reasonable estimates of the cost of care in advance of service. Generally, estimates would also reflect consideration of patient insurance benefits (e.g., any deductible owed by the patient, co-payments, and coinsurance). If official prices were unavailable or historical average prices could not be determined, an estimate would not be generated.

Fairview's credit management and financial policies and procedures dictated how Fairview handled patient credits. At the time of Fairview's partnership with Accretive Health, Fairview hospitals and clinics had a significant backlog of credits owed to self-pay patients. Accretive Health implemented initiatives consistent with Fairview's policies and in collaboration with Fairview management to help Fairview resolve this backlog. With the use of Accretive Health's tools, during the period from November 2010 to February 2012, Fairview *decreased the number of refunds owed by approximately 60 percent*.

Question 9b. With respect to Accretive's operations at the Fairview system, how often are refunds issued within 30 days?

Question 9c. With respect to Accretive's operations at the Fairview system, what are the mean and median wait times for a refund to be issued?

Question 9d. With respect to Accretive's operations at the Fairview system, what are the mean and median amounts of such refunds?

Answer 9b, 9c, and 9d. Fairview at all times retained primary responsibility for processing and paying refunds. As a result of the termination of Accretive Health's Revenue Cycle services to Fairview, Accretive Health no longer has access to detailed data concerning refunds paid to Fairview patients and therefore cannot provide detailed responses to questions 9(b), (c), and (d). However, in early 2012, Fairview's board of directors requested that Accretive Health compile certain information concerning refunds. From this information, Accretive Health can report that, from approximately October 2010 through April 2012, Accretive Health reviewed 30,576 credit accounts in the PASS system and resolved 27,842 (with a value of $3.49 million), reviewed 10,978 credit accounts in the EPIC HB system and resolved 10,169 (with a value of $802,000), and reviewed 317,821 credit accounts in the EPIC PB system and resolved 310,602 (with a value of $9.16 million). In other words, Accretive Health assisted Fairview in resolving more than $13.4 million in outstanding credit balances.

Question 10. In your written testimony, you wrote that the attorney general's "allegations are, more often than not, founded on mischaracterizations of Accretive Health documents and misstatements of significant facts." Insofar as Accretive believes that the attorney general provided only excerpts of documents when the complete document is needed for accurate context, please provide my office with the complete document at issue.

Answer 10. Below, we provide several examples of instances in which the Minnesota attorney general's allegations are founded upon mischaracterizations of Accretive Health documents:

• The attorney general cites an Accretive Health e-mail 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." (Volt. 2, p. 19.) However, the attorney general's use of ellipses mischaracterizes the document. The "anger" and "emotional responses" from Fairview line staff being reported in the e-mail were directed against the attorney general's office as a result of the January 2012 lawsuit, not against Accretive Health. (Volt. 2, Ex. 93.) In fact, the e-mail states that "[s]everal of the Fairview line staff teams have met since the [Attorney General's] complaint was announced. Some of the teams have expressed anger at the AG['s] office be-

cause the complaint seemed off base." A complete copy of this e-mail chain is attached to this response as Exhibit 5.

• The attorney general makes reference to a December 2011 "incident" at the University of Minnesota Amplatz emergency room during which the treatment of a child was allegedly delayed while a financial counselor met with the child's parents. (Volt. 2, PP. 16–17.) However, the attorney general mischaracterizes this event. According to the documents, the child's father proactively requested to meet with the counselor to discuss his family's financial situation and the cost of care. Following the meeting, the father expressed his appreciation that Accretive Health was able to assist his family.

• The attorney general references the employee scripts used by Revenue Cycle employees at Fairview and states that "[t]he scripts can lead a patient or her family to believe that the patient will not receive treatment until payment is made." (Volt. 2, PP. 13–14.) In support of this statement, the attorney general attaches to her report selected pages from two versions of a script in use at Fairview, one version in use shortly after Accretive Health began working with Fairview and a later version containing revisions by Accretive Health and Fairview. The first page of the later version of the script, which the attorney general did not attach to her report, includes a disclaimer, in red, capitalized, bolded language stating that:

> ***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 complete copy of this document is attached to this response as Exhibit 6.

• The attorney general states that Accretive Health offered prizes to Revenue Cycle employees in violation of Fairview policy, and that one Fairview employee complained that the prizes were a "slap in the face." (Volt. 2, PP. 11–12.) This is a mischaracterization of both the underlying facts and the cited document. Prior to Accretive Health's partnership with Fairview, Fairview policy permitted gift cards as a form of employee recognition. In November 2010, a Fairview employee sent an e-mail discussing a year-end gift card incentive program to increase point-of-service collections. The author of the e-mail suggested that an employee could receive between $130 and $280 per month by meeting certain goals. Dan Fromm, Fairview's chief financial officer, responded that the program "violates corporate policy" because it potentially exceeded Fairview's limits on monetary gifts. Following meetings with Fromm and other Fairview employees, the program was implemented consistent with Fairview policy at the University of Minnesota Medical Center for the last few weeks of 2010. The program continued for 1 month and was then replaced by incentive programs using solely non-monetary incentives. One employee, apparently irritated by the termination of monetary incentives, stated to an Accretive Health employee that the new, non-monetary incentives were "a slap in the face" and that employees "were annoyed by the abrupt change between the gift card program and this [non-monetary] one." A copy of an e-mail reflecting the Fairview employee's complaint is attached to this response as Exhibit 7.

• The attorney general cites an e-mail in which an Accretive Health employee purportedly dismissed Fairview doctors' concerns about point-of-service collections as "country club" talk. (Volt. 2, p. 15.) However, the attorney general does not cite the full e-mail and thereby mischaracterizes the substance of the document. The non-cited portion of the e-mail identifies steps Accretive Health could take to address any doctors' concerns, including providing information on the point-of-service collections process and meeting with Fairview representatives. A copy of this e-mail is attached to this response as Exhibit 8.

• The attorney general claims that Accretive Health prepared and distributed to Fairview a sample script that violated the AG Agreement by instructing collectors to condition discounts for uninsured patients on same-day payment. (Volt. 3, PP. 6–7; Ex. 7.) However, the script the attorney general cites was not used at Fairview, as is evident from the absence of a Fairview header on the script. The script therefore does not provide support for the attorney general's allegation that Accretive Health directed Revenue Cycle employees at Fairview to condition uninsured discounts on same-day payment.

Question 11a. During the field hearing, I asked about Exhibit 37 to Volume 5 of the attorney general's report, an e-mail from a Revenue Cycle employee describing patients as "dead beats" and "plebeians," among other things. You agreed that the e-mail was unacceptable, though you noted that you were "somewhat comforted" because "the employee who received the e-mail was—you could tell by the response—was somewhat taken aback" and that you "could see in the tone [that he] didn't want to engage in the exchange."

Please provide my office with the full e-mail chain, redacted as appropriate, from which you can discern the recipient's tone and can tell that the recipient was taken aback.

Question 11b. The e-mail at the top of Exhibit 38 to Volume 5 of the attorney general's report describes a patient as a "low life." What is the relationship, if any, between this e-mail and the e-mail contained in Exhibit 37 to Volume 5? In responding, please note whether these e-mails were written by the same or different employees, and please describe the nature and extent of the PHI to which the authors of the e-mails had access.

Answer 11a and 11b. Exhibits 37 and 38 to Volume 5 of the Minnesota attorney general's report were both written by the same Accretive Health employee, a patient financial counselor in Accretive Health's Kalamazoo call center. This employee was terminated within 24 hours after these e-mails were brought to the attention of Accretive Health management.

In his oral testimony at the May 30, 2012 Field Hearing, Mr. Kazarian's suggested that the recipient of the referenced e-mail was "taken aback" by the e-mail. Mr. Kazarian meant to refer to the response of the employee who authored the e-mail when that employee received his notice of termination. During his termination meeting, the employee expressed surprise and explained that he had intended the e-mails as a joke. Nonetheless, company management concluded that the e-mails constituted improper conduct and, therefore, grounds for dismissal.

Question 12a. During the field hearing, the attorney general alleged that Accretive had failed to enter into a Business Associate Agreement (BAA) with North Memorial Hospital and that Accretive manufactured and backdated a BAA once this omission came to light. After the hearing, Accretive issued a statement which, among other things, said:

> The parties believed they executed a BAA prior to or at the time services commenced and, in accord with ordinary and customary practice, acted at all times consistent with the terms of the BAA, meeting all the requirements of HIPAA and HITECH. In October 2011, the parties could not locate the executed copy of the BAA. Accordingly, a replacement BAA was signed in October 2011."

Who executed the BAA for Accretive "prior to or at the time services commenced?"

Answer 12a. Etienne H. Deffarges, Accretive Health's executive vice president, believes he executed the North Memorial Business Associate Agreement.

Question 12b. Were both parties—Accretive and North Memorial Hospital—provided with copies of the originally executed BAA? If so, is it Accretive's position that both parties subsequently and independently misplaced the BAA?

Answer 12b. From November 2008 to early 2009, Accretive Health and North Memorial undertook an initial assessment in anticipation of executing a Revenue Cycle contract. In connection with these discussions, Accretive Health believes the Business Associate Agreement ("BAA") was executed by Mr. Deffarges. Accretive Health believes that it returned the executed BAA to North Memorial and understands that North Memorial believes that it executed the BAA as well.

The Revenue Cycle contract between Accretive Health and North Memorial ultimately was not completed until March 21, 2011. In early March 2011, in connection with finalizing that agreement, a draft BAA was prepared. Because the parties believed that a BAA had already been executed in connection with the 2008/2009 initial assessment, it does not appear that the March 2011 draft BAA draft was executed. From March 21, 2011 onward, however, both Accretive Health and North Memorial acted at all times consistent with the terms of the BAA.

In October 2011, Accretive Health was contacted by North Memorial, asking for a copy of the executed BAA, which they stated that they too could not locate in their files. Upon a diligent search, Accretive Health also could not locate an executed copy of the BAA. As a result, another BAA was executed in October 2011. The October 2011 BAA was ***not*** backdated, but instead identified an "effective date" of March 21, 2011 to accurately reflect the period of time during which Revenue Cycle services, consistent with the terms of the BAA, had been provided by Accretive Health to North Memorial.

[**Editor's Note: Due to the confidential and proprietary nature of the exhibits they will be maintained in the committee's files.**]

JEAN ROSS

Question 1. During the field hearing, you testified that patients should not be approached about payments when they are in the hospital, receiving medical treatment. Why is this?

Answer 1. Patients come into the hospital for treatment. Whether planned or emergent, we teach them to try putting aside other concerns such as family issues and finances so they can concentrate on recovering and healing. This is difficult enough for most people to do when they are healthy, let alone when they are hurting.

If they are fortunate enough to be in a good, supportive family and also be financially sound, they don't need a new worry placed in front of them, intruding on their thoughts. For those in less than ideal situations, another reminder of their situation isn't conducive to healing.

They may already know they will have a great deal of trouble paying their bill later. It's less than helpful for them to wonder if they need to find a way to come up with the money now, especially if there is an assumption of no care or lesser care if one can't pay. A non-professional approaching a patient without regard to that person's diagnosis can also be dangerous, not just to the patient but also to that individual. For example, it might not be advisable to approach many patients who have certain mental health conditions and request payment at the time of a crisis.

Question 2. In your many years as a nurse, what measures did you take to protect patients' personal health information?

Answer 2. In the years before electronic health records (EHR) the paper chart was kept in the desk area, away from all patients and visitors. Only staff directly caring for the patient was allowed to view it. The same is true now with the EHR.

Any admitting, discharging or teaching of a patient or family member is done confidentially to safeguard the patient's privacy. This includes discussions about the diagnosis and prognosis. Unless a patient leaves written permission a nurse is not allowed to speak with family or others about the patient's condition.

No paperwork with any identifying information can be left for others to possibly see. All nurses must log out before leaving a screen open to a patient's computerized chart. We are not allowed to write the patient's full name on the grease board in the patient's room. Any public listing of patients must be done by initials only.

MICHELE GOODWIN

Question 1. The Federal Debt Collection Practices Act's (FDCPA) prohibition on abusive practices does not cover collections for debts that are not "in default." Do you believe that this aspect of the law should be changed, and, if so, how?

Answer 1. Yes, the Federal Debt Collection Practices Act (FDCPA) should be amended or changed to address loopholes. Specifically, the FDCPA currently does not cover collections of debts not in default. Largely, this appears to be an oversight, particularly as the spirit of the law is intended to prohibit abusive debt collection practices. That a debt is not in default should not provide a loophole for debt collectors to engage in practices deemed abusive, coercive, exploitative, humiliating or embarrassing to consumers. It is particularly shocking that egregious debt collection practices are now a party of general payment practices at hospitals. In effect, paying a hospital medical bill can mean exposing oneself to threatening behavior or the denial of medical treatment. The FDCPA is intended to protect consumers, particularly when they are at their most vulnerable and this includes when a consumer has endured extreme financial difficulties.

Importantly, the FDCPA is a law that speaks to principled corporate behavior. That a debt has not lapsed into default should not privilege debt collection agencies and the organizations that hire them to circumvent the spirit and intent of the law. We should be mindful that the law is a protection for all consumers. The law does not make a distinction between different categories of consumers based on wealth, income or debt status.

Given the significance of the most recent economic turn down, Members of Congress must be sensitive to the economic challenges and hardships experienced by hardworking Americans who have lost their jobs and homes and now find it difficult to pay their bills. These men and women deserve the same protections as consumers who are not in default.

Proposed change:

1. Amend the FDCPA by including language that extends consumer protections to individuals not in default.

2. Extend the statute of limitations for consumers to file suit to 2 years (rather than the current 1 year).

3. Impose fines against debt collection agencies that violate this provision.

Question 2. Debt collectors are not allowed to have access to more personal health information than is absolutely necessary for them to perform their jobs. In your

view, what personal health information would a debt collector need to collect a medical debt?

Answer 2. In my opinion, debt collection agencies **do not need** personal health information to collect consumer debts. At present, many debt collection organizations gain access to a very broad set of consumer information, including: mailing addresses, phone numbers, e-mail addresses (if the consumer has an e-mail account), and social security information. Often, debt collection organizations also have access to employer information as well. This type of information is extensive and highly sensitive. There is no rational reason for providing personal medical information to debt collectors. This applies to medical debt collection as well. For example, there is no need for a debt collector to know that a patient is HIV positive or suffered a miscarriage. Possessing medical information is not rationally related to medical debt collection. Personal medical information is irrelevant to the successful collection of debts. Moreover, placing this type of information in the hands of debt collectors would severely undercut patient privacy interests, and Federal law including HIPAA.

Question 3. Under what circumstances is it appropriate for non-profit hospitals to contract with for-profit companies?

Answer 3. Increasingly, not-for profit hospitals are collaborating with for-profit entities. Not all of this is bad or should be prohibited. For example, a non-profit hospital may contract out food services. This might be understandable to better manage hospital costs and hopefully pass along savings to consumers. That said, Members of Congress should be cautious about charitable hospitals using for-profit debt collection agencies to collect debt. In all things, non-profit hospitals must be mindful of their charitable mission and the spirit of laws that provide a very unique tax status for their organizations. **The test should be: is the use of the for-profit entity in the patients' best interest?** If the use of the contractor in question does not serve in the patients' best interests, the services should not be used.

JESSICA L. CURTIS, J.D.

Question 1. What criteria should hospitals use to evaluate the performance of revenue cycle employees?

Answer 1. The Hospital Accountability Project at Community Catalyst does not focus on hospitals' internal management of revenue cycle employees. We work primarily on strengthening public policy and supporting community initiatives to address local hospitals' harmful billing and collections practices. Our response is limited to what we have observed in the course of those efforts.

From a patient's perspective, receiving the right information—at the appropriate time—about a payment obligation and resources available to help defray the costs of care can be critical to meeting their payment responsibilities. There is much hospitals can do to make this an easier process for patients. While revenue cycle employees play a critical role in getting this information to patients in a timely, respectful manner, it is important to remember that employee evaluation is just one method of incentivizing staff to create a patient-friendly billing experience. The hospital's mission, overall culture, and leadership's commitment to creating an environment and protocols for treating patients fairly throughout the billing process are also key.

We suggest the following as steps hospitals should take to appropriately motivate and evaluate staff, including revenue cycle employees, who assist patients who may have difficulty paying for out-of-pocket expenses. We note that hospitals that outsource portions of the patient billing and revenue cycle to third parties add an additional layer of complexity to the mix. They should take appropriate steps during the initial contracting phase and throughout the duration of the business relationships to ensure that third parties adhere to the same policies and practices the hospital has adopted.[1]

Leadership sets the tone. Achieving the best results for patients starts with the hospital's leadership and governing board.[2] Revenue cycle employees will take their cue from senior managers and hospital leadership, who should view access to health care and community health improvement as critical objectives for their organiza-

[1] Compliance guidance for third-party medical billing companies may be a useful model. See, *e.g.*, Office of Inspector General, U.S. Department of Health & Human Services, Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70,138 (Dec. 18, 1998). Available at *http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf*.

[2] See Curtis, J. and Trocchio, J. "Community Benefit: Hallmarks for Assessing a Solid Program," *Health Progress: Journal of the Catholic Health Association of the United States*, PP. 64–65, May–June 2012. Available at *http://www.chausa.org*.

tions. The hospital's governing body should approve and routinely review compliance with key policies related to hospital financial assistance, billing and collection. Senior managers and executive leadership should take steps to clearly communicate—internally with revenue cycle staff and externally with community stakeholders and relevant third-party agents—their commitment to fair, clear, and transparent billing and collection policies. This includes devoting sufficient internal resources to revenue cycle staff education, infrastructure and support systems, and performance evaluation to ensure that employee practices align with the hospital's policies and legal requirements.

Even best-intentioned policies and protocols will fall short without regular staff education. Many of our State and local partners working on hospital billing and collections issues have observed that they routinely encounter frontline hospital employees who, unfamiliar with their own hospital's billing and financial assistance policies, fail to direct patients seeking more information to the appropriate staff. Furthermore, not all revenue cycle employees appear to have the appropriate training and expertise needed to help uninsured and underinsured patients navigate the complicated maze of private health insurance, public coverage programs, and financial assistance that routinely, if unintentionally, create roadblocks for patients. To counter this, hospitals should provide regular in-service trainings and continuing education opportunities on these topics for revenue cycle staff. All hospital staff should also have a basic familiarity with the hospital's financial assistance policies and related legal requirements, and be able to direct patients to the appropriate staff for more information.

Build infrastructure, support, and evaluation tools that incentivize employees to implement patient-friendly billing and collections policies. Many hospitals have invested in tools and resources designed to help their revenue cycle teams function effectively, with metrics aimed at helping revenue cycle employees hit key financial targets related to patient collections. Hospitals could expand these metrics to also audit and monitor employees for the consistency and accuracy with which they provide timely information about financial assistance or public coverage programs, such as eligibility criteria and how to apply; assist patients in completing applications for financial assistance or other forms of coverage; comply with State and Federal requirements and the hospital's established protocols for patient-friendly billing, particularly for patients who may be unable to pay for care; maintain appropriate tone and accuracy in verbal communications with patients or their representatives; and contribute to an overall reduction in the percentage of patients whose accounts are written off as "bad debt" though they are eligible for financial assistance or other coverage.

Involve patients and employees in discussions about ways to improve the revenue cycle. Patients are at the heart of the revenue cycle process, and forward-thinking hospitals will strive to make their experience of the revenue cycle as pleasant as possible. Hospitals could use feedback loops such as employee focus groups and patient satisfaction surveys to evaluate how effectively revenue cycle employees are communicating with patients—particularly those who appear to be uninsured or underinsured—about their out-of-pocket balances, financial assistance and payment plans, other potential forms of coverage and other issues that can help patients avoid falling behind on bills.[3] Hospitals could go even further and structure internal review processes that incorporate input from employees, patients, community leaders, advocates and others to identify areas where their current billing and collections process or policies need to be revised (*e.g.*, Are billing statements unclear? Is information available in languages appropriate to the hospital's community? Are financial assistance applications too onerous or hard for patients to understand? Are collections activities authorized by the hospital's board appropriate?).

Question 2. Do you have any recommendations about the content of scripts that are provided to revenue cycle employees? If so, what are they?

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[3] See "Strategies for a High Performance Revenue Cycle," Healthcare Financial Management Association, PP. 20–7. Accessed June 18, 2012 at *http://www.hfma.org/HFMA-Initiatives/Patient-Friendly Billing/Strategies-for-High-Performance-Revenue-Cycle/Strategies-for-a-High-Performance-Revenue-Cycle—About-the-Report/*. The committee may also wish to review the recommendations of the PATIENT FRIENDLY BILLING® Project, a collaborative endeavor organized by the Healthcare Financial Management Association (HFMA). Designed to help health care administrators and finance teams run efficient but patient-friendly billing operations, the Project includes guiding principles, case examples, and practical tips for hospital revenue cycle programs seeking to treat their patients fairly, fulfill their missions, and maintain financially viable health care institutions. "PATIENT FRIENDLY BILLING® Project," Healthcare Financial Management Association. Accessed June 18, 2012 at *http://www.hfma.org/HFMA-Initiatives/Patient-Friendly-Billing/Patient-Friendly-Billing/*.

Answer 2. Community Catalyst has not developed model scripts for revenue cycle employees. However, our work in the States has repeatedly shown that front-line hospital employees play a key role in informing patients about their financial obligations, options, and available financial help at the right time and the right place. [4]

We believe the following recommendations will help patients avoid unnecessary delays in care and medical debt.[5] Implemented fully, they may also help hospitals be better stewards of limited dollars by streamlining the billing and collections process, helping hospitals do a better job of connecting eligible patients with other coverage programs (such as State Medicaid, the Children's Health Insurance Program [CHIP], or other indigent care funding) that may partially or fully pay for care they have rendered.

General recommendations are as follows:

1. At a minimum, hospitals will want to ensure that revenue cycle employees' scripts comply fully with all legal requirements as well as the hospital's own policies.[6] Hospitals have to meet State and Federal legal requirements—as well as local ordinances, in some cases—for informing patients about financial obligations and notifying them about financial assistance and other programs.

2. Scripts, as well as related materials such as billing statements and application forms for hospital financial assistance, should be written in simple, easy-to-understand language.

3. Patients should have verbal and written access to billing, collections and financial assistance information in the appropriate languages.

4. Timing and context matter. Hospitals need to observe EMTALA requirements when discussing payment with patients. But they should also take proactive steps to inform patients and the communities they serve about financial assistance. Hospitals should post their policies through signs, Web sites, newspapers and social services agencies in languages that are appropriate to the communities they serve; routinely train staff members and personnel about financial assistance, billing and debt collection policies (as discussed above); and give all patients information about financial help prior to their discharge from the hospital, in compliance with EMTALA requirements.

In addition, revenue cycle employees should be prepared to discuss the following with patients (note that, in the absence of Federal standards, the implementation of these recommendations will likely vary based on hospital-established policies and State laws):

• **Patient rights and responsibilities.** Revenue cycle employees should advise patients of their rights to apply for financial assistance, receive a determination of eligibility in a reasonable timeframe, and file grievances pursuant to the hospital's internal appeals process. Patients should be advised of their responsibilities to cooperate in providing information necessary to make a determination of financial assistance and/or other forms of coverage.

• **Eligibility for the hospital's financial assistance program.** All patients should be asked whether they require financial help paying for the hospital bill. Revenue cycle employees—including any third-party agents engaged by the hospital—should notify patients about the hospital's financial assistance policies in every collection action, including pre-admission or pre-treatment conversations, bill-

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[4] By way of a negative example, in a random national survey of 99 non-profit hospitals, researchers found that under one-quarter (23) of hospital staff contacted by phone provided an application for financial assistance upon request; and fewer than one-third (26) of hospitals contacted by phone were able to offer financial assistance information in languages other than English. C. Pryor, et al. *Best-Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs*?, The Access Project and Community Catalyst, May 2010. See also, *e.g.*, Ames Alexander, Karen Garloch & Joseph Neff, *Prognosis: Profits*, *Charlotte Observer* and *Raleigh News & Observer*, April 22–6, 2012; Nina Bernstein, *Hospital Flout Charity Aid Law*, *New York Times*, February 12, 2012. By contrast, Massachusetts hospitals played a pivotal role in helping patients enroll for newly available coverage during State health reform. See S. Dorn, et al., *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, State Health Access Reform Evaluation, November 2009.

[5] For a full list of recommendations, please see Community Catalyst, "Patient Financial Assistance Act," available at *http://www.communitycatalyst.org/doc_store/publications/model_act_and_guide_may04.pdf*.

[6] For example, Section 9007 of the Affordable Care Act requires hospitals with Federal tax exempt status to have a written financial assistance policy that specifies eligibility criteria, application procedures, the basis on which patients are charged, billing and collections procedures (unless the hospital has a separate policy), and steps the hospital will take to make the policy known to the community. Many States require hospitals to notify patients that financial assistance is available. See Community Catalyst, "*Free Care Compendium National Snapshot: Mandatory Notification States*," for a summary of State laws on notification (last updated December 2010).

ing statements, letters and e-mails, telephone and in-person contacts and any other activity related to collecting a hospital bill.

- **Eligibility for public programs.** Any patient who requests financial assistance or is otherwise determined to be uninsured, underinsured, or unable to pay any portion of their out-of-pocket costs should be screened for eligibility in public coverage programs, such as Medicaid, SCHIP or other public programs. Scripts should include prompts to help assist patients in applying for these programs.[7]
- **Application procedures.** Staff should inform patients of the relevant application periods, documentation requirements, and timelines they can expect to receive a determination of eligibility for financial assistance and public programs. The process and documentation requirements should be limited to what is absolutely necessary for determining eligibility, and should not be unduly burdensome.[8]
- **Clarify no denial of care.** Staff should make clear to patients that there will be no denial or delay of care while applications for financial assistance are pending.
- **Reasonable payment plans.** For some patients, payment plans are an effective way to pay down a hospital debt. However, discussions about payment plans should take place only after the patient is determined to be ineligible for financial assistance, medical hardship or other forms of coverage. The terms of the payment plan should be keyed to the patient's ability to pay, rather than the size of the outstanding balance, and the terms of any payment plan should be reasonable in light of the patient's income and other financial obligations.
- **Billing and collections actions.** Staff should advise patients about the steps they may take to collect on a bill, in keeping with the hospital's billing and collections policies.

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[7] Importantly, a patient's failure to apply for public coverage should not be a bar to considering them for hospital financial assistance. In some instances, patients are already aware that they do not qualify for programs like Medicaid. Making them jump through hoops is at best an unnecessary administrative burden and at worst a delay tactic that could deter patients from applying for financial assistance.

[8] Lack of official documentation should not preclude patients from being considered for financial assistance. For example, patients could sign an affidavit attesting the information is accurate.