IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

THE SHANE GROUP, INC. et al.	)	
	)	
Plaintiffs, on behalf of themselves and all others similarly situated	)	Case No. 2:10-cv-14360-DPH-MKM
	)	
v.	)	Judge Denise Page Hood
	)	Magistrate Judge Mona K. Majzoub
BLUE CROSS BLUE SHIELD OF MICHIGAN,	)	
	)	
Defendant.	)	

SECOND NOTICE OF FILING PUBLIC VERSION OF BLUE CROSS BLUE SHIELD OF MICHIGAN'S BRIEF IN OPPOSITION TO NON-PARTIES JOSEPH T. AOUN AND NUYEN, TOMTISHEN AND AOUN, P.C.'S MOTION TO QUASH SUBPOENA [DKT. 110]

Pursuant to the April 20, 2018 Notice of Supplementing the Public Record Consistent with the Court's April 17, 2018 Order [Dkt. 322], Defendant Blue Cross Blue Shield of Michigan (BCBSM) now files full versions of briefs previously filed under seal, making public material disclosed in previously-sealed filings that the Parties and Third Parties agree may be unsealed, materials that Third Parties did not move to seal, and materials that the April 17, 2018 Order has ordered unsealed or redacted as listed in Exhibit 1 to the April 20, 2018 Notice of Supplementing the Public Record Consistent With the Court's April 17, 2018 Order. Attached hereto as Exhibit 1 is Blue Cross Blue Shield of Michigan's Brief

in Opposition to Non-Parties Joseph T. Aoun and Nuyen, Tomtishen and Aoun, P.C.'s Motion to Quash Subpoena [Dkt. 110] and corresponding exhibits.

This 20th day of April.

/s/ Todd M. Stenerson
Todd M. Stenerson (P51953)
Rachel Mossman (Adm. E.D. MI, DC Bar 1016255)
SHEARMAN & STERLING LLP
401 9th Street N.W.
Washington, DC 20004
(202) 508-8093
todd.stenerson@shearman.com
rachel.mossman@shearman.com

Thomas Van Dusen (P30602)
Thomas Rheaume, Jr. (P74422)
BODMAN PLC
6th Floor at Ford Field
1901 St. Antoine Street
Detroit, Michigan 48226
(313) 259-7777
tvandusen@bodmanlaw.com
trheaume@bodmanlaw.com

Robert A. Phillips (P58496)
BLUE CROSS BLUE SHIELD OF MICHIGAN
600 Lafayette East, MC 1925
Detroit, MI 48226
(313) 225-0536
rphillips@bcbsm.com

Attorneys for Defendant

CERTIFICATE OF SERVICE

I hereby certify that on April 20, 2018, I electronically filed the foregoing paper with the Clerk of the Court using the ECF system, which will send notification of such filing to all parties of record. I further certify that I have caused the foregoing document to be sent by email or U.S. Mail to all individuals or entities who filed objections to the previous Settlement Agreement or, for those individuals or entities represented by counsel, their counsel.

/s/ Todd M. Stenerson
Todd M. Stenerson
401 9th Street N.W.
Washington, DC 20004
(202) 508-8093
todd.stenerson@shearman.com

April 20, 2018

Attorney for Defendant

EXHIBIT

1

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

THE SHANE GROUP, INC., et al.,
on behalf of themselves and all others
similarly situated

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF
MICHIGAN, a Michigan nonprofit
healthcare corporation,

Defendant.

Civil Action No. 11-cv-14360-DPH-MKM
Hon. Denise Page Hood
Hon. Mona K. Majzoub

_____/

Joseph A. Fink (P13428)
Thomas G. McNeill (P36895)
Michelle L. Alamo (P60684)
Michelle R. Heikka (P66122)
Patrick B. Green (P68759)
DICKINSON WRIGHT PLLC
500 Woodward Avenue, Suite 4000
Detroit, Michigan 48226
313-223-3500
jfink@dickinsonwright.com

Todd M. Stenerson (P51953)
D. Bruce Hoffman (Adm. E.D. MI, DC Bar 495385)
Neil K. Gilman (Adm. E.D. MI, DC Bar 449226)
David A. Higbee (Adm. E.D. MI, DC Bar 500605)
Ashley Cummings (Adm. E.D. MI, GA Bar 186005)
Jonathan H. Lasken (Adm. E.D. MI, DC Bar 997251)
HUNTON & WILLIAMS LLP
1900 K Street, NW
Washington, DC 20006
202-955-1500
tstenerson@hunton.com

Alan N. Harris (P56324)
G. Christopher Bernard (P57939)
Jason R. Gourley (P69065)
Rebecca D. O'Reilly (P70645)
Carl Rashid (P66064)
BODMAN PLC
201 South Division St.
Suite 400
Ann Arbor, MI 48104
734-930-2482
aharris@bodmanlaw.com

Robert A. Phillips (P58496)
BLUE CROSS BLUE SHIELD OF MICHIGAN
600 Lafayette East, MC 1925
Detroit, MI 48226
313-225-0536
rphillips@bcbsm.com

_____/

BLUE CROSS BLUE SHIELD OF MICHIGAN'S BRIEF IN OPPOSITION TO NON-PARTIES JOSEPH T. AOUN AND NUYEN, TOMTISHEN AND AOUN, P.C.'S MOTION TO QUASH SUBPOENA

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I. INTRODUCTION

Blue Cross Blue Shield of Michigan's ("Blue Cross") subpoenas to Joseph Aoun ("Mr. Aoun") and his law firm, Nuyen, Tomtishen and Aoun, P.C. (the "Firm"), seek factual information regarding the negotiation of numerous contracts between several Michigan hospitals and commercial health insurers – information that this Court previous found to be "highly relevant to the central issue in this case." [1] *United States v. Blue Cross Blue Shield of Michigan*, No. 10-cv-14155; 2012 U.S. Dist. LEXIS 141355, *14-15 (E.D. Mich., Oct. 1, 2012) (D.E. 216; the "October 1 Opinion and Order"). Further, Blue Cross seeks factual information regarding other economic factors affecting the state of competition among commercial insurers in the State of Michigan. This information is specifically relevant to rebutting allegations made by the Department of Justice ("DOJ") and State of Michigan in their Complaint and otherwise supporting Blue Cross's defenses.

The record – which includes Mr. Aoun's own statements –demonstrates that Mr. Aoun:

- was personally involved in the negotiations between at least sixteen different Michigan hospitals and commercial health insurers at all times relevant to this litigation, and negotiated numerous such contracts during the time period;
- was personally involved in the negotiation of one of – if not, the – first "most favored nation" provisions ("MFN") included in any Blue Cross contract with a Michigan Hospital;
- has personal knowledge regarding the effect (or lack thereof) of the inclusion of MFNs in Blue Cross contracts with certain hospitals on those hospitals' contracts with other commercial payers, and provided that information to the Department of Justice;

[1] The subpoenas to Mr. Aoun and his Firm were served only in the Department of Justice case. This is consistent with the parties' practice in all three coordinated cases, whereby subpoenas are often served in one case, but the discovery is applicable in all cases. Indeed, the recent stipulated orders entered by the Court on December 5, 2012 and December 6, 2012 in all three cases for depositions to be taken after the November 30, 2012 close of discovery included Mr. Aoun's deposition in all three cases. Moreover, the Orders expressly conditioned that deposition on the resolution of this motion. Thus, the motion and this response is applicable to all three cases, and Blue Cross will therefore file its response under all three docket numbers.

- has personal knowledge regarding the existence of other economic factors affecting Michigan hospitals, such as Medicare and Medicaid shortfalls, bad debt and uncompensated care, that directly rebut allegations in Plaintiffs' Complaint;

- participated as a "consultant" in at least one meeting with the Governor's senior staff regarding the "Competitive Environment" for the Michigan insurance market;

Thus, Blue Cross seeks information acquired by Mr. Aoun through his involvement in or observation of transactions or occurrences that are part of the subject matter of this lawsuit. Accordingly, such information is not "expert opinion" and is discoverable.

Further, Mr. Aoun's unsubstantiated claims of privilege and undue burden are contradicted and nullified by evidence in the record and his own Motion to Quash Subpoena (the "Motion") that Mr. Aoun voluntarily disclosed the requested information during the course of the relevant negotiations and/or to attorneys for the DOJ, officials of the State of Michigan, and at various other public presentations and/or meetings. Plainly, Mr. Aoun cannot maintain that any information disclosed to or exchanged with entities he was not representing (including the DOJ, State of Michigan, or Blue Cross itself) or at public forums is protected by the attorney-client privilege. Moreover, the fact that Mr. Aoun recently and repeatedly disclosed information regarding the same topics on which Blue Cross now seeks discovery demonstrates that the burden (if any) of testifying at the requested deposition and otherwise responding to the subpoenas now would not be undue, and surely would not outweigh the considerable relevance of the information requested.

Accordingly, the instant Motion must be denied and the discovery sought by Blue Cross via the subpoenas at issue should be compelled.

II. STATEMENT OF FACTS

Plaintiffs filed this lawsuit alleging, generally, that Blue Cross has reduced competition in the sale of health insurance throughout Michigan by including MFNs in its contracts with various

Michigan hospitals. *See, generally*, Complaint (D.E. 1). Specifically, Plaintiffs contend, among other things, that Blue Cross began incorporating MFNs into its contracts with Michigan hospitals in response to and as an attempt to suppress increased competition from other commercial insurers for business from Michigan hospitals, by (1) forcing those hospitals to increase their rates to other commercial payers, and/or (2) overpaying those hospitals and thereby forcing them to demand prices that are too high to allow Blue Cross's competitors to compete effectively. Accordingly, Plaintiffs' claims and Blue Cross's defenses are predicated upon the negotiations, terms and effect of the various contracts and transactions between the various commercial insurers (including Blue Cross) and the various hospitals throughout the State of Michigan.

Discovery taken to date demonstrates that Mr. Aoun was directly involved in and has first-hand factual knowledge regarding the negotiation and contracting between various Michigan hospitals and commercial health insurers. Documents produced and depositions taken to date demonstrate that Mr. Aoun has been involved in the negotiation and contracting with Blue Cross and/or other commercial health insurers on behalf of at least sixteen different Michigan hospitals since 2003: Allegan, Allegiance, Beaumont, Charlevoix, CHC-Branch, Covenant, Gratiot, Marlette, MMC, Northern Michigan, Oaklawn, POH, Pennock, Spectrum, Sturgis, and West Branch. A sample of representative documents is attached hereto as **Exhibit A**. Scores of documents have been produced to date evidencing correspondence between Mr. Aoun and hospitals, Blue Cross, and/or other consultants regarding contract terms, rates, MFNs, or other contracting and negotiation items, or referencing conversations with or statements by Mr. Aoun regarding the same. *See, e.g.* Exhibits A, B, C.

One such contract negotiated by Mr. Aoun was one of the very early, if not the first, Blue Cross contract with a Michigan hospital to contain an MFN provision. *See,* June 2, 2004 Correspondence; **Exhibit B**. Thus, Mr. Aoun should have relevant information about the benefits of these provisions and the reasons why these provisions are included in contracts. These issues are at the core of this case.

In addition, Mr. Aoun disclosed to the DOJ information, apparently based on his personal knowledge, regarding the effect – or lack thereof – of the MFNs on other commercial payers' hospital contracts. Specifically, non-party Pennock Hospital produced a recording of a conference call with Mr. Aoun and an attorney for the DOJ. A transcript of that recording is attached hereto as **Exhibit C**. During that call, Mr. Aoun described the circumstances under which Pennock Hospital agreed to an MFN with Blue Cross. Mr. Aoun also discussed subsequent negotiations for a contract without an MFN. Mr. Aoun stated that he worked closely with Pennock Hospital's former Chief Financial Officer during the time period in question and "was not aware of any situation where the hospital was having to change the rates it had with other commercial payers because of the Blue Cross MFN clause in the side letter . . . just so you're aware, I was never aware of that becoming an issue for any of the Michigan Hospital Group hospitals that had agreed to that clause." *See*, Exhibit C, p. 6. The factual basis for these statements and any other conversations Mr. Aoun may have had where similar information was conveyed are clearly relevant to this lawsuit.

During that same conversation with the DOJ, Mr. Aoun disclosed personal knowledge regarding economic factors faced by hospitals and their effect on the rates paid by commercial insurers other than Blue Cross. Specifically, Mr. Aoun discussed his observations of Medicare and Medicaid shortfalls for hospitals in the State of Michigan and the extent to which Blue Cross

is covering those expenses. Mr. Aoun stated: "[Blue Cross] will recognize the Medicare and Medicaid loss for Peer 5 hospitals, basically saying yeah that's a component of your financial requirements – we recognize it – we'll pay our share but then when it comes to Peer 1 through 4 hospitals, Blue Cross doesn't do it and to me that's a pretty big issue especially as these programs, Medicare and Medicaid, continue to pay below cost . . . ." *See,* Exhibit C, p. 9. Further: ". . . the real problem with whether the Blue's payment is fair or not is that their refusal to recognize any of [cost resulting from underpayment from Medicare and Medicaid] results in this disproportionate level of cost shifting to the other payers and then the other payers are rendered uncompetitive . . . ." *See,* Exhibit C, p. 9. In other words, contrary to the allegations that Blue Cross ***overpays*** hospitals, Mr. Aoun told the DOJ that Blue Cross ***underpays*** hospitals. Moreover, he clearly told DOJ that Blue Cross's hospital cost advantage was caused by something other than MFNs. Again, these issues are not only relevant, they are central to this case.

Finally, Mr. Aoun's dissemination of knowledge relevant to this lawsuit is not limited to these proceedings. As stated in his Motion, Mr. Aoun has publically disclosed his personal experience regarding Blue Cross's business practices, including the inclusion of MFNs in contracts with Michigan Hospitals, in various public forums and hearings. Mr. Aoun produced certain Power Point slides used in a presentation he gave in September, 2012, including a slide titled "Provider Rates – Strategies to Level the Playing Field," stating "Most Favored Nation Clauses – Should be prohibited; Status of current litigation against BCBSM." *See*, **Exhibit D**, Aoun000414.

Other documents produced demonstrate that Mr. Aoun attended at least one meeting between the Michigan Association of Health Plans' CEO and Executive Board and the

Governor's senior staff on the "Competitive Environment" of insurance within the State of Michigan. *See,* **Exhibit E**. The document states Mr. Aoun attended as a "consultant," not as counsel for any of the other attendees or interested parties. *Id*. That document further demonstrates that a discussion took place regarding "the inequity of payments relative to charges of BCBSM compared to other payers . . . ." *Id*.

Prior to the filing of the instant Motion, Blue Cross advised Mr. Aoun that it was aware of the information he had disclosed to the DOJ, in addition to the public presentations and hearings he gave or otherwise participated in, and sought his deposition given the relevance of his personal knowledge to the claims and defenses asserted in this lawsuit. Mr. Aoun nonetheless sought to avoid compliance with the Subpoenas by filing his Motion to Quash making the bald, unsubstantiated and incorrect claim that Blue Cross is seeking his "expert" opinion. Moreover, notwithstanding the fact that Mr. Aoun previously, on multiple occasions, publically disclosed the information sought to the DOJ and/or in public presentations and hearings, he claims that testifying and otherwise producing the same information pursuant to Blue Cross's subpoenas would risk disclosure of privileged information and be unduly burdensome. Mr. Aoun's Motion fails to establish any meritorious reason why the relevant discovery requested should not be had, and therefore must be denied.

III. ARGUMENT

Blue Cross's third-party subpoenas to Aoun and his Firm were issued under Rule 45 and are therefore subject to the same general relevancy standard applicable to discovery set forth in Rule 26 (b)(1). *See,* October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *14-15 (citing *Martin v. Oakland County*, No. 06-12602, 2008 U.S. Dist. LEXIS 84217, at *1 (E.D. Mich., Oct. 21, 2008)). "Parties may obtain discovery on any matter that is not privileged and is relevant to any party's claim or defense if it is reasonably calculated to lead to the discovery of

admissible evidence." October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *6-7; Fed.R.Civ.P. 26 (b)(1). "Relevancy under this rule is construed broadly to encompass 'any matter that bears on, or that reasonably could lead to other matter[s] that could bear on, any issue that is or may be in the case." *Borom v. Town of Merrillville*, No. 2:07 CV 98, 2009 WL 1617085, at *1 (N.D. Ind. June 8, 2009) (quoting *Chavez v. DaimlerChrysler Corp.*, 206 F.R.D. 615, 619 (S.D. Ind. 2002)).

A non-party seeking to quash a subpoena bears a heavy burden of proof of demonstrating that the discovery sought should not be allowed. *Operating Eng'rs Local 324 Health Care Plan v. Mid Michigan*, No. 10-CV-12987, 2011 U.S. Dist. LEXIS 41575, at *7 (E.D. Mich. Apr. 18, 2011) (Mazjoub, M.J.); *see also,* October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *18; *Lowe v. Vadlamudi*, No. 08-10269, 2012 U.S. Dist. LEXIS 127586, *2 (E.D. Mich., Sept. 7, 2012); 9A Wright & Miller, Federal Practice & Procedure § 2643, p. 507). A non-party seeking to avoid a subpoena "cannot rely on a mere assertion that compliance would be burdensome and onerous without showing the manner and extent of the burden and the injurious consequences of insisting upon compliance with the subpoena." October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *18. Even if the non-party makes such a showing, the Court still must weigh "the likely relevance of the requested material . . . against the burden . . . of producing the material." *EEOC v. Ford Motor Credit Co.*, 26 F.3d 44, 47 (6th Cir. 1994).

A. The subpoenas seek information that is "highly relevant to the central issue in this case."

As demonstrated above, Mr. Aoun possesses information bearing directly on the claims, allegations, and defenses in this action, and that is therefore relevant and discoverable under Fed.R.Civ.P. 26(b)(1) and 45.

It is beyond dispute that Mr. Aoun has information regarding contracting and negotiations between various Michigan hospitals and commercial health insurers. The record is replete with examples of Mr. Aoun's active involvement in this regard. *See,* Exhibit A, B, C. This Court previously ruled that such information is "highly relevant to the central issue in this case, that is, whether [Blue Cross's] use of MFN clauses had an anti-competitive effect on the marketplace." October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *17-18. Mr. Aoun negotiated various hospital contracts with both Blue Cross and other commercial health insurers, some of which contained MFNs and others that did not. As the Court held previously, testimony and documents relating to those contracts and/or negotiations "specifically relate to [Blue Cross's] competitors negotiations with the Hospitals and how those negotiations were impacted by the MFN clauses, even if the documents do not specifically mention [Blue Cross] or the MFN clauses. At the very least, these documents are 'reasonably calculated to lead to admissible evidence.'" *Id*. at *18. Because Mr. Aoun's testimony fits within the Court's finding, his Motion must be denied.

Among the hospital contracts negotiated by Mr. Aoun is what is believed to be one of the first Michigan hospital contracts with Blue Cross to contain an MFN. Given the allegations that Blue Cross orchestrated and implemented a scheme to use MFNs in hospital contracts to stifle competition with commercial payers, information about Mr. Aoun's negotiations of that early contract is likely to be important, and is clearly relevant to address Plaintiffs' allegations regarding the origin, use, intent and purpose of the MFN clause in that instance, and in general.

Moreover, Mr. Aoun's disclosure to the DOJ, based on personal knowledge, that he was aware of a specific instance where an MFN clause in a Blue Cross contract did not cause that hospital to increase, or otherwise change, its rates with any other commercial payers is clearly

relevant to Plaintiffs' allegations to the contrary. *See*, Exhibit C, p. 6. Thus, Blue Cross is entitled to discovery of Mr. Aoun's testimony and his and his Firm's unprivileged documents regarding those contracts and negotiations, and any other contracts and negotiations observed by Mr. Aoun, or in which he was involved, between Michigan hospitals and commercial health insurers.

The record also establishes, and Blue Cross seeks to discover, Mr. Aoun's knowledge regarding other economic factors that are affecting hospital's rates with commercial insurers. For instance, Plaintiffs allege in this lawsuit that Blue Cross uses MFNs to, essentially, overpay hospitals in an attempt to drive up prices to a point that other commercial insurers cannot afford to compete. *See, e.g.,* Complaint at pp. 20 – 30 (¶¶ 41, 44, 50, 58, 65, 75). However, contrary to this contention, Mr. Aoun told the DOJ that he has observed the opposite: that Blue Cross has not paid Michigan hospitals enough to cover hospital costs, such as Medicare and Medicaid shortfalls. Mr. Aoun stated: "[T]he real problem with whether the Blue's payment is fair or not is that their refusal to recognize any of [cost resulting from underpayment from Medicare and Medicaid] results in this disproportionate level of cost shifting to the other payers and then the other payers are rendered uncompetitive . . . ." *See,* Exhibit C, p. 9. Any information or documents in Mr. Aoun's or his Firm's possession relating to this observation, or any other factors affecting competition among commercial health insurers, are relevant to Blue Cross's efforts to disprove further Plaintiffs' allegations and are therefore discoverable.

Blue Cross is also entitled to discovery regarding the presentations Mr. Aoun gave or meetings Mr. Aoun attended regarding either this lawsuit itself, or the operative facts at issue in this lawsuit. For instance, the factual basis and any materials relied upon for Mr. Aoun's assertion in his July 2012 presentation that MFN provisions "[s]hould be prohibited," and his

status report of the current litigation, are relevant to the same assertions made in this lawsuit. Similarly, the facts disclosed during the January 31, 2012 meeting Mr. Aoun attended with the Governor's senior staff on "Competitive Environment" may bear on the same issue at the center of this lawsuit.

Accordingly, Blue Cross has easily demonstrated the relevance of the information sought to this lawsuit.

B. Blue Cross seeks to depose Mr. Aoun as a percipient witness with relevant knowledge and information, not as an "expert".

Mr. Aoun erroneously contends that the subpoena for his deposition should be quashed because it seeks his self-proclaimed "expert opinions." Notably, Mr. Aoun makes no attempt to establish that the information sought would be expert opinions or otherwise substantiate his conclusory assertion. To the contrary, as stated above, Blue Cross intends to depose Mr. Aoun as a percipient witness, seeking information obtained by Mr. Aoun through his involvement in and observations of contract negotiations and business transactions of various Michigan hospitals implicated in this lawsuit.

A witness is not treated as an expert witness, and the limitations under the Federal Rules of Civil Procedure on discovery from "expert" witnesses do not apply, with respect to information "not acquired in preparation for trial but rather because he was an actor or viewer with respect to transactions or occurrences that are part of the subject matter of the lawsuit. Such an expert should be treated as an ordinary witness." *See*, Fed.R.Civ.P. 26(b)(4) Advisory Committee Notes. *See, Talk-N-Surf Communications, Inc. v. Gualtieri*, 1:12-MC-229, 2012 U.S. Dist. LEXIS 135164 (S.D. Miss., Sept. 21, 2012). *See also*, *Jones v. Celebration Cruise Operator, Inc.*, No. 11-61308, 2012 U.S. Dist. LEXIS 40502 (S.D. Fla. March 26, 2012) (recognizing "it is possible for a witness to wear two hats: one as a specially employed expert in

anticipation of litigation and one as an ordinary witness"); *Statutory Comm of Unsecured Creditors v. Motorola, Inc.*, 218 F.R.D. 325, 327 (D.D.C. 2003) ("When . . . a party seeks only factual information relating to an issue in the case, a witness cannot demand any greater compensation than any other witness merely because he or she can claim some expertise in a discipline or calling.") Accordingly, federal courts refuse to quash subpoenas pursuant to Fed.R.Civ.P. 45(c)(3)(B)(ii) where, as here, the subpoena does not seek a non-party's opinions (expert or otherwise) but, rather, seeks information regarding transactions or occurrences at issue in the lawsuit acquired through the witness's involvement or observations of the same. *Talk-N-Surf Communications*, 2012 U.S. Dist. LEXIS 135164.

As set forth above, the record demonstrates that Mr. Aoun possesses relevant knowledge, acquired through his direct involvement or observations, regarding: (1) contracting and negotiations between various Michigan hospitals and commercial health insurers; (2) what, if any, affect the inclusion of an MFN in one (if not more) hospital's contract with Blue Cross had on its contractual rates with other commercial health insurers; (3) various hospital costs and other economic factors, and the effect of the same on competition between commercial health insurers; and (4) various meetings and other public presentations regarding hospital contracting and the competitive environment for commercial health insurers in Michigan.

Because the subpoenas do not seek to compel Mr. Aoun to be an involuntary expert as Mr. Aoun contends, but rather seek the testimony and documents of an ordinary witness, the cases he cites are inapplicable. Accordingly, the subpoenas should not be quashed pursuant to Fed.R.Civ.P. 45(c)(3)(B)(ii).

C. Mr. Aoun fails to demonstrate any basis for quashing the subpoenas for his deposition.

Mr. Aoun's mere assertion that complying with the deposition subpoena would be burdensome is insufficient to quash the subpoena, particularly given the importance of the information sought, as outlined above. *Operating Eng'rs*, 2011 WL 1464851, at *2; *EEOC v. Ford Motor Credit Co.*, 26 F.3d at 47.

Mr. Aoun makes no attempt to substantiate any claim that appearing for and testifying at the requested deposition would be unduly burdensome. In his affidavit in support of his Motion, Mr. Aoun states that he believes the requested deposition would be "impractical." *See*, Motion at Exhibit D, ¶ 9. Mr. Aoun's conclusory statement in this regard plainly fails to meet his evidentiary burden to quash the subpoena. October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *18.

Mr. Aoun repeatedly contends that the "opinions" he believes Blue Cross seeks are based upon and "inextricably tied to" his legal practice, and that the requested deposition presents the risk that privileged information may be revealed and must therefore be quashed. However, as stated above, Blue Cross simply seeks to depose Mr. Aoun regarding factual information he acquired through his involvement or observation in various transactions or occurrences at issue in this lawsuit. Those facts are not protected by the attorney-client privilege. Indeed, at least some of this information has already been disclosed to the DOJ, demonstrating that this argument is simply a makeweight attempt to avoid the deposition.

The party asserting attorney-client privilege bears the burden of proving its existence and applicability. *Volkswagon AG v. Dorling Kindersley Publ'g, Inc.*, No. 05-CV-72654-DT, 2007 U.S. Dist. LEXIS 4225, *6 (E.D. Mich., Jan. 22, 2007) (Majzoub, M.J.). The elements of the attorney-client privilege are: (1) where legal advice of any kind is sought; (2) from a professional

legal advisor in his capacity as such; (3) the communications relating to that purpose; (4) made in confidence; (5) by the client; (6) are at his instance permanently protected; (7) from disclosure by himself or by the legal adviser; (8) unless the protection is waived. *Reed v. Baxter*, 134 F.3d 351, 355-56 (6th Cir. 1998).

"It is . . . well established that attorney-client communications related to areas other than legal counseling, such as business advice, are not privileged." *In re Search Warrant Executed at Law Offices of Stephen Garea*, No. 97-4112, 1999 U.S. App. LEXIS 3861, *4 (6th Cir., March 5, 1999); *Taylor v. Allstate Ins. Co.*, 2012 U.S. Dist. LEXIS 163032, *2 (E.D. Mich., Nov. 15, 2012). "When lawyers produce both documents containing business advice and documents containing legal advice, courts place *a particularly heavy burden* upon the proponent of the privilege to make a clear showing that allegedly privileged document actually concerns legal, as opposed to business, advice." *Flagstar Bank v. Fed. Ins. Co.*, No. 05-CV-70950, 2006 U.S. Dis. LEXIS 58559, *10 (E.D. Mich., Aug. 21, 2006) (Mazoub, M.J.) (emphasis added) (citing *In re Feldberg*, 862 F.2d 622, 626-27 (7th Cir. 1988); *Amway Corp. v. Procter & Gamble Co.*, No. 1:98-cv-726, 2001 U.S. Dist. LEXIS 4561 *18 (W.D. Mich., Apr. 3, 2001). Further, "the attorney-client privilege is waived by voluntary disclosure of private communications by an individual or corporation to third parties." *In re Lott*, 424 F.3d 446, 452 (6th Cir. 2005); *see also, In re Columbia/HCA Healthcare Corp. Billing Practices Litigation*, 293 F.3d 289, 294 (6th Cir. 2002) ("As a general rule, the attorney-client privilege is waived by voluntary disclosure of private communications by an individual or corporation to third parties.")

Plainly, no information Mr. Aoun acquired from or communicated to Blue Cross, another commercial health insurer, any consultant, other hospital, or any other entity or individual he was not representing is protected from disclosure by the attorney-client privilege. The record is

replete with examples of such correspondence, and Blue Cross is entitled to depose Mr. Aoun regarding those exchanges and the underlying facts.

Moreover, any information exchanged between Mr. Aoun and any of his purported clients for the purpose of providing business advice is not privileged and is freely discoverable. Mr. Aoun has not demonstrated that information he exchanged with the various hospitals he represented regarding contracting and negotiations with Blue Cross and other commercial insurers was exchanged for the purpose of legal, as opposed to business, advice and is therefore privileged. To the contrary, evidence in the record demonstrates that Mr. Aoun's clients themselves believed that Mr. Aoun provided business consulting services with respect to certain contract negotiations, beyond any legal advice he may have also provided.

For instance, Mark Gronda, the Chief Financial Officer of Covenant HealthCare ("Covenant"), testified at deposition on December 13, 2012 that Mr. Aoun provided Covenant with business consulting advice beyond any legal services he may have also provided. *See,* **Exhibit F**,[2] p. 119. Mr. Gronda testified that Mr. Aoun provided *business* advice to Covenant regarding its negotiations with BCBSM and other commercial insurers, generally, and regarding a Medicare Advantage PPO contract with Blue Cross, specifically. *See,* Exhibit F, pp. 119, 155-157. Further, Mr. Gronda testified that he does not believe there is a direct correlation between premium increases for patients and the rates that hospitals negotiate based on charts prepared by Mr. Aoun, which Mr. Gronda specifically stated "wasn't legal advice." *See,* Exhibit F, p. 119.

Finally, any information voluntarily disclosed outside of Mr. Aoun's purported attorney-client relationships is not protected from disclosure by the attorney-client privilege because the disclosure to any third-party would waive any such privilege. Thus, any information disclosed to

[2] Relevant portions of the rough draft of the transcript are attached as Exhibit F. Blue Cross has not received the final, certified transcript as of the time of this filing.

the DOJ (such as any of the statements made in the recording produced by Pennock Hospital), to a consultant, at a legislative hearing or meeting with state officials, or at a public presentation of any sort is readily discoverable. To the extent Mr. Aoun is nonetheless concerned that he may be asked questions that inadvertently seek the disclosure of privileged information, he will surely be represented by competent counsel who will, like the counsel representing the parties and third parties in this and every other litigation, instruct him not to answer the questions.

Neither the potential disclosure of privileged communications, nor the existence of any supposed burden prevented Mr. Aoun from discussing hospital contracting and negotiation and other commercial insurance competition issues with the DOJ in December of 2010, with officials from the State of Michigan in January of 2012, or at any of his various public presentations referenced in his Motion. Here, Mr. Aoun has failed to establish any basis for quashing the subpoena for his deposition, thus his Motion to quash that subpoena must be denied.

D. Mr. Aoun fails to demonstrate any basis for quashing the subpoena seeking the production of documents.

Similarly, Mr. Aoun has failed to demonstrate any basis to quash or otherwise modify the subpoena seeking the production of documents of the type this Court has previously held to be "highly relevant."

As an initial matter, since the issuance of the subpoenas, Blue Cross has expressed its willingness to reasonably limit the scope of the document requests in order to minimize the burden upon Mr. Aoun and his Firm. As stated in his Motion, Mr. Aoun made an initial production of "public documents," however that production was devoid of any contracting or negotiation documents or materials, reference to his communications with the DOJ, or documents or materials relating to his meeting with officials for the State of Michigan. At the time of his production Mr. Aoun advised, as he contends in his Motion, that other documents

exist but were not produced either because the documents themselves are privileged or because they are stored with other documents that are privileged.

Mr. Aoun's objections in this regard fail to establish any basis to quash Blue Cross's document requests. As stated above, no information obtained by Mr. Aoun when providing business advice, as opposed to legal advice, is privileged or otherwise protected from disclosure. *In re Search Warrant*, 1999 U.S. App. LEXIS 3861, *4; *Taylor*, 2012 U.S. Dist. LEXIS 163032, *2. Evidence in the record demonstrates that Mr. Aoun was acting, at least in part, as a business advisor with respect to contracting and negotiations between his hospital clients and Blue Cross and other commercial insurers, and Mr. Aoun has yet to demonstrate that any documents in his possession concern legal, as opposed to business, advice. *Flagstar Bank*, 2006 U.S. Dist. LEXIS 58559, *10. Further, no documents disclosed to other parties to the negotiations, the DOJ, the State of Michigan, or otherwise outside of Mr. Aoun's purported attorney-client relationships are privileged as disclosure to a third party waives any privilege that may exist. *In re Lott*, 424 F.3d at 452. Accordingly, contrary to Mr. Aoun's assertions, the vast majority of contracting and negotiation documents would not be privileged.

Nonetheless, in order to minimize whatever burden may exist to collect responsive documents, Blue Cross is willing to agree to the same litany of accommodations and limitations to the scope of the subpoena it has proposed to other non-parties. For instance, Blue Cross is willing to accept a search of files known to have responsive documents and not require a search for "all documents." Further, Blue Cross is willing to allow key word searches on active emails, and agrees that Mr. Aoun and his Firm need not search archive tapes or off-site storage. Moreover, Blue Cross is willing to send its own attorney to Mr. Aoun's Firm to search files and copy responsive, non-privileged documents at Blue Cross's expense. This list is not exhaustive,

as Blue Cross is willing to work with Mr. Aoun and his Firm to reduce the burden of producing the relevant information requested. Such accommodations have not been afforded to date based solely on Mr. Aoun's willingness to produce only "public documents" based, at least in part, on his unfounded assertion of privilege.

Mr. Aoun's remaining objections to Blue Cross's document requests are also unfounded. Mr. Aoun objects to Blue Cross's requests for communications regarding provider agreements (Requests 1 – 4) as "overbroad on their face as they are not limited to the MFN agreements at issue in this lawsuit." Motion, p. 11. However, this Court previously rejected this objection, holding that documents discussing contracting and negotiation of commercial health insurance contracts "specifically relate to [Blue Cross's] competitors' negotiations with the Hospitals and how those negotiations were impacted by the MFN clauses, even if the documents do not specifically mention [Blue Cross] or the MFN clauses." October 1 Opinion and Order, 2012 U.S. Dist. LEXIS 141355, *18. Thus, Mr. Aoun's objection is unfounded.

Mr. Aoun objects to Blue Cross's requests for documents regarding hospital shortfall coverage, compensation for bad debt or uncompensated care, communications regarding PA 350, and his analysis of Blue Cross's positions in this litigation (Requests 6 – 11) as either irrelevant or the subject of his expert opinion. But Mr. Aoun has demonstrated personal knowledge regarding the extent of shortfalls, bad debt, and uncompensated care on hospitals, and the extent to which that affects hospital's rates with commercial health insurers. *See,* Exhibit C, Exhibit A. As demonstrated above, the information requested is plainly relevant to the claims and defenses asserted in this lawsuit. Moreover, the information is not "expert opinion," as it is factual information based Mr. Aoun's own actions and observations.

Similarly, Mr. Aoun objects to Blue Cross's request for communications with Plaintiffs regarding this litigation and Blue Cross's "contracting practices" as both overbroad and calling for his opinions. Again, any documents regarding Blue Cross contracting practices are relevant to the central issues in this case, and factual information regarding Mr. Aoun's involvement and observations of those relevant transactions does not constitute expert opinion.

Finally, Mr. Aoun objects to Blue Cross's request for proof of an attorney-client relationship with Aetna (Request 12) as irrelevant. The relevance of this request is demonstrated within Mr. Aoun's Motion and his repeated assertion of privilege emanating from that very relationship. Mr. Aoun bears the burden of establishing the existence of the attorney-client privilege if he is to invoke it as a shield from the requested discovery. *Volkswagon AG*, 2007 U.S. Dist. LEXIS 4225, *6. To do so, Mr. Aoun must demonstrate the existence of an attorney-client relationship. To that end, Mr. Aoun is not only obligated to produce documents establishing the existence of an attorney-client relationship with Aetna, but also each and every hospital, consultant, association, or other entity with whom he claims to represent and regarding which he withholds discovery on the basis of privilege.

III. CONCLUSION

For the reasons stated above, Blue Cross respectfully requests that this Court deny non-parties Joseph A. Aoun's and Nuyen, Tomtishen and Aoun, P.C.'s Motion to Quash Subpoena and enter an order compelling the production of the discovery requested by the subpoenas at issue.

Respectfully submitted,

/s/ Patrick B. Green
Joseph A. Fink (P13428)
Michelle L. Alamo (P60684)
Michelle R. Heikka (P66122)
Patrick B. Green (P68759)

DICKINSON WRIGHT PLLC
500 Woodward Ave, Suite 4000
Detroit, MI 48226
Phone: 313-223-3500
Fax: 313-223-2598
pgreen@dickinsonwright.com

Todd M. Stenerson (P51953)
Hunton & Williams LLP
2200 Pennsylvania Ave., NW
Washington, DC 20037
Phone: 202-955-1500
Fax: 202-778-7436
tstenerson@hunton.com

CERTIFICATE OF SERVICE

I hereby certify that on December 17, 2012, I electronically filed the foregoing document with the Clerk of the Court using the ECF system which will send notification of such filing to, and that a copy of the sealed documents will be e-mailed to, the following:

Attorneys Plaintiff - United States of America:

Amy Fitzpatrick: amy.fitzpatrick@usdoj.gov
Barry Joyce: barry.joyce@usdoj.gov
Steven Kramer: steven.kramer@usdoj.gov
David Gringer: david.gringer@usdoj.gov

Attorneys for Plaintiff - State of Michigan:

M. Elizabeth Lippitt: lippitte@michigan.gov
Thomas Marks: markst@michigan.gov

Attorneys for Plaintiffs - The Shane Group, Michigan Regional Council of Carpenters Employee Benefits Fund, Scott Steele, Bradley A. Veneberg, Abatement Workers National Health and Welfare Fund, and Monroe Plumbers & Pipefitter Local 671 Welfare Fund:

Mary Jane Fait: fait@whafh.com
John Tangren: tangren@whafh.com
Beth Landes: landes@whafh.com
Theo Bell: tbell@whafh.com
Daniel Small: dsmall@cohenmilstein.com
Meghan Boone: mboone@cohenmilstein.com
Brent Johnson: bjohnson@cohenmilstein.com
Dan Gustafson: dgustafson@gustafsongluek.com
Dan Hedlund: dhedlund@gustafsongluek.com
Ellen Ahrens: eahrens@gustafsongluek.com
E. Powell Miller: epm@millerlawpc.com
Jennifer Frushour: jef@millerlawpc.com
Casey Fry: caf@millerlawpc.com

Attorneys for Plaintiff - Aetna Inc.:

Joshua Lipton: jlipton@gibsondunn.com
Dan Matheson: dmatheson@gibsondunn.com
Veronica Lewis: vlewis@gibsondunn.com
Cara Fitzgerald: cfitzgerald@gibsondunn.com
Sarah Wilson: sawilson@gibsondunn.com

Attorneys for Defendant - Blue Cross Blue Shield of Michigan:

Todd Stenerson: tstenerson@hunton.com
Bruce Hoffman: bhoffman@hunton.com
Neil Gilman: ngilman@hunton.com
Ashley Cummings: acummings@hunton.com
Jack Martin: martinj@hunton.com
Jason Beach: jbeach@hunton.com
Jonathan Lasken: jlasken@hunton.com

Respectfully submitted,

/s/ Patrick B. Green

Patrick B. Green (P68759)
DICKINSON WRIGHT PLLC
500 Woodward Ave, Suite 4000
Detroit, MI 48226
Phone: 313-223-3500
Fax: 313-223-2598
pgreen@dickinsonwright.com

INDEX OF EXHIBITS

EXHIBIT A

[Filed Under Seal]

SCH-DOJ-012299, SCH-DOJ-012300, SCH-DOJ-012379, SCH-DOJ-012380 and SCH-DOJ-015174

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

RECEIVED
GERALD NOXON
AUG 31 2004
Director
Provider Contracting & Reimbursement

VIA EMAIL AND FACSIMILE

August 30, 2004

Mr. Douglas E. Darland
Director, Regional Contracting
Blue Cross Blue Shield of Michigan
600 Lafayette East
Detroit, MI 48226-2998

Re: Sturgis Hospital

Dear Mr. Darland:

Our firm has been asked to assist Sturgis Hospital in connection with negotiations with Blue Cross concerning payment rates and other matters. As you may be aware, the Hospital and Blue Cross began negotiations in April 2003. Recently, the Hospital received your letter dated July 30, 2004 with respect to the Hospital's emergency room charges. Your letter indicates that the charges increased at a level of approximately 173.4% which amount is in excess of the attestation statement for the period between 1997-2002. Blue Cross proposes to recover approximately $231,000. Your letter indicates that the Hospital will have thirty days to comment on the proposed recovery, and our comments are set forth below.

Given the current negotiations, the Hospital believes it would be appropriate (and more expedient to both the Hospital and Blue Cross) if the proposed recovery was addressed during those negotiations. We believe that resolution of the negotiations could include resolution of the emergency room charge issue as well. The Hospital does not believe that the recovery is appropriate or that the current analysis properly takes into account changes in acuity and changes in prices (charges). Although we have a number of concerns with respect to the proposed recovery, we have identified three of the larger concerns below. In light of these meritorious concerns, we believe pending the recovery during the negotiations is appropriate.

Time Period: 1997-2002

The years to which the recovery relates are all closed. As a result, we do not believe that Blue Cross has the authority to make the proposed recovery. If Blue Cross believes that such action is proper, it should identify specifically the basis for its conclusion and the appeal rights available to Sturgis Hospital.

Increase in Acuity

The analysis with respect to the emergency room charges focuses on the average emergency room charge per case, and how that average has changed over the years. The primary reason for the change in the Hospital's average charge per case is due to acuity or case complexity. Generally, there are six different emergency room charges which correspond to six different levels of intensity/resource consumption. Even if the rate for each of the six levels remains the same, the average charge per case can increase due to a change in the mix or acuity of cases. As described below, there has been a significant change in acuity for the Hospital over the past several years, and this is the primary reason that the average charge has increased.

During 2000, the number of emergency room cases (among Traditional and PPO enrollees) was 2,955, of which 734 were with respect to cases that were Level 3 or higher (about 25%). In 2002, the number of emergency room cases (among Traditional and PPO enrollees) was 3406, of which 2072 were with respect to cases that were Level 3 or higher (about 61%). Because there was a large increase in higher acuity cases, the average charge per case increased significantly. This acuity needs to be factored into the Blue Cross analysis in terms of determining whether there should be any recovery at all.

In this regard, we note that your letter indicates that the issue of an increase in intensity is considered since the formula for the amount of recovery considers Blue Cross' cost report liability. As we understand it, the Blue Cross cost report liability serves as a cap or ceiling to the amount of the recovery. In other words, the recovery will not exceed some determined amount designated as "Blue Cross Cost Report Liability." In this case, the proposed recovery is $231,000 which is less than the Blue Cross Cost Report Liability of $812,000. Thus, the recovery is limited to $231,000. We fail to see how application of this ceiling takes into account the changes in acuity. In fact, we fail to see how the average charge per case has been case mix adjusted at all.

Increase in Charge Master Rates

The purpose of the audit is to measure the extent to which charges increased relative to the attestation. In doing the audit and related analysis, Blue Cross did not examine the actual cumulative increase in emergency room charges. The Hospital's charge master for the six emergency room codes reflects the year-to-year and cumulative increases in the emergency room codes. During the time period, none of the emergency room codes had a cumulative increase anywhere near the "observe actual % change" of 173.4%. In fact, the increase among the six emergency room charges were approximately 5% (Level 6); 10% (Level 5); 28% (Level 4); 29% (Level 3); 28% (Level 2); and 41% (Level 1). In no case did the Hospital increase its charges at the level calculated by Blue Cross.

Current Negotiations and Preparation of a Revised Analysis

Given the concerns expressed above, we request that Blue Cross withhold making any recovery and/or adjustment to the Hospital's header file rates. As noted above, we recommend that this matter be addressed as part of the overall negotiations between the parties. Sturgis Hospital desires to conclude those negotiations as quickly as possible.

If Blue Cross intends to continue this emergency room recovery initiative on a basis that is independent from the current negotiations, then we request that Blue Cross prepare a revised analysis that properly takes into account acuity and actual charge master increases. We object to any recovery being made on the basis of the current analysis. We also request the detail supporting the (a) calculations of average charge per case (lines A through E1); and (b) Cost Report Liability (line b). In the event that Blue Cross proceeds to initiate this recovery (and the corresponding change in header file rates), we request that you immediately make available to Sturgis Hospital all of its appeal rights.

Please contact me after you have had a chance to review this letter. Thank you in advance for your cooperation.

Very truly yours,

Joseph T. Aoun

JTA/llm
cc: Mr. Gerald Noxon ✓
Ms. Connie Downs
N0020798

Gearig, Al

From: Aoun, Joseph T. [jta@NTALAW.com]
Sent: Monday, June 19, 2006 9:05 AM
To: Gearig, Al
Cc: Ron Rybar
Subject: FW: Allegan

Al,

Please see the response from Blue Cross regarding our latest effort to obtain rate relief. After you have reviewed this, please give me a call to discuss possible options.

Joe

****

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
640 Griswold
Northville, MI 48167
248-735-6920 (direct)
248-449-2700 (general)
248-449-8775 (fax)
jta@ntalaw.com

From: Noxon, Gerald [mailto:gnoxon@bcbsm.com]
Sent: Fri 6/16/2006 1:10 PM
To: Aoun, Joseph T.
Subject: Allegan

Joe,

I received a message that you called regarding Allegan and have the following to report to you:

I have reviewed all of the information that you gave me regarding Allegan and have considered their request for additional reimbursement and have concluded that no adjustment is warranted at this time.

Specifically:

As I indicated in prior correspondence, Allegan is showing a margin of approximately 25% on Blue Cross. I realize that the latest response from the provider shows that they are slightly under 25%, however, I never meant to indicate

that 25% was a specific threshold, only a general benchmark to evaluate the reasonableness of our payments. Also, in reviewing the work that has been completed to date, I do believe that the actual margin is well above 25%. When I gave the data, that Allegan submitted, to a member of my staff for review, that person brought to my attention that the charges in my analysis (2005) were not updated for the latest charge increase (15%) issued by the provider. That increase would cause the overall cost to charge ratio to go down significantly, which would cause our margin to increase given that the payment rate I have been using was adjusted for the 15% charge increase.

The discussion of whether or not there should be a PPO differential seems to be an effort to maximize the situation. I will not deny that language can be pointed to and beliefs may have been that there would be no differential, but my spoken word to Allegan was that I would terminate their LOU. That action caused me to take them back to the situation they were in prior to the LOU. I think maintaining my position on this given that I had no obligation to terminate the LOU early is reasonable.

I indicated in our first meeting that the current work related to the PHA and specifically changes to the peer group 5 reimbursement would not prevent me from considering the request for additional reimbursement. While I stand by that statement, discussions are taking place starting in July regarding possible revisions to the peer group 5 payment methodology and it would not be appropriate to enter into an agreement that could possibly exempt Allegan from any possible changes, without some overriding compelling reason. I do not see that reason.

In considering the overall financial situation that Allegan has described, it is apparent that there is a need to improve the financial situation. I certainly do not want to minimize the efforts that Allegan has taken and will need to take, but I do not see why BCBSM should be required to do more. We are providing a healthy margin on our business and we did terminate our LOU early. I believe we have done all that we can be expected to do at this time.

I realize this is not the answer you or the provider was looking for. I also realize that the PPO discount seems like a small concession for a large company like BCBSM to make, but in all negotiations, a line has to be drawn somewhere. I believe that drawing the line where we have is appropriate and would allow Allegan to be financially viable if it works out its other issues on cost containment and other payer contract renegotiations.

Sincerely,

Jerry

6/19/2006

From: Aoun, Joseph T. [jta@NTALAW.com]
Sent: Tuesday, May 23, 2006 8:28 PM
To: Noxon, Gerald
Subject: Allegan attachment

Jerry, one of my attachments to my emails was your correspondence to me dated April 21. Pasted below is the text of your email to me and I have attached the same spreadsheet that was attached to your email of April 21. I am sending it to you this way since your server is rejecting the zip file attachment and since your original email was sent via secure server and the time period for reply has expired. Thanks Joe

##########

Joe,
Attached is a spread sheet that shows how I calculate margin on a peer group 5 hospital. I've used the 2005 financial statement that you sent me. I haven't had a chance to review the other data that was sent, but I wanted to get this to you for review in case there was any disagreement or errors in the way margin was calculated.

FYI - [redacted] is a "magic" number for margin. While nothing has been formally discussed, the feeling at BCBSM is that a [redacted] margin on peer group 5's is a very reasonable amount and I believe that is the number we will be looking for the industry to support as we move forward. Given that this analysis shows Allegan's margin at [redacted] I am very unlikely to agree to any rate adjustments.

Please review the calculation and give me your thoughts. In the meantime, I will review the rest of the data that was sent and prepare to finalize this discussion.

Jerry

From: Aoun, Joseph T. [mailto:jta@NTALAW.com]
Sent: Wednesday, April 19, 2006 9:15 AM
To: Noxon, Gerald
Cc: AlGearig@aghosp.com
Subject: Allegan General Hospital

Jerry.

As a follow-up from our discussions on March 28, I am enclosing the following material for your review:
Draft Audited Financial Statements for the year ended 12/31/05. These are expected to be finalized by month end.
Narrative prepared by Al Gearig, Allegan Hospital's CFO, along with some exhibits outlining operating profit/loss matters.
As you review the financials please note in particular the following:
1. The Hospital's cash and short term investment position declined 59% from 2004 to 2005. This decline is due in part to the substantial equipment and capital purchases made by the Hospital in 2005. As

reflected in note 4 (p. 8), the capital spend increased by approximately $1.4 million.

2. The Hospital's current liabilities increased 34% from 2004 to 2005, and the Hospital's overall net worth (fund balance) declined 18.7%.

3. The Hospital's operating revenue declined by close to 3% from 2004 to 2005. The key reasons for the drop in revenue are described in the attached narrative. Due to management discipline, the growth in operating expenses was quite low--below 2%. Overall, the Hospital lost $1.9 million from operations in 2005 (2004: $399K) and it had a total loss in 2005 of $2.2 million (2004: $507K).

4. Bad debt and charity care expenses are rising rapidly, from $1.6 million to $2.2 million, an increase of 43% (bad debt is reflected on p.3 and charity care is reflected on p.16).
During our meeting on March 28, you inquired about the steps the Hospital is taking relative to other commercial payors. The largest commercial payors in the Hospital's community besides Blue Cross are PPOM, Priority Health and IBA. The Hospital renegotiated its PPOM contract last fall, and the payment rates under that contract (which also apply to Aetna business) are higher than Blue Cross. The Hospital also renegotiated its Priority Health contract last fall, resulting in improved reimbursement. Similar to the situation with Blue Cross, the Hospital is pleased with the improved reimbursement arising from last fall's negotiation, but it seeks to increase reimbursement further. It plans to pursue additional improvement during this Spring/Summer. The Hospital has also begun negotiations with IBA, and a meeting has been scheduled early next month to discuss improvement in reimbursement levels.

I hope you find this email and attachments responsive to your inquiries and helpful as you review Allegan's situation. We are trying to pull together some additional, comparative information, and we will share that with you under separate cover.

Please contact me after you have had a chance to review the enclosed. Also, feel free to contact Al Gearig, the Hospital's CFO, who is copied on this email. Al's phone number 269-686-4284.

Thanks.

Joe

****

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
640 Griswold
Northville, MI 48167
248-735-6920 (direct)
248-449-2700 (general)
248-449-8775 (fax)
jta@ntalaw.com

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Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

.
This message was secured by ZixCorp(R).

****

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
640 Griswold
Northville, MI 48167
248-735-6920 (direct)
248-449-2700 (general)
248-449-8775 (fax)
jta@ntalaw.com

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-----Original Message-----
From: InterScan MSS Notification [mailto:postmaster@bcbsm.com]
Sent: Tuesday, May 23, 2006 4:20 PM
To: Aoun, Joseph T.; NotificationRecipient@bcbsm.com
Subject: Prohibited File Type Attachment

We removed the file _RE~_Allegan_General__04212006.zip from this message because it violated our content security policy. Please follow up with the sender to determine an alternate method of transmitting this information. For suggestions or questions, please call the IS Customer

Margin Calc using 2005 data.xl...

Service Helpdesk at (800) 859-2583.

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

October 14, 2003

RECEIVED
MARK JOHNSON
OCT 15 2003
Vice President
Traditional Product

Mr. Mark Johnson
Vice President
Provider Contracting and Quality Assessment
Blue Cross and Blue Shield Michigan
600 Lafayette East—J744
Detroit, MI 48226-2998

Re: Michigan Hospital Group

Dear Mark:

I am writing to follow-up on our discussions on payment rates for the following hospitals: Community Health Center of Branch County, Gratiot Community Hospital, Memorial Medical Center of West Michigan, and Pennock Hospital. Each of the hospitals is part of the Michigan Hospital Group (sometimes referred to herein as MHG).

On March 31, 2003, we met to discuss the hospitals' desire to improve payment rates. Scott Currie, the Chief Financial Officer of Gratiot Community Hospital, and Wade Nitz, the Chief Financial Officer of Pennock Hospital (and Board Chair of MHG), participated in the meeting. During our discussions, you indicated that a first step would be for Blue Cross to prepare a "margin analysis" for each hospital. Your office provided me a copy of the margin analysis on June 30, 2003, and on July 8, 2003, Wade Nitz and I met with you to discuss the analysis. After walking through the analysis, you requested that each hospital review their respective report. You also pointed out issues that the hospitals may wish to raise in response to the margin analysis, such as the treatment of bad debt and the A-8 adjustments to the Medicare Cost Report. You indicated that before rate negotiations could commence, it would be necessary for you to receive a response to the margin analysis. The hospitals have completed their review of the margin analysis, and I am writing to provide you their comments.

I. Overview of Participating Hospitals

Prior to discussing the details of the hospitals' comments on the margin analysis, I thought it may be helpful if I provided you some background information concerning each hospital. This information is, as discussed in more detail below, relevant to some of the comments on the margin analysis.

All of the hospitals are relatively small rural hospitals: Community Health Center of Branch County (108 beds); Gratiot Community Hospital (142 beds); Memorial Medical Center of West Michigan (95 beds); and Pennock Hospital (88 beds). None of the hospitals are part of a larger health system, and they do not enjoy the economies of scale that some rural hospitals have through affiliations with large systems.

As rural hospitals, the communities that they serve tend to have an older and sicker population. A recent report by the National Advisory Committee on Rural Health noted that "[t]he reality is that rural Americans are more likely to be poor (14% vs. 11% in urban areas), old, and experiencing poor health and disabilities than their urban counterparts....The rural elderly are less likely than the urban elderly to have private supplemental insurance and more likely to be on Medicaid."[1] Under the Balanced Budget Refinement Act of 1999, Congress required the Medicare Payment Advisory Commission (MedPAC) to study and report on the adequacy of payments to rural providers. In its report to Congress, MedPAC made similar findings, noting that rural areas have "a declining and disproportionately older population," and that a high proportion of the population is "lacking health insurance or with limited coverage."[2] Not surprisingly, the MHG hospitals treat a large number of Medicare and Medicaid patients. On the basis of discharges, the Medicare and Medicaid volume at the hospitals ranges from 54% to 65%. Additionally, each of the hospitals provides substantial charity care to their communities.

Other than Gratiot Community Hospital (Peer Group 3), the MHG hospitals are Peer Group 4 hospitals. The nearest competing hospitals to the MHG hospitals are generally Peer Group 5 hospitals or Peer Group 1 hospitals which have higher Blue Cross rates of payment. For example, in the case of Pennock Hospital, the closest hospitals are Peer Group 1 hospitals in Lansing and Kalamazoo. Similarly, in the case of Memorial Medical Center of West Michigan, the closest hospital is Westshore Hospital in Manistee, a Peer Group 5 hospital.

The 2002 net patient service revenues for the MHG hospitals range from $38.6 million to $69.6 million. In fact, the Blue Cross investment income for 2002 ($85.2 million) is greater than any of the hospitals' overall revenue. In terms of Blue Cross payments, the margin analysis identified that total payments made by Blue Cross to the four hospitals were approximately $34.2 million. While the hospitals do not account for a significant portion of Blue Cross' business, Blue Cross is the largest payor to the hospitals other than Medicare. Blue Cross volume, when combined with the Medicare and Medicaid volumes, comprises a substantial percentage of the hospitals' business. **For the four MHG hospitals, the combined Blue Cross, Medicare and**

[1] National Advisory Committee on Rural Health, Medicare Reform: A Rural Perspective, May 2001, p. vi (footnotes omitted). The National Advisory Committee on Rural Health is comprised of national rural health experts and was chartered in 1987 to advise the Secretary of the Department of Health and Human Services on ways to address health care problems in rural areas.

[2] MedPAC, Report to the Congress: Medicare in Rural America, June 2001, Chapter 1, p. 8.

Medicaid volumes range between 67-87%. If Blue Cross payments are not adequate, the overall viability of the hospitals is at risk.

II. Comments on the Margin Analysis

As we understand it, the purpose of the margin analysis is to assess the adequacy of Blue Cross payments by comparing the payments to certain costs. While this may be one way to evaluate payment adequacy, we do not believe that the approach taken by Blue Cross is appropriate for purposes of defining "costs." We question why the Medicare Cost Report was the starting point for determining costs. Cost reports may have some relevance if Blue Cross paid the hospitals on a cost basis, but it does not. In fact, Blue Cross has even stopped requiring hospitals to prepare and submit cost reports.

We also do not believe that the margin analysis of allocating costs, by line item, to departments is appropriate. This approach results in calculating a separate cost to charge ratio for each line item and, as a general matter, results in an overall lower cost to charge ratio. In our view, this level of cost finding would be appropriate if the goal was to determine the payment rate for a particular service, such as lab services (line #44). Since the focus is not how to price a particular service, we fail to see why determining the line item cost to charge ratio is relevant for the purpose of assessing the adequacy of payments. Instead, a better approach would be to look at overall costs relative to overall payments.

Since Blue Cross does not make payments on the basis of the cost report, and since the goal of the analysis is to evaluate the adequacy of payments overall (and not to determine the rate of any particular line item of service), we believe that the margin analysis should be prepared on the basis of audited financial statements. The audited financial statements identify, under generally accepted accounting principles, the costs of the hospitals. By determining Blue Cross' share of each hospital's business on the basis of charges, it is quite easy to determine if Blue Cross payments are covering costs. Set forth below is a summary of the margin analysis using audited financial statements:

Hospital	Margin per AFS	Margin per Blue Cross
Community Health Center of Branch County	($1,273,470) -17.0%	$98,304 1.31%
Gratiot Community Hospital	$393,141 2.5%	$606,529 3.92%
Memorial Medical Center of West Michigan	($1,040,138) -14.9%	$512,320 7.35%
Pennock Hospital	($879,882) -20.5%	$196,997 4.58%

See Attachment A for more detail.

III. Specific Adjustments to the Margin Analysis

For the reasons outlined above, we believe that the audited financial statement approach is the proper approach to reviewing Blue Cross payments relative to costs. As illustrated above, a substantial increase in Blue Cross payments is needed in order for the MHG hospitals to obtain payments that cover their costs plus a reasonable margin. Even if the cost report approach is utilized, however, we believe that adjustments are necessary in order to better reflect costs. Set forth below is a summary of the revised margin analysis after taking into account the various adjustments:

Hospital	Margin as Adjusted	Margin per Blue Cross
Community Health Center of Branch County	($1,122,000) -14.98%	$98,304 1.31%
Gratiot Community Hospital	($1,200,000) -7.75%	$606,529 3.92%
Memorial Medical Center of West Michigan	($432,000) -6.20%	$512,320 7.35%
Pennock Hospital	($560,000) -13.03%	$196,997 4.58%

See Attachment B for more detail.

A brief summary of the adjustments is also included in Attachment B. In the event additional information is needed in order to review the adjustments, please let me know.

As the above amply demonstrates, Blue Cross substantially underpays each of the hospitals. Under the margin analysis, the difference between payments and costs, in the aggregate, is approximately $3.3 million. When one considers a reasonable margin of 5% on the business, **the overall amount of underpayment for the four hospitals is in the range of $5.2 million ($3.3 million plus 5% of $37.55 million (total costs))**. Moreover, the level of underpayment at each hospital is exceedingly large given the relative size and financial position of each hospital. The losses associated with Blue Cross business are more than half of the overall bottom line of some of the hospitals. 147. (13.87)

IV. Other Factors Relevant to Assessing Payment Adequacy

The MHG hospitals recognize that evaluating the relationship between payments and costs is part of the assessment of the adequacy of payment rates. We do not believe, however, that the margin analysis is all that should be considered. Other factors should also be considered, particularly those that bear on the financial positions of the hospitals and the markets in which they operate. A "one size fits all" approach does not work in setting payment rates (hence the

different peer groupings), nor should this approach work when evaluating the adequacy of the rates.

We note that when the Medicare Payment Advisory Commission (MedPAC) evaluates the adequacy of payment rates, it does not end its inquiry by examining the Medicare margins. In its most recent report to Congress, for example, it commented on the need to evaluate the adequacy of payments by looking at a variety of factors such as the hospitals' financial health, their access to capital, their vulnerability to significant volume changes, and beneficiary access to care.[3] Just as the MedPAC focus is broader than margin, we urge Blue Cross to also have an expanded focus and, in particular, to consider the following:

1. **Small Rural Hospitals.** The margin analysis does not consider the overall size and location of the hospital. The revenue and costs of any hospital, from a 50 bed rural hospital to a 900 bed tertiary hospital, can be "run through" the margin analysis model. However, it is well recognized that size can make a difference in terms of a hospital's ability to absorb large increases in expenses or large changes in volume.[4] For example, MedPAC has repeatedly raised the issue that a small rural hospital's volume can change dramatically by the addition or loss of one or two physicians.[5] As independent, small hospitals, the MHG hospitals also lack economies of scale to deal with rising costs, such as HIPAA, nursing salaries, pension and malpractice.

There is a growing recognition that, while Medicare may pay adequately for some "classes" of rural hospitals (such as "Medicare dependent" and "critical access" hospitals), a much larger segment of rural hospitals is underpaid. In the MedPAC Report, nearly all recommendations relating to changes in payment policy were targeted to rural hospitals. MedPAC Report at pp. 60-62. We believe that the same phenomenon arises with Blue Cross. The Peer Group 5 methodology adequately addresses certain of the very small rural hospitals in the same way Medicare protects the "Medicare dependent" and "critical access" hospitals.

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[3] MedPAC, Report to the Congress: Medicare Payment Policy, March 2003, Section 2A, Assessing Payment Adequacy and Updating Payments for Hospital Inpatient and Outpatient Services (hereinafter referred to as the MedPAC Report).

[4] *See* MedPAC Report at pp. 59-60 on the rationale for making recommendations to improve rates for rural hospitals: "In each case, our recommendation was based on evidence that the current payment system does not account for factors that systematically raise some providers' unit costs beyond their short-term control, or that the current system does not treat rural and urban hospitals equitably." *See also* Fitch Ratings, Health Care Special Report: 2003 Median Ratios for Nonprofit Hospitals and Health Care Systems, August 6, 2003, at p. 5 (hereinafter referred to as the Fitch Report). The report states that "liquidity trends become less favorable as revenue size decreases, which demonstrates increasing difficulty to absorb rising expenses such as labor and insurance costs with a smaller revenue base. Fitch continues to view hospitals with revenue bases of smaller than $100 million as viable candidates for investment-grade ratings but notes the potential risk in size and ability to absorb large expense increases." *Id.*

[5] *See* MedPAC, Report to the Congress: Medicare in Rural America, June 2001; MedPAC Report.

However, when it comes to Peer Group 3 and Peer Group 4 rural hospitals, Blue Cross, like Medicare, is not paying adequately.

2. **Disparate Treatment under Medicare.** Rural hospitals are faring the worst under Medicare, a fact which is not "captured" by the margin analysis. The following summarizes the most recent analysis of overall Medicare margins prepared by MedPAC:[6]

Hospital Class	1999	2000	2003 (est)
Large Urban	8.4%	8.4%	6.9%
Other Urban	3.3%	2.9%	1.7%
Rural	-2.5%	-2.9%	-1.9%

One of the reasons rural hospitals fare so badly is that, unlike urban counterparts, rural hospitals generally do not receive graduate medical education and disproportionate share payments. It is well recognized that those payments are not correlated to costs and serve in large part to compensate the hospital for its charity care and Medicaid burdens, e.g., some residency programs operate clinics for Medicaid and the uninsured. The MHG hospitals are in the unenviable position of having the Medicaid and charity care burden, yet no supplemental support to cover those costs.

We believe this information is particularly relevant in deciding whether the Blue Cross payment rates are adequate. Blue Cross should consider the disparate impact that Medicare payment rates have on rural hospitals and recognize the need to account for their costs and margins differently.

3. **Financial Position.** The operating margins at the MHG hospitals are very low. Based on the most recent audited financial statements, the 2002 operating margins ranged from 1.5% to 3.4%. Given the relatively small revenue streams of the MHG hospitals (ranging from $38.6 million to $69.6 million), the operating margins, when stated in dollars, are quite small and do not generate enough "equity" to address volume changes (due to the loss of one or two key physicians). Likewise, a larger operating margin is necessary in order for hospitals to have the funds to update facilities and make other capital improvements. In connection with medical technology, it is common for certain equipment to become obsolete sooner than it is depreciated.

The margin also makes it possible for the hospital to continue to provide services to all members of the community regardless of their ability to pay. The number of uninsured is

[6] MedPAC Report at p. 41.

growing, and this burden is substantial.[7] Likewise, Medicaid enrollment is growing due to Michigan's weak economy, and Medicaid payments are, on average, less than 75% of Medicare payments.[8] Blue Cross participated in the Detroit Health Care Stabilization Workgroup which made a similar finding as to the substantial level of underpayment by Medicaid.[9] Even though Medicaid payments are substantially below costs, the state is in the process of trying to obtain a federal waiver which would reduce payments to hospitals by more than $110 million. The need for the MHG hospitals to have a strong margin is essential for them to be able to handle these adversities.

4. **Access to Care.** The MHG hospitals provide convenient access to Blue Cross subscribers for inpatient and outpatient services. In addition to the benefit to the community of reasonable access, if the MHG hospitals were not participating providers, Blue Cross would likely pay more for the same services at neighboring Peer Group 5 and Peer Group 1 hospitals.

5. **Wage Index.** Labor costs are one of the key factors driving costs. The Fitch Report indicated that the median personnel costs as a percentage of total operating revenue ranged between 54%-59% for hospitals the size of MHG hospitals. The well-known nursing staff shortage is driving up costs at the hospitals well beyond the rate of inflation. *See* BCBSA Report at p. 18 noting that each 1% increase in the gap between demand and supply results in a 0.5% to 1% increase in hospital inpatient expenditures per capita. The MHG hospitals compete against other large urban hospitals for nurses and other personnel. As a result, several of the hospitals have been re-classified under Medicare for purposes of the wage index. No similar adjustment has occurred to date by Blue Cross and this is compounding the payment inadequacy. We note that the Blue Cross Payment Manual states that "[f]or hospitals that have had Medicare geographic reclassification, BCBSM accepts the reclassified wage indices." *See* Payment Manual, Section 4.5.

6. **PPO Differentials.** As noted above, the Trust product has been growing by acquiring Traditional market share. The hospitals' costs for treating the Trust enrollees are

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[7] *See* U.S. Census Bureau, Health Insurance Coverage in the United States: 2002 (issued in September 2003). The report notes that an estimated 15.2% of the population is without health insurance, up from 14.6% the year before. *Id.* at p.1. Michigan's rate of increase in the number of uninsured was among the highest in the nation. *Id.* at p. 11. Additionally, a recent report by the Blue Cross Blue Shield Association noted that one of the key drivers in health care costs was the cost of the uninsured. The report noted that 5.6% of all hospital discharges are for uninsured patients. Blue Cross and Blue Shield Association, Medical Cost Reference Guide (updated June 19, 2003), p. 11 (hereinafter referred to as the BCBSA Report).

[8] Health Management Associates, The Future of Michigan Medicaid: Issues, Trends and Principles for Reform, May 2003, p. 1.

[9] *See* Strengthening the Safety Net in Detroit and Wayne County, Report of the Detroit Health Care Stabilization Workgroup, August 2003, p. 5.

roughly the same as Traditional enrollees, yet the hospitals are paid less for inpatient services. Some of the hospitals have side letters which establish a differential and others do not. In some cases, the differential is 75% of the PHA rate. We believe the rates need to be adjusted and that the parties need to re-examine the proper level of differential for this business.

Whether one evaluates the adequacy of Blue Cross payments on the basis of audited financial statements, the "margin analysis," or in light of the myriad of other relevant factors discussed above, it is unmistakable that Blue Cross is not paying the MHG hospitals adequately, and a significant change in payment rates is in order.

After you have had a chance to review this letter and the enclosures, please contact me to discuss any questions or comments that you may have. I will be calling your office to set up a meeting to discuss this matter further.

Very truly yours,

Joseph T. Aoun

Joseph T. Aoun

Enc.
cc w/enc: Mr. Bruno Bettin
Mr. Scott Currie
Mr. Randy DeGroot
Mr. Wade Nitz

N0014698

MICHIGAN HOSPITAL GROUP

ATTACHMENT A

AUDITED FINANCIAL STATEMENTS

	Community Health Center of Branch County 2001	Gratiot Community Hospital 2002	Memorial Medical Center of West Michigan 2001	Pennock Hospital 2001
Gross Charges	75,842,563	116,332,262**	70,024,857	61,950,385
Cost	42,783,081	69,299,083	34,408,345	35,632,740
Bad Debt	(2,050,610)	(2,064,720)	(1,459,506)	(1,707,892)
NET Cost	**40,732,471**	**67,234,363**	**32,948,839**	**33,924,848**
RCC	**0.5371**	**0.5780**	**0.4705**	**0.5476**
Bad Debt Charges	2,050,610	2,064,720	1,459,506	1,707,892
RCC	0.5371	0.5780	0.4705	0.5476
Bad Debt Cost	**1,101,313**	**1,193,307**	**686,742**	**935,264**
TOTAL Cost	**41,833,784**	**68,427,670**	**33,635,581**	**34,860,112**
REVISED RCC	0.5516	0.5682	0.4803	0.5627
BC Charges	15,885,221	25,664,784	16,668,673	9,199,437
Cost (Revised RCC x Charges)	8,762,084	15,096,254	8,006,593	5,176,617
Reimbursement (Margin Analysis)	7,488,614	15,489,395	6,966,455	4,296,735
MARGIN	**(1,273,470)**	**393,141**	**(1,040,138)**	**(879,882)**
% MARGIN	**-17.0%**	**2.5%**	**-14.9%**	**-20.5%**

** *Includes significant renal dialysis and home health revenues where BCBSM has very low utilization.*

Prepared by The Rybar Group, Inc. 10/10/2003

THE RYBAR GROUP
HEALTHCARE FINANCIAL CONSULTANTS

MICHIGAN HOSPITAL GROUP
ATTACHMENT B
BLUE CROSS MARGIN ANALYSIS

	Community Health Center of Branch County 2001	Gratiot Community Hospital 2002	Memorial Medical Center of West Michigan 2001	Pennock Hospital 2001	TOTAL
BC Margin Analysis	98	606	512	197	1,413
Cost Issues					
Physician Office/RHC Overhead Allocation	(68)	(180)	(92)	0	(340)
HHA Overhead Allocation	(38)	(32)	(46)	(16)	(132)
Medicare adjusted cost	(170)	(376)	(141)	(118)	(804)
OB split	(357)	(89)	(161)	(313)	(920)
Physician Recruitment addback (A-8)	(10)	(18)	n/a	(47)	(75)
Physician Guarantee addback (A-8) ?	(60)	n/a	(211)	n/a	(271)
Marketing addback (A-8)	(49)	(19)	n/a	n/a	(68)
Cost Report offset correction (A-8)	n/a	n/a	n/a	(49)	(49)
Physician Office Losses (A-8)	(56)	(135)	(52)	(82)	(325)
Net of Domestic Charges	(153)	(196)	(127)	(44)	(520)
Bad Debt Impact	(117)	(282)	(188)	(120)	(707)
Revised Margin Analysis	(980)	(720)	(376)	(522)	(2,598)
Other Issues					
Migration Traditional to Trust	(6)	(30)	0	(3)	(39)
Additional Impacts (Future Issues)					
Building Renovations	(136)	(450)	(56)	(35)	(677)
New Margin Analysis (As Adjusted)	(1,122)	(1,200)	(432)	(560)	(3,314)

** This analysis makes no provision for Audited Financial Statement cost allocation.

Prepared by The Rybar Group, Inc. 10/10/2003

Michigan Hospital Group
ATTACHMENT B
BLUE CROSS MARGIN ANALYSIS – SPREADSHEET EXPLANATIONS

BLUE CROSS MARGIN ANALYSIS

- **Profit and Loss Margin from Blue Cross.**

ADJUSTMENTS TO MARGIN ANALYSIS

- **Overhead Allocation (Physician Office, RHC and Home Health)**
  A calculation of overhead for BC non-reimbursable cost centers. Physician Offices, Rural Health Clinics and Home Health Agency were reviewed and overhead calculated. Medicare direct costs, after A-6 reclassifications and A-8 adjustments, were subtracted from total Medicare cost after step-down allocations. The Blue Cross clinic policy allowing 45% overhead was applied.

- **Medicare Adjusted Cost**
  This adjustment reflects the inclusion of costs that are considered allowable under Blue Cross cost reporting principles, but are not allowable under Medicare. Medicare allowable costs after step-down was adjusted per BCBSM policy. FY 2000 BCBCSM cost to Medicare costs were used for the ratios applied to the year used for the analysis.

- **Obstetric Split from Adult & Peds**
  This adjustment reflects the fact that the line item for adults/pediatrics includes obstetrics, and Blue Cross' utilization among the hospitals for OB is higher than average. Consequently, the weighted average cost to charge ratio for adults/pediatrics is understated in the margin analysis.

- **A-8 Adjustments**
  The adjustment for physician recruitment, physician guarantee, marketing and investment income are the "A-8 Adjustments." You will note that the hospitals are not seeking Blue Cross recognition of all types of A-8 adjustments. Physician Recruitment, Physician Guarantees, Marketing are part of the cost of doing business independent of prior Blue Cross reimbursement policy.

- **Physician Office Losses**
  Blue Cross portion of the operational losses for physician offices owned by the Hospital.

- **Net of Domestic Charges**
  This adjustment reflects the fact that the margin analysis does not include Blue Cross charges (and corresponding hospital expense) for domestic claims.

Prepared by The Rybar Group, Inc. 10/10/2003

THE RYBAR GROUP
HEALTHCARE FINANCIAL CONSULTANTS

Michigan Hospital Group
ATTACHMENT B
BLUE CROSS MARGIN ANALYSIS – SPREADSHEET EXPLANATIONS

- **Bad Debt**
  As noted in the transmittal letter conveying the margin analysis, the costs of bad debt were not included. We determined the bad debt costs (not charges) and made the corresponding adjustments.

OTHER ISSUES

- **Migration Traditional to TRUST**
  Lost reimbursement from Traditional Blue Cross due to the migration to the TRUST product lines.

ADDITIONAL IMPACTS

- **Building Renovations**
  Incremental costs associated with renovations to main patient areas of the hospital.

Prepared by The Rybar Group, Inc. 10/10/2003

THE RYBAR GROUP
HEALTHCARE FINANCIAL CONSULTANTS

Chen, Briana

From: Johnson, Mark A., VP,TRAD QUAL ASSUR
Sent: Monday, November 03, 2003 5:04 PM
To: Chen, Briana
Subject: FW: Michigan Hospital Group


CHCBC2001.ZIP


Gratiot2002.ZIP


Pennock.ZIP


Migration Traditional to Trust...


Cost Detail Pg2.jpg


Cost Detail Pg1.jpg


Ludington2001.ZIP

Can you print all of these to my printer...not sure I can do this given all the formats below.
-----Original Message-----
From: Lashbrook, Aimee E. [mailto:ael@ntalaw.com]
Sent: Monday, November 03, 2003 3:58 PM
To: Johnson, Mark A., VP,TRAD QUAL ASSUR
Cc: Robinson, Henrietta; Aoun, Joseph
Subject: Michigan Hospital Group

Mr. Johnson:

Joe Aoun asked that I forward to you various documentation of the Michigan Hospital Group (MHG) that supports information previously provided to you by MHG.

Attached please find four zipped files containing supporting documentation of each of the four MHG hospitals. Also attached to this e-mail is a chart that details the migration from Traditional to Trust at Pennock Hospital, Gratiot Community Hospital, and Community Health Center of Branch County. As an example, a margin analysis of Gratiot Community Hospital, which includes handwritten notes explaining which figures flow to which columns in the supporting documentation of each hospital, is attached as well.

Please see Pam Sanborn's e-mail below for additional information regarding the supporting documentation attached to this e-mail. If you have questions regarding the attached supporting detail, please contact her at (810) 750-6822.

If you have any other questions, please contact Joe Aoun at (248) 449-2700. Additionally, please let me know if you have trouble opening any of the seven (7) attachments.

Thank you,

Aimee Lashbrook

Aimee E. Lashbrook
Nuyen, Tomtishen and Aoun, P.C.
640 Griswold
Northville, MI 48167
248-449-2700
248-449-8775 fax
****

-----Original Message-----
From: Pam Sanborn [mailto:psanborn@therybargroup.com]
Sent: Monday, November 03, 2003 1:36 PM

To: Lashbrook, Aimee
Subject: PDF files for Michigan Hospital Group

Aimee,

Attached is a zipped file for each hospital. Each hospital contains detail support files. If you have any questions, please give me a call. I PDF a copy of Gratiot's "Cost detail" file with notes on what support files flow to what columns - this file is the main calculation file for "cost" Charges and Payments came directly from BC's analysis. Our starting point was Medicare Cost from Worksheet B part I column 25. Adjustment for Blue Cross allowable costs, A-8 addbacks and Overhead calculations were added to cost. Revised Costs were then spread I/P and O/P based on Total Charges. Blue Cross costs were calculated based on the Facility Settlement report charges (Blue Cross charges) to Total charges by I/P and O/P and by Traditional and Trust. The "Cost detail" file is before Bad Debt, Physician Office Losses, Migration calculation and Building Renovation calculations. Physician Office Losses and Building Renovation numbers came directly from the Hospitals and I applied BC portion.

If Joe has any questions, please let me know. Also, if Mark Johnson has questions regarding the file setup, etc. please let me know. Thanks

Pam Sanborn, Consultant
The Rybar Group, Inc.
1495 Dauner Road
Fenton, MI 48430-1561
P: 810-750-6822 ext. 111
F: 810-750-6733

Traditional to Trust migration

Pennock Hospital FY 2001

	TRAD	PPO	TOTAL
Charges			
I/P	1,432,208	1,353,223	2,785,431
O/P	3,812,770	2,601,236	6,414,006
	5,244,978	3,954,459	9,199,437
	57%	43%	
Reimbursement			
I/P	861,201	728,908	1,590,109
O/P	1,605,008	1,116,568	2,721,576
	2,466,209	1,845,476	4,311,685
	47%	47%	
I/P Reimb %	60%	54%	
2001 I/P Dif		90%	
2002 I/P Dif *per HFR*		80%	
2003 I/P Dif *per HFR*		75%	
50% I/P		1,392,716	
PPO change		39,493	
I/P reimb	23,747	21,272	
	60%	54%	
Lost Reimbursement		(2,475)	

Gratiot FY 2002

	TRAD	PPO	TOTAL
Charges			
I/P	2,301,635	4,914,268	7,215,903
O/P	7,059,745	11,389,136	18,448,881
	9,361,380	16,303,404	25,664,784
	36%	64%	
Reimbursement			
I/P	1,679,465	3,285,360	4,964,825
O/P	4,014,370	6,437,935	10,452,305
	5,693,835	9,723,295	15,417,130
	61%	60%	
	73%	67%	
		92%	
		92.5%	
		92.5%	
		5,411,927	
		497,659	
	363,134	332,703	
	73%	67%	
		(30,431)	

CHCBC FY 2001

	TRAD	PPO	TOTAL
Charges			
I/P	2,073,068	2,525,892	4,598,960
O/P	6,034,956	6,368,489	12,403,445
	8,108,024	8,894,381	17,002,405
	48%	52%	
Reimbursement			
I/P	1,235,370	1,245,968	2,481,338
O/P	2,452,339	2,629,219	5,081,558
	3,687,709	3,875,187	7,562,896
	45%	44%	
	60%	49%	
		83%	
		82.0%	
		79.0%	
3% movement			
	62,192		
	37,061	30,678	
	60%	49%	
		(6,383)	

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

January 30, 2003

VIA CERTIFIED MAIL

Mr. Mark Johnson
Vice President, Provider Contracting
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., MCJ744
Detroit, MI 48227-2009

Re: Michigan Hospital Group, Inc.

Dear Mr. Johnson:

We represent Michigan Hospital Group, Inc., a joint venture among seven small, independent rural Michigan hospitals ("MHG"). Through MHG, the participant hospitals seek to achieve administrative efficiencies by coordinating certain administrative activities and thereby reducing efforts currently being duplicated. As you can appreciate, as rural hospitals, the MHG hospitals each must engage in much the same administrative activity as their urban counterparts, yet do not enjoy anywhere near the same volume of patients over which to recoup the costs associated with performing that activity.

One means by which MHG hospitals intend to reduce duplicative administrative activity is through joint financial and legal review, and negotiation, of certain third party payment arrangements. Toward that end, on October 4, 2002, MHG obtained from the United States Department of Justice a favorable business review advice letter indicating that it is permissible for the MHG hospitals to jointly negotiate with third party payors through MHG.

In this regard, certain MHG hospitals desire, through MHG, to initiate a dialogue with Blue Cross Blue Shield of Michigan ("Blue Cross") as respects their existing Blue Cross reimbursement relationships. Since, as small, independent rural health care providers, these hospitals share many similar concerns and face similar issues, a coordinated dialogue seems particularly appropriate and should result in meaningful efficiencies.

The specific MHG hospitals on behalf of which MHG is writing are:

- Community Health Center of Branch County, Coldwater
- Gratiot Community Hospital, Alma
- Memorial Medical Center of West Michigan, Ludington
- Pennock Hospital, Hastings

For convenience, these four hospitals will be referred to as the "MHG Hospitals" throughout this letter.

While in no way intended to delineate a complete, detailed list of all of the MHG Hospitals' concerns and issues, in an effort to give you an appreciation for the direction the requested dialogue might take we will identify certain of their principal concerns and issues. Of considerable importance for each MHG Hospital as it evaluates its reimbursement relationship with Blue Cross is the fact that, without exception, each receives payments from Blue Cross which are insufficient to cover the cost of services provided to the Blue Cross membership. As I am sure you can appreciate, given the unique issues they face as rural facilities, the MHG Hospitals are particularly unable to sustain continued losses on their Blue Cross business. Moreover, the present reimbursement situation is contrary to Blue Cross' view that Blue Cross payments to hospitals should allow those hospitals to recoup their costs plus make a reasonable margin.

While the MHG Hospitals cannot continue to sustain losses with regard to any aspect of their Blue Cross business, one observation worth noting is that losses appear to be weighted more heavily in favor of the Blue Cross TRUST business where hospital reimbursement rates generally are considerably lower than for the Blue Cross Traditional product. As you probably are aware, a principal reason why Blue Cross established the differential in payment rates, as between TRUST and Traditional, was the belief that the TRUST membership would consist of a healthier population (i.e., better "risks") than the Traditional product population. It was expected, therefore, that TRUST members would generally require lower acuity, less costly hospital services. Yet, as has been widely documented, including in the most recent Blue Cross Hospital Provider Class Plan, there has been a substantial migration of Blue Cross members from the Traditional product to the TRUST product as employers pursue health care cost containment goals. As a result, the assumption justifying the payment rate differential has been substantially undermined, if not eliminated in its entirety.

As I am sure you also are aware, hospitals such as the MHG Hospitals have experienced particularly significant increases in input costs which are largely beyond their control. For example, recent substantial increases in pharmaceutical supply costs and professional liability insurance have been widely publicized. Like Blue Cross, the MHG Hospitals also are saddled with significant HIPAA compliance costs. These are all costs which are imposed by the market on the MHG Hospitals and over which they have little real control. Since Blue Cross has similarly experienced recent significant increases in its administrative costs, I am sure it can appreciate the MHG Hospitals' experience.

Yet, while costs have been increasing significantly, real payments by Blue Cross have not. As is explained in Blue Cross' most recent Hospital Provider Class Plan, increases in payments to hospitals have largely been the result of an increase in utilization, and not in the amount paid to the hospital per admission or outpatient visit. In fact, that Plan indicates that

while there were only nominal increases in the price per admission and per outpatient visit as between 1998 and 1999, the price per admission and per outpatient visit actually fell from 1999 to 2000.

Since Blue Cross payments and the MHG Hospitals' costs have been moving in opposite directions, it is not difficult to understand why the MHG Hospitals are receiving from Blue Cross less in payments than the costs of the services which they provide to Blue Cross members. Yet, because Blue Cross reimbursement to the MHG Hospitals is insufficient to cover their costs, and is substantially less than the reimbursement which MHG Hospitals receive from other non-government payors, the MHG Hospitals are concerned that Blue Cross is not bearing its fair share of their costs as it is required to do under Public Act No. 350, the Blue Cross enabling act.

As small rural hospitals that are not affiliated with a larger system, the MHG Hospitals do not have the same access to capital, purchasing power or cost control opportunities as do many of their counterparts. This makes the issue of costs exceeding payments even more acute for these hospitals. At the same time, these hospitals fulfill vital and special roles in their communities, as evidenced by the special recognition they have received under the Medicare program as "sole community hospitals" or "regional referral centers." Moreover, they serve Blue Cross' essential access needs in the small rural communities in which they operate. In MHG's view, the small, rural and independent nature of the MHG Hospitals, and their vital importance to the communities they serve, distinguish them from other hospitals which do business with Blue Cross.

MHG knows that Blue Cross recognizes and appreciates the vital role small independent rural hospitals play in their communities and, at the same time, the financial stress that fixed rate reimbursement systems, such as Blue Cross' system, impose on those hospitals. It was that rationale which led Blue Cross to develop the peer group 5 designation and to establish separate, charge-based reimbursement for those hospitals. Due to the limitations governing what hospitals qualify for peer group 5 treatment, however, a few rural hospitals which fulfill the same vital role as peer group 5 hospitals, and which are small independent facilities facing the same viability issues as peer group 5 hospitals, are lumped together with their larger, urban or system-affiliated counterparts when it comes to Blue Cross' reimbursement. MHG believes it is time for Blue Cross to re-examine the appropriateness of this categorization scheme in these few limited instances.

Lastly, we are aware of the liquidity crisis which Blue Cross has faced in recent times as a result of the acquisition strategy it has chosen to pursue. This liquidity crisis, in fact, is discussed in detail in the Blue Cross examination conducted by the Office of Financial and Insurance Services in 2000. While liquidity concerns resulting from Blue Cross' acquisition strategy no doubt influence Blue Cross' reimbursement policies, they cannot, and do not, justify insufficient reimbursement payments. Nevertheless, MHG is prepared to work with Blue Cross to resolve the concerns of the MHG Hospitals through creative solutions that will allow all parties to accomplish their mutual objectives.

Thank you for taking the time to consider our position. I will call you within the next week to establish a mutually acceptable timeframe for discussions that will address these concerns.

Very truly yours,

Joseph T. Aoun

JTA/grp
cc: Mr. Scott Currie
Mr. Randy DeGroot
Mr. Daniel Hamilton
Mr. Robert Marquardt

N0009999

{In Archive} Revised Letter to Blue Cross
Aoun, Joseph T.
to:
mgronda@chs-mi.com
06/30/2009 09:02 AM
Cc:
"JRivet@chs-mi.com", "KAlbosta@chs-mi.com", "Peggy Maine (pmaine@chs-mi.com)", "Ronald K. Rybar"
Show Details

Archive: This message is being viewed in an archive.

Mark, enclosed is a revised draft of the letter to Blue Cross which reflects the additional information that I received from Jerry Rivet. I have not heard from anyone else in terms of comments. Assuming the letter is acceptable to everyone, I recommend that you send it as soon as possible to keep the momentum going and to have the letter "on file" with the Blues before the start of the new fiscal year. I am available to discuss this further at your convenience.

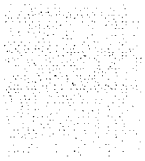
I have also enclosed a redlined copy that shows the changes that have been made to yesterday's draft.

Joe

****

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
2001 Commonwealth Blvd., Ste. 300
Ann Arbor, MI 48105
734-372-4106 (direct)
734-372-4100 (general)
734-372-4101 (fax)
jta@ntalaw.com
www.ntalaw.com

From: Aoun, Joseph T.
Sent: Monday, June 29, 2009 11:15 AM
To: 'mgronda@chs-mi.com'
Cc: 'JRivet@chs-mi.com'; 'KAlbosta@chs-mi.com'; Peggy Maine (pmaine@chs-mi.com); 'Ronald K. Rybar'
Subject: Letter to Blue Cross



Please see the attached. The highlighted areas need attention from Jerry Rivet and Ron Rybar. Please give me a call to discuss after you have reviewed. If possible we should try to finalize and send this today. Thanks. Joe

****

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
2001 Commonwealth Blvd., Ste. 300
Ann Arbor, MI 48105
734-372-4106 (direct)
734-372-4100 (general)
734-372-4101 (fax)
jta@ntalaw.com
www.ntalaw.com

June ~~29~~30, 2009

Mr. Kim Sorget
Vice President, Provider Contracting & Pharmacy Services
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Re: Support for Payment Increase

Dear Kim,

I am writing to follow up on our previous meetings. As you know, we had originally requested an 8% increase in our payments effective January 1, 2009. Although our request was made prior to that date, due to calendars, we were not able to meet until after the first of the year. In the spirit of good faith negotiations, ~~we~~the hospital agreed to the mid-year change in our rates to reflect the market based pricing of certain outpatient services.

During our meetings, we emphasized several factors that support our request for payment. We will not report~~repeat~~ those in this letter, but note that for the past several years, the hospital has been paid pursuant to the model. While there are features of the model that are favorable, our analysis indicates that the model does not result in adequate payment to the hospital. In reviewing adequacy, we take into account factors that are not considered by the model, such as payor mix and government underfunding, as well as factors that are considered by the model but are not, in our view, appropriately addressed. For example, the model disallows a substantial portion of the hospital's costs relating to physicians. These costs are generally not driven by the hospital's desire to "one-up" the competition, but rather due to our efforts to improve inpatient efficiency (such as through the employment of hospitalists and our on-call trauma program) and meet the needs of the community (as the sole provider of obstetric and pediatric services, we incur unique physician costs in recruiting and retaining specialists and subspecialists in these service lines). The latest iteration of the model—which estimates a payment ***reduction*** of $12.8 million—confirms the fact that significant adjustments to the model are in order in our case.

In our meetings, you had indicated support for an increase in our payments effective July 1, 2009. While the increase would not be effective January 1st as we had requested, you indicated that the six month deferment would be taken into account in establishing new rates. At our last meeting, you asked that we review the latest model calculations and identify specific areas to support the requested increase. Blue Cross and BCN comprise approximately 19.6% of business, and annual payments are approximately $91.7 million per year.~~[CONFIRM]~~ We believe that the following costs, if recognized by Blue Cross, support our requested 8% increase:

Issue	Total Cost	BCBSM Share
Physician overheads costs: Treat similar to clinic policy (45% allowable)	$4.7 million	$1.2 million
Physician costs, net of revenue, for pediatric surgeons, hospitalists, intensivists and ~~pediatric surgeons~~trauma on-call	$~~9.4~~ million	$~~1.5~~ million
Increase in electronic medical records investment	$1.9 million	$.4 million
Wage and salary adjustment	$16.3 million	$3.2 million
Uncompensated care adjustment	N/A	$1.2 million
Total	$~~32.3~~ million	$~~7.5~~ million

The uncompensated care adjustment follows the model approach, but uses ~~the~~ fiscal 2009 data. The wage and salary adjustment reflects the disparity which we have raised with you previously concerning the Medicare wage index for our ~~Hospital~~hospital and St. Mary's. Due to unusual circumstances, St. Mary's has been re-classified to the Flint area for wages, and its wage index is 1.0769 whereas Covenant's index is .90. This results in approximately a 16% increase in Medicare payment to St. Mary's. Moreover, due to the favorable Medicare payment, St. Mary's is able to pay higher wages to its staff. Its average hourly wage (per the most recent Federal Register data) is 10% higher than Covenant's. The higher wage and salary cost benefits St. Mary's since it results in higher reimbursement from Blue Cross. Blue Cross pays Covenant *less* because Covenant has not been able to increase wages, even though such increase would be reflective of market conditions. While we do not expect Blue Cross to remedy the Medicare disparity in payment, Blue Cross can be reasonably expected to improve our payment by appropriately adjusting our wage base. We also believe that this adjustment will strengthen the competition in the Saginaw market which ultimately inures to the benefit of Blue Cross and other payors.

We are happy to furnish you additional financial details to support the above. We believe that these adjustments, when combined with the current reimbursement levels, will result in fair payment to the ~~Hospital~~hospital.

Please give me a call to discuss this matter further after you have had an opportunity to review ~~the enclosed~~this letter.

Very truly yours,

Mark Gronda
Vice President and Chief Financial Officer

MG/ms
cc: Mr. Robert Milewski
Mr. Doug Darland
Mr. Spencer Maidlow

June 30, 2009

Mr. Kim Sorget
Vice President, Provider Contracting & Pharmacy Services
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Re: Support for Payment Increase

Dear Kim,

I am writing to follow up on our previous meetings. As you know, we had originally requested an 8% increase in our payments effective January 1, 2009. Although our request was made prior to that date, due to calendars, we were not able to meet until after the first of the year. In the spirit of good faith negotiations, the hospital agreed to the mid-year change in our rates to reflect the market based pricing of certain outpatient services.

During our meetings, we emphasized several factors that support our request for payment. We will not repeat those in this letter, but note that for the past several years, the hospital has been paid pursuant to the model. While there are features of the model that are favorable, our analysis indicates that the model does not result in adequate payment to the hospital. In reviewing adequacy, we take into account factors that are not considered by the model, such as payor mix and government underfunding, as well as factors that are considered by the model but are not, in our view, appropriately addressed. For example, the model disallows a substantial portion of the hospital's costs relating to physicians. These costs are generally not driven by the hospital's desire to "one-up" the competition, but rather due to our efforts to improve inpatient efficiency (such as through the employment of hospitalists and our on-call trauma program) and meet the needs of the community (as the sole provider of obstetric and pediatric services, we incur unique physician costs in recruiting and retaining specialists and subspecialists in these service lines). The latest iteration of the model—which estimates a payment ***reduction*** of $12.8 million—confirms the fact that significant adjustments to the model are in order in our case.

In our meetings, you had indicated support for an increase in our payments effective July 1, 2009. While the increase would not be effective January 1st as we had requested, you indicated that the six month deferment would be taken into account in establishing new rates. At our last meeting, you asked that we review the latest model calculations and identify specific areas to support the requested increase. Blue Cross and BCN comprise approximately 19.6% of business, and annual payments are approximately $91.7 million per year. We believe that the following costs, if recognized by Blue Cross, support our requested 8% increase:

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We are happy to furnish you additional financial details to support the above. We believe that these adjustments, when combined with the current reimbursement levels, will result in fair payment to the hospital.

Please give me a call to discuss this matter further after you have had an opportunity to review this letter.

Very truly yours,

Mark Gronda
Vice President and Chief Financial Officer

MG/ms
cc: Mr. Robert Milewski
Mr. Doug Darland
Mr. Spencer Maidlow

From: Aoun, Joseph T. [jta@NTALAW.com]
Sent: Thursday, February 22, 2007 3:24 PM
To: Darland, Doug
Subject: RE: Pennock

Doug,

In advance of our call today, I wanted to provide you some additional information. I also wanted to reply to your email below regarding the calculation of the Blue Cross payment to charge ratio.

I agree with you that the calculations that I had previously furnished to you did not take into account the expected incentive payments and that, once the incentives are included (approximately $176,000), the 2004 payment to charge ratio would be approximately [redacted] (Your email referenced [redacted] but I was not able to tie out to that number.) In any event, the Blue Cross payment to charge ratio is well below the hospital's cost to charge ratio. Your email states that the hospital's Blue Cross cost to charge ratio is approximately [redacted]. This calculation is based on Blue Cross recognized costs based on the departmentalization approach. Due to the hospital's substantial outpatient services, the amount of costs allocated to Blue Cross are understated. This understatement is illustrated as follows:

- **GAAP Expenses.** The hospital's cost to charge ratio per its audited financial statements is [redacted] Even if one excludes the costs and charges associated with physicians, clinics and home health, the cost to charge ratio is [redacted] In each case, Blue Cross payment is well below GAAP costs.

- **Medicare Cost.** The hospital's cost to charge ratio using Medicare principles of cost recognition and apportionment is [redacted]. If Blue Cross used this ratio, the impact would be an improvement in reimbursement in the range of $930,000.

- **Weighted Medicare Cost.** We also calculated a Medicare cost to charge ratio separately for inpatient and outpatient services. We then weighted those ratios based on the Blue Cross mix at Pennock (29% inpatient/71% outpatient). Under that construct, Blue Cross payment would be approximately $530,000 higher.

I understand the rationale for why Blue Cross prefers to determine its share of costs using the departmentalization approach, but as you can see, it results in major distortions for the hospital due to the high outpatient volumes and relatively low inpatient volume-- a dynamic common to small rural hospitals. Moreover, if other costs are included which are critical for small rural hospitals, such as physician costs, then the reimbursement level needed to yield cost + 3% would be higher. We note that Blue Cross recognized these costs during the prior negotiations. This recognition occurred even thoughthe "standard model" at the time--the so called full cost margin analysis--did not count these costs. In the spirit of developing fair payment, however, Blue Cross considered these additional costs. In addition, Blue Cross stated in 2003 and 2004 that it recongized that small rural hospitals that did not qualify for peer 5 treatment had unique issues. It also indicated that discussions were underway with MHA to make improvements. The LOU included a clause along those lines and allows the hospital to get the benefit of any rural hospital improvements. See Section VIII of the attached. When the hospital renegotiated its LOU at the request of Blue Cross in order to provide TRUST rates to BCN, this clause was again inserted,

representing another commitment by Blue Cross to consider the small rural hospital issues. The rural hospital improvements never materialized under the new PHA, and the new PHA treats Pennock the same as it does a large urban hospital in terms of cost recognition and payment. Just as Blue Cross previously recognized certain costs of small rural hospitals (albeit outside the standard model), the hospital continues to expect that Blue Cross to do so here.

In terms of Medicare and Medicaid, the volumes of these programs during 2004 were 45% and 8.9%, respectively. The 2004 payment to charge ratios were 44.96% (Medicare) and 40.81% (Medicaid). As noted earlier, the hospital's Medicare cost to charge ratio was 49.67% in 2004, thus Medicare and Medicaid paid below cost. The problems with Medicare are heightened due to the high level of outpatient services and the negative margins on Medicare outpatient payments. With Blue Cross payments under the new model at [redacted], the hospital would recover less than cost from Blue Cross as well. In order for the hospital to have an overall positive margin, it is essential that Blue Cross pay its fair share of costs. Please see the attached spreadsheet for further information and an illustration of how Blue Cross payments at full cost plus 3% would still result in Blue Cross having a significant advantage over other payors in the community.

I look forward to discussing this information with you further at 3:30 p.m.

Joe

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Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
640 Griswold
Northville, MI 48167
248-735-6920 (direct)
248-449-2700 (general)
248-449-8775 (fax)
jta@ntalaw.com

From: Darland, Doug [mailto:ddarland@bcbsm.com]
Sent: Fri 2/2/2007 12:54 PM
To: Aoun, Joseph T.
Subject: RE: Pennock

Joe, I do not think your conclusions are supported by the facts that you cite. I see a BCBSM payment to charge ratio is [redacted] (using the Model applied to 2004 – I think you did not include incentive payments) compared to a cost ratio of [redacted] This illustrates a significant margin on the Blue book of business. The BCBSM cost ratio is actually a little less than [redacted] as this figure does not include cost offset related to other operating revenue. The Medicare cost ratio of .4967

is not necessarily relevant at all. It may be, but without knowing the Medicare payment ratio, comparing cost to charge ratios is not conclusive.

The financials you sent do not paint a bright picture at Pennock, but (without, admittedly, reading the notes) do not explain why expenses increased so dramatically in 2006 compared to 2005 when net revenue was relatively flat. And Joe, this is not meant to be sarcastic, why on earth did they not accept the reimbursement adjustment payment of almost $500,000? I presume this was not on your advice.

At the moment, I do not have a suggestion on how best to compare BCBSM payment levels to Medicare payment levels, but I think this is one of the two things that will be required to get Pennock reimbursement rates back on the table. The other is a guaranteed commitment on the part of the hospital to provide a better discount to BCBSM than is available to all other non-gov't payors. - Doug

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From: Aoun, Joseph T. [mailto:jta@NTALAW.com]
Sent: Wednesday, January 31, 2007 10:28 AM
To: Darland, Doug
Subject: Pennock

Doug,

Glad we had a chance to talk today relative to Pennock's situation. I will wait to hear from you in terms of your suggestions about proceeding. I wanted to pass along some information concerning the comparison to Medicare and the prior negotiations:

Comparison to Medicare

As noted in Wade's letter to Jerry Noxon, the Blue Cross payment to charge ratio under the new model would be [redacted]. The Medicare cost to charge ratio is approximately 49.7%. Thus, the level of Blue Cross payment in relation to Medicare costs is approximately [redacted]/49.7%). Given the fact that the assigned margin to Pennock is [redacted] the recognition of charity care and the uncompensated care gross-up, one would expect that the Blue Cross payment ratio would be well above the Medicare cost to charge ratio.

The enclosed final pricing worksheets provide the detail for the above calculations. The Medicare cost to charge ratio is on page 2 of 16 (.4967). The Blue Cross charges in 2004 were $3.9M inpatient and $9.5M outpatient per the Grand Total line on page 4 of 16. The estimated payments under the new model for the same period are $2.3M inpatient (per page 12 of 16) and $3.9M outpatient (per page 13 of 16). Thus payments of [redacted] against charges of [redacted] result in a Blue Cross payment to charge ratio of [redacted].

Prior Negotiations

I also wanted to pass along to you some information concerning the LOU negotiations that were concluded in 2004. The increase to Pennock was $562,800. Much of this increase however related to the TRUST differential. Its prior TRUST rate was set in 1997 and the gap between the TRUST rate and the Traditional rate had grown over the years in excess of 25%. While Pennock received a meaningful increase under the LOU, the increase made up in part the lower TRUST payments in earlier years. Ron Rybar has detail on this since I recall that it was an important issue during the earlier negotiations. If you would like more information concerning this, I can probably get it from Ron.

During the earlier negotiations we also provided Mark Johnson with information concerning the third party payor reimbursement. In 2004, Pennock shared that the average reimbursement from HMOs and PPOs was 85% of charges and that the lowest level with any plan other than the Blues was 72% of charges. To give you a sense of the magnitude of the differential, at that time, the Blue Cross payment level was around [redacted] of charges. I will try to obtain more updated information from the Hospital and explore their interest in some type of "guaranty." As I mentioned today, the current side letter, which was recently revised to address [redacted] contains a most favored nations clause

Please call if you have any questions or if I can provide any additional information concerning this matter.

Joe

****

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
640 Griswold
Northville, MI 48167
248-735-6920 (direct)
248-449-2700 (general)

248-449-8775 (fax)
jta@ntalaw.com


Pennock.xls

Pennock Hospital LOU (SFXB80)....

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

September 29, 2005

VIA EMAIL

Mr. Douglas E. Darland
Director, Regional Contracting
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Re: Northern Michigan Hospital

Dear Doug:

As you know, our firm is counsel to Northern Michigan Hospital in Petoskey, Michigan. The Hospital has requested that we assist it in negotiating a new arrangement with Blue Cross Blue Shield of Michigan, effective January 1, 2006. The Hospital has also asked for our assistance with respect to the cash flow issues arising under the current arrangement (which expires on December 31, 2005).

Background

In the spring of 2003, the Hospital and Blue Cross reached an understanding concerning reimbursement levels with respect to the traditional, TRUST and BCN HMO products. The understanding was memorialized in a short letter from Mark Johnson to the Hospital dated May 14, 2003, a copy of which is enclosed. To our knowledge the arrangement was never reduced to a written Letter of Understanding.

The arrangement guarantees the Hospital an overall margin of 4% on the entire block of Blue Cross/BCN business for fiscal years 2003, 2004, and 2005. So far, Blue Cross has made one reconciliation payment in respect to fiscal year 2003. It is our understanding that the payment was made in November, 2004.

Cash Flow Issues Under Current Arrangement

The current arrangement presents significant cash flow issues to the Hospital since reconciliation payments are made long after the services are rendered and no recognition (in the form of interest or otherwise) is made for the time value of the money owed. The payment with respect to fiscal year 2003 was made nearly one year after the period during which the services were rendered. The amount was not insignificant (approximately $1.7 million), and the

Hospital's need for this additional cash flow is compelling, as discussed below. Moreover, the Hospital estimates that Blue Cross owes more than $781,000 with respect to fiscal year 2004 and $3.1 million with respect to the first eight months of fiscal year 2005.

Due to substantial operating losses (over $13 million during 2003 and 2004) and capital requirements to improve and maintain plant, property and equipment, the Hospital's cash position has deteriorated substantially. Its cash and cash equivalents as of December 31, 2004 were below $9.0 million, a reduction of more than $5.6 million from the year before. A copy of the Hospital's 2004 audited financial statements is also enclosed. Given the Hospital's financial position, we strongly urge Blue Cross to settle promptly the 2004 fiscal year and make an interim, expedited payment as respects the 2005 fiscal year. The Hospital stands ready, willing and able to assist Blue Cross in confirming the amounts owed.

Unlike Blue Cross, which is enjoying unprecedented profits and capital reserves[1], the Hospital cannot afford to wait for amounts properly due it, particularly where, as here, the payment relates to services rendered many months ago, and the Hospital's cash reserves are low. The Hospital requests that we meet to address the cash flow issues and commit to a quick timeframe for making the reconciliation payments.

Framework for New Arrangement

The Hospital is not prepared to continue the current arrangement beyond 2005 since the current arrangement does not recognize all of the Hospital's financial requirements. Financial requirements arise not only from the Hospital's uncompensated care obligation, but also its growing Medicaid volume due to the economic downturn. The underfunded Medicaid program, when coupled with the costs associated with bad debt and charity care, make it essential that Blue Cross, like every other private payor, pay its fair share.

In addition, the Hospital's financial requirements have been affected adversely by the nursing strike (which lasted nearly two years). The strike not only drove up the Hospital's operating costs, particularly for contracted labor, it affected the Hospital's ability to make needed capital expenditures. As a result, the Hospital's capital needs in the near future are significantly higher than in the past, and the Hospital's ability to meet those capital demands is based nearly exclusively on its operating income. The current capital needs for the Hospital are in excess of $30 million; for fiscal 2006, the Hospital, due to financial constraints, is expected to only spend $7.0 million in basic capital improvements (e.g. repairs, maintenance). The Hospital just does not have the cash and investments on hand to fund the needed purchases. Unlike other hospitals that

[1] Through June 30, 2005, Blue Cross reported pre-tax profits of $251 million, and Blue Care Network reported profits of $17.8 million. As of June 30, 2005, Blue Cross has more than $2.4 billion in capital and surplus.

can look to investment income to assist in capital spending, the Hospital does not have significant investment income due to the reduced levels of cash and short term securities.

The Hospital values its relationship with Blue Cross. Blue Cross, in turn, should recognize the strategic value that the Hospital provides not only in terms of cost, but also in terms of access and quality. The Hospital wishes to work with Blue Cross to establish a new arrangement that enhances the Hospital's ability to meet its community obligations. Because the current arrangement expires on December 31, 2005, the Hospital would like to work in earnest during the fall to complete the negotiations of the new arrangement.

Thank you in advance for your consideration of this matter. Please contact me at your earliest convenience to discuss the processes for negotiating the new arrangement and resolving the cash flow issues under the current arrangement.

Very truly yours,

Joseph T. Aoun

JTA/tde
Enclosures
cc (w/enc.): Mr. Timothy Jodway

N0034977.2

Blue Cross
Blue Shield
of Michigan

600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

May 14, 2003

Mr. Joseph A. Schodde
Chief Financial Officer
Northern Michigan Hospital
416 Connable Avenue
Petoskey, MI 49770

Dear Joe:

Again, I would like to thank you for rearranging your schedule to accommodate our telephone conference on May 2, after I had to cancel our previously scheduled meeting. This letter is to confirm and document what we agreed to during our conversation.

BCBSM will guarantee a margin of 4% on the total Blue book of business (all Traditional, TRUST, and BCN related products) for your fiscal years ending 2003 through 2005. This 4% margin will be calculated based on the methodology you had presented to us subsequent to our meeting of March 24, 2003. I have attached a copy of the calculation you provided. In addition, BCN rates and payment methodology will be set to be the equivalent of our TRUST rates and methodology. All payment rates will be adjusted to the extent necessary to yield the 4% margin and to maintain an inpatient price differential of 10% between Traditional and TRUST/BCN, i.e. TRUST and BCN rates will be set at 90% of Traditional.

On a separate issue, you had brought up the difficulties you have faced due to the fact that you are not considered to be a network provider for our PPO related lab work. We have contacted Ed Spring, who manages our vendor contract administration program, and you should expect to hear from him if you have not already. Ed will be able to answer your questions and explore the possible options. After you have discussed this issue with Ed, please feel free to call me if you have continued concerns. I cannot promise I will be able to solve this matter as you would like, but I will take whatever action I can on your behalf.

I understand we are in the process of organizing a golf outing on June 27, to officially consummate our deal. I look forward to that and to working with you collaboratively in the future.

Sincerely,

Mark Johnson /DEA

Mark A. Johnson, Vice President
Provider Contracting & Quality Assessment

MAJ:pjl
(13:northernmri051403.doc)

Attachment

cc: G. Noxon
K. Seitz
D. Darland

Northern Michigan Hospital
Blue Cross Analysis
Per Cost Accounting System
For Year Ended December 31, 2002

Inpatient	Discharges	Charges	Cost	CCR	Reim	Gain/Loss
Blue Cross - PHA	950	$9,569,042	$5,845,900	61.09%		
Blue Cross - Trust	1,750	18,905,669	11,252,278	59.52%		
	2,700	28,474,711	17,098,178	60.05%	15,045,447	(2,052,731)
Blue Care North HMO	102	1,107,164	644,496	58.21%	985,930	341,434
All Other Inpatient	7,288	96,536,366	55,428,012	57.42%		
Total Inpatient	10,090	126,118,241	73,170,686	58.02%		
Outpatient						
Blue Cross		31,468,807	13,228,888	42.04%	14,748,800	1,519,912
Blue Care North HMO		1,203,196	547,371	45.49%	857,277	309,906
All Other Outpatient		56,314,905	24,128,631	42.85%		
Total Outpatient		88,986,908	37,904,890	42.60%		
Totals In & Out		$215,105,149	**$111,075,576**	51.64%		

Total Expenditures from Financial Statement	**$125,715,922**
Less: Other Operating Income	(5,334,872)
Less: Interest Income	(508,879)
Less: Other Non-Operating Income	(254,401)
Less: Bad Debts	(3,190,029)
Less: Goodwill Amortization	(401,034)
Less: Incremental Strike Costs	(3,158,829)
Less: Physician Revenue	(1,790,977)
Less: Rounding	(1,325)
Net Expenditures for Cost Accounting	**$111,075,576**

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

RECEIVED AUG 0 4 2003

July 30, 2003

Mr. Mark Johnson, CPA
Vice President, Provider Contracting and Quality Assessment
Blue Cross/Blue Shield of Michigan
600 Lafayette East – J 744
Detroit, MI 48226-2998

RE: Oaklawn Hospital Reimbursement Rates

Dear Mark:

As a follow-up to our discussions today, Oaklawn Hospital has asked our firm to assist it with respect to its arrangements with Blue Cross and Blue Shield of Michigan ("BCBSM"). Oaklawn and BCBSM previously entered into a Letter of Understanding which addressed TRUST participation and payment rates. A copy of the Letter of Understanding is attached. The arrangement under that Letter of Understanding will expire on December 31, 2003. In order to ensure continued participation after the end of this year, the Hospital would like to immediately begin traditional and TRUST rate negotiations.

In order to begin the rate negotiations, we expect that BCBSM would prepare a "margin analysis" that examines the relationship between BCBSM payments and costs. Accordingly, I would appreciate your arranging for such an analysis to be prepared. As noted on the attached, the President of the Hospital authorizes BCBSM to share that analysis with me.

As you may know, Trillium Hospital (a peer group 5 hospital) in Albion (a city 12 miles from Marshall) closed in 2002, and Oaklawn Hospital (a peer group 4 hospital) intervened at tremendous expense to continue medical coverage to that community. Oaklawn Hospital expended over $900,000 to respond to the Albion health care crisis, and because of that is now in default on its cash reserves covenant on its bonds. Oaklawn Hospital expended $400,000 for a Federally Qualified Health Clinic and equipment in Albion, $400,000 to expand its emergency room, and over $100,000 to maintain primary care physicians in Albion. Oaklawn has experienced a 20% increase in volume since Trillium's closing. Oaklawn Hospital simply must have increased reimbursement from Blue Cross and cannot continue to receive reimbursement from Blue Cross which is substantially below its costs. In fact, Blue Cross pays

Oaklawn Hospital significantly less than they paid Trillium for the same patients.

As we discussed, I will contact your assistant to set up a meeting during the latter part of August to discuss this matter further.

In the event that you have any questions or comments concerning this matter, please feel free to contact Rob Covert, the Hospital's President (269-789-3924) or myself. Thank you in advance for your cooperation.

Very truly yours,

Joe Aoun

Joseph T. Aoun

JTA/ag
Enc.

N0013353

Mr. Mark Johnson, CPA
July 28, 2003
Page Three

Oaklawn Hospital hereby consents to BCBSM completing and sharing the margin analysis and other financial information with its counsel, Nuyen, Tomitshen, and Aoun, P.C.

Rob Covert
President and Chief Executive Officer

Blue Cross Blue Shield of Michigan

Barb, Review & Sign

600 Lafayette East
Detroit, Michigan 48226-2998

December 17, 1999

Thomas E. Evans
Director of Finance
Oaklawn Hospital
200 North Madison
Marshall, Michigan 49068

Re: TRUST Hospital Agreement

Dear Tom,

Barb Shelley communicated Oaklawn Hospital's dissatisfaction with the TRUST outpatient reimbursement parameters delineated in my November 9, 1999 letter to you. After internal discussion, BCBSM will agree to modify this component. With the exception of establishing a term, BCBSM will agree to the TRUST reimbursement provisions outlined in your September 3, 1999 letter and summarized as follows:

- Contract term of four years, beginning on January 1, 2000.
- Inpatient reimbursement at 95% of the PHA level.
- Outpatient reimbursement at the same level as the PHA.

I have drafted a Letter of Understanding (LOU) to reflect our mutual agreement. If the provisions of the LOU are acceptable, please sign it and return it to me. An executed copy will be returned to you.

If you have any questions, please feel free to call me (248) 448-7892.

Sincerely,

Eric Kropfreiter

Eric Kropfreiter, Senior Analyst
Provider Contracting

cc: D. Darland
G. Steinhauer

a: ETK OaklawnTRUST2

Blue Cross
Blue Shield
of Michigan

600 Lafayette East
Detroit, Michigan 48226-2998

November 9, 1999

Thomas E. Evans
Director of Finance
Oaklawn Hospital
200 North Madison
Marshall, Michigan 49068

Re: TRUST Hospital Agreement

Dear Tom.

I apologize it has taken so long to respond to your proposal, however, after internal discussion and evaluation, BCBSM extends the following counterproposal.

- Contract term of four years, beginning on January 1, 2000.
- Agree to establish inpatient reimbursement at 95% of the PHA level.
- Outpatient reimbursement at the standard TRUST methodology (gain/loss sharing not applicable and independent price updates).

Please call me at (248) 448-7892 if you have any questions, or sign below to indicate acceptance of this proposal. Upon acceptance, I will have a more formal Letter of Understanding drafted for signatures.

Sincerely,

Eric Kropfreiter

Eric Kropfreiter, Senior Analyst
Provider Contracting

cc: D. Darland
G. Steinhauer

Concur: _____
Tom E. Evans
Director of Finance
Oaklawn Hospital
12-16-99

a: ETK OaklawnTRUST1

Ella E M Brown Charitable Circle and Blue Cross Blue Shield of Michigan
TRUST Hospital Agreement
Letter of Understanding

This Letter of Understanding (LOU) amends and supplements certain provisions of the BCBSM TRUST Hospital Agreement entered into by Blue Cross Blue Shield of Michigan (BCBSM) and Ella E M Brown Charitable Circle doing business as Oaklawn Hospital (the parties). If any provisions of the LOU conflict with the terms and conditions of the TRUST Hospital Agreement, the terms and conditions of the LOU shall prevail. Unless otherwise specified in this LOU, all other terms and conditions of the standard TRUST Hospital Agreement, as they may be modified from time to time, will apply. As referenced in this LOU, the term "standard" means the agreement on file with the Michigan Insurance Bureau in effect on the date of admission/service.

I. **Prior Agreements**
This LOU together with the standard TRUST Hospital Agreement shall supersede any and all prior TRUST agreements and understandings between the parties, whether written or oral, regarding the matters herein, and shall constitute the entire agreement and understanding between the parties.

II. **Term and Termination**
This LOU shall become effective January 1, 2000 and shall continue for 48 months until December 31, 2003. Except as provided herein, the LOU may not be terminated by either party prior to December 31, 2003 unless both parties agree, or unless there is a material breach which remains uncured after 30 days notice to the breaching party. Termination of the LOU does not terminate the TRUST Hospital Agreement.

III. **Amendment**
The LOU may be amended only upon written agreement. In the event that unforeseeable circumstances occur which materially affect the intent of this LOU, the parties agree to make a good faith effort to resolve such matters in a timely manner. Any resulting modifications or clarifications to this LOU will be evidenced by a written agreement signed by both parties.

IV **Reimbursement Provisions**
The following reimbursement provisions are applicable:

A. TRUST Inpatient Reimbursement
Inpatient admissions occurring on or after January 1, 2000 will be reimbursed at 95% of Oaklawn Hospital's PHA level of reimbursement.

B. TRUST Outpatient Reimbursement
Outpatient services occurring on or after January 1, 2000 will be reimbursed at Oaklawn Hospital's PHA level of reimbursement.

V. **Term of PHA and TRUST Agreement**
Oaklawn Hospital agrees to continue its BCBSM TRUST Hospital Agreement for the period of January 1, 2000 through December 31, 2003.

VI. **Severability**
In the event that any provision of this LOU is rendered invalid or unenforceable by any state or federal law, rule or regulation or by any court of competent jurisdiction, the remainder of the provisions of this LOU shall remain in full force and effect. In the event that a provision of this LOU is rendered invalid or unenforceable and its removal would have the effect, in the judgment of the party affected, (i) of causing serious financial hardship to such party, or (ii) would cause such party to act in violation of its corporate articles of incorporation or bylaws, the party so affected shall have the right to terminate this LOU upon 30 days prior written notice to the other party.

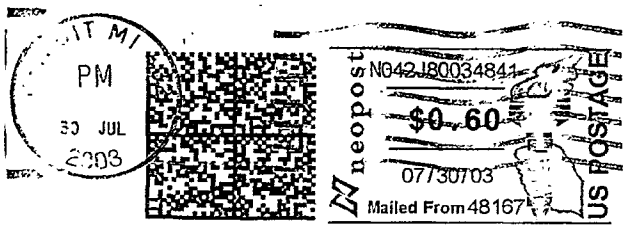
VII. **Confidentiality**
Oaklawn Hospital and BCBSM shall maintain the confidentiality of this Letter of Understanding, and they will not disclose this LOU or the contents of this LOU to any person or entity other than their agents, employees or representatives who have a need to know, and they shall require their respective employees, agents or representatives to be bound by this provision.

Oaklawn Hospital and Blue Cross Blue Shield of Michigan hereby agree to the terms of this Letter of Understanding as evidenced by the signatures below.

Oaklawn Hospital	**Blue Cross Blue Shield of Michigan**
By: [signature] (Authorized Representative)	By: _____ (Authorized Representative)
Name: THOMAS E. EVANS (Print or Type)	Name: _____ (Print or Type)
Title: DIRECTOR OF FINANCE	Title: _____
Date: 12-23-1999	Date: _____

ETK Oaklawn-LOU-1

LAW OFFICES
NUYEN, TOMTISHEN AND AOUN, P.C.
640 GRISWOLD
NORTHVILLE, MICHIGAN 48167



Mr. Mark Johnson, CPA
Vice President, Provider Contracting and
Quality Assessment
Blue Cross/Blue Shield of Michigan
600 Lafayette East – J 744
Detroit, MI 48226-2998

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

August 12, 2004

Mr. Mark Johnson, CPA
Vice President
Provider Contracting and Quality Assessment
Blue Cross Blue Shield of Michigan
600 Lafayette East - J744
Detroit, MI 48226-2998

RECEIVED
Mark Johnson
AUG 13 2004
Vice President
PCQA

Re: POH Medical Center

Dear Mark:

Our firm has been asked to assist POH Medical Center in discussions with Blue Cross Blue Shield of Michigan relative to its reimbursement rates. As I am sure you are aware, POH Medical Center is an independent community hospital located in Pontiac. It is committed to providing high quality care on a cost-effective basis to all members in its community, and it has consistently achieved top rankings under the Blue Cross incentive program. POH Medical Center's commitment to quality is also reflected in its graduate medical education program, and the Hospital is one of the largest osteopathic teaching facilities in the state. During 2004, Blue Cross and Blue Care Network accounted for approximately 25.3% of the Hospital's gross revenues.

As was recently reported in the Detroit Free Press, the Hospital is undergoing significant financial difficulties. With the exception of breaking even in fiscal 2003, the Hospital has incurred substantial operating losses over the last five years, and the loss for the 2004 fiscal year alone was approximately $2.6 million. Due to the losses and deteriorating balance sheet position, at least one credit rating agency lowered the outlook for the Hospital from stable to negative. Among the challenges faced by the Hospital are a poor payor mix (approximately 57% of its revenues relate to the Medicare, Medicaid and the county indigent program) and declining inpatient volumes.

In the course of examining its financial position and determining strategies to improve performance, the Hospital has reviewed more than five years of Blue Cross reimbursement data. Based on that review, a summary of which is provided below, the Hospital believes an increase in payment by Blue Cross is clearly in order. Although Blue Cross and the Michigan Hospital Association are in current discussions about revising the Participating Hospital

ROUTING & REQUEST

Please...

- ☐ Read
- ☐ Handle
- ☐ Approve

And...

- ☐ Forward
- ☐ Return
- ☐ Keep or Recycle
- ☐ Review with Me

To: _____

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From: _____

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Date: _____

Agreement and improving payment to hospitals generally, POH Medical Center's financial position is such that it needs rate improvement now; it simply cannot afford to wait.

Blue Cross Traditional Inpatient Rates

Over the last five years (fiscal 2001 through 2005), the increase in the Hospital's traditional base rate has been $267 (from $4,970 to $5,237). This amounts to an average increase of about 1% per year. This is well-below any measure of hospital cost inflation. For example, the market basket measure of hospital inflation prepared by the Centers for Medicare and Medicaid Services reflects annual increases in the range of 3.3% to 3.5% during the same period.

During the past five years, the Hospital has experienced rapidly rising costs in wages and benefits, including pension, as well as substantial increases in malpractice premiums. The exceptionally low increase to the Hospital's base rate simply does not reflect the reality of the cost increases experienced by the Hospital and over which it has limited control.

Blue Cross PPO Inpatient Rates

Over the last five years, Blue Cross has not increased the PPO base rate ($4,981) at all. This has created a substantial burden to the Hospital given the fact that its costs are rising over this same time period, as described above. Moreover, the situation of low rates is made worse as more and more business migrates from the traditional product to the PPO product. In fact, the differential is now more than 22%. In other words, the Hospital is paid a little less than 78% of the traditional rate for providing the same level of services to a population that is, in essence, the same that historically purchased the traditional product. The migration is evident. In fiscal 2000, traditional discharges were approximately 54% of the combined traditional and PPO discharges. In fiscal 2004, the traditional discharges had declined to approximately 36%.

Blue Cross Pass Throughs

During some prior discussions between the Hospital and Blue Cross, Blue Cross expressed concern regarding the amount of the pass-through payments for capital, graduate medical education and bad debt. In fiscal 2001, the sum of the traditional pass throughs was $1,864 per case; in fiscal 2005, it is $2,066. This represents an annualized increase of approximately 2.1%--again a level well below the rate of inflation. With respect to the PPO product,

the pass throughs have not increased at all over the last five years ($1,498/case). Based on the above, the Hospital does not believe that its pass through amounts have increased in any significant way.

Blue Cross Outpatient Rates

For services that are not reimbursed pursuant to fee screens, the Hospital is to be paid on the basis of a payment ratio that reflects costs. Under the Blue Cross Payment Manual, the payment ratio is to be updated each year by the Reimbursement Committee update factor, after making an adjustment to account for hospital charge increases. For reasons that are not known, Blue Cross has not provided any update to the payment ratio for the Hospital since 2001. In other words, Hospital has not received the benefit of any rate increase (net of charge changes) to cost-reimbursed outpatient services.

Blue Cross Pays Less Than Medicare

On an overall basis, Blue Cross payment in relation to charges during fiscal 2004 was 51.5%. This amount is *less* than Medicare. Medicare payment during 2004 approximated 52.3% of charges.

***

Based on the above, the Hospital has asked me to arrange a meeting with you to discuss these issues in more detail and seek an expeditious resolution. As you may be aware, the Hospital also has filed appeals with respect to the 2000 and 2001 fiscal years where significant amounts are at stake. If possible, the Hospital would like to resolve these appeals as part of the effort to establish fair payment rates going forward.

I will be contacting you shortly to discuss these matters. Thank you in advance for your cooperation.

Very truly yours,

Joseph T. Aoun

JTA/llm

N0020419

LAW OFFICES
NUYEN, TOMTISHEN AND AOUN, P.C.
640 GRISWOLD
NORTHVILLE, MICHIGAN 48167

CERTIFIED MAIL

7002 0460 0003 0371 4531

neopost N042J80034841 $4.42 08/12/04 Mailed From 48167 US POSTAGE

CERTIFIED MAIL--RETURN RECEIPT REQUESTED

Mr. Mark Johnson, CPA
Vice President
Provider Contracting and Quality Assessment
Blue Cross Blue Shield of Michigan
600 Lafayette East - J744
Detroit, MI 48226-2998

4822642998 17

Spencer Johnson

From: Fojtasek, Georgia [Georgia.Fojtasek@allegiancehealth.org]
Sent: Saturday, October 24, 2009 7:53 PM
To: Spencer Johnson
Cc: Peter Schonfeld
Subject: FW: BCBSM Final Contract Offer
Attachments: Doc1 (17).doc

Spence and Peter Keeping you informed. Here is the BX response. Disappointing. Trust stays at rate differential from traditional. Not sure how that is for those on PHA and will ask Jeanne to break it down. Favored nations commentary is interesting.

We are now inviting not only our Board, but also all Board Comt members to our session w/ Hal on November 6. This will involve more community members and physicians who serve throughout the System. We will use to educate and garner support. Our Lady of the Citizen Patriot serves on our Board Quality Comt so she can be there and learn although we understand that the paper is running an editorial opinion on Tuesday. To what end we do not know except Mdm. Publisher has commented to others that our story would be stronger if we had mass layoffs or some other show of dire straights. She doesn't get it.

Anyway, we are now contacting legislators and Muchmore has said that BX will know in a nano-second that we are making appts. As you likely know, Aetna is hosting a fundraiser for Mike Cox on Thursday and their brass are in town and have asked us to dinner. I have planned to accept. If you have advice otherwise, I am open to that. I want to be wisely aggressive. We do need to insure more payer plurality in Jackson however.

My best. Ga.

We lead our community to better health and well being at every stage of life.

Georgia Fojtasek
President & CEO
Tel: (517) 788-4942
Fax: (517) 788-4829
georgia.fojtasek@AllegianceHealth.org

Allegiance HEALTH

From: Wickens, Jeanne
Sent: Friday, October 23, 2009 3:26 PM
To: Fojtasek, Georgia; Aoun, Joseph T.; Vannest, Nancy; Garen, Margaret; Brunner, Micheal; Keener, Timothy; Noble, Chad; Gardner, Anthony; Scholten, Shannon
Subject: FW: BCBSM Final Contract Offer

Well, they sent an offer.

1% above previous offer
BCN IP rates at traditional rates or a 4% improvement which approximates $180K pick-up per year.
So technically, they have offered a 1.3% increase.
We are now at 4.7% versus the 7% per year we requested.

10/26/2009

Bad thing – they want a favored nations clause of 15%.

Everyone noodle and we can discuss Monday.

J'

Jeanné Wickens, CPA
Sr. VP Finance & CFO
Ofc: (517) 841-6979
Fax: (517) 788-4769
Web: AllegianceHealth.org
Allegiance HEALTH

From: Sorget, Kim [mailto:KSorget@bcbsm.com]
Sent: Friday, October 23, 2009 2:06 PM
To: Wickens, Jeanne
Cc: Milewski, Robert; Noxon, Gerald
Subject: BCBSM Final Contract Offer

Jeanne',

As promised, I did discuss your proposal to reimburse BCN at the Traditional product reimbursement with the BCN leadership team. BCN reluctantly agreed as a good faith measure and an attempt to draw the negotiations to closure. In return, BCBSM and BCN expects a favored discount provision. We have discussed this in the past and based upon your statements the margin of discount spread is wider than we are requesting and would like to believe would not be an issue.

Attached is a complete list of elements of our final contract offer that I thought would be best represented on one document. If you have questions or require clarification, please let me know. We will await the outcome of your Board's decision early in November.

Thanks, KIM

BCBSM Final Offer
Allegiance Health
October 23, 2009

The following summarizes BCBSM's final offer to Allegiance Health relative to the contractual relationship:

1) Inpatient and outpatient cost based services will receive the model update inflationary increase, plus one percent in fiscal years 2010, 2011 and 2012.

2) Price based services reimbursement updates will be at published rates that apply to all other providers.

3) Blue Care Network reimbursement will be at Traditional reimbursement rates for hospital services.

4) Resolution of full value of the P4P issue identified via a cash reconciliation.

5) Inclusion of a market shift protection provision.

6) Resolution of outstanding charge attestations by the end of 2009.

7) A favored discount provision of a minimum of a 15 percentage point spread advantage for both the TRUST and BCN products compared to other non-governmental payers.

From: Douglas Darland <Douglas.Darland@beaumont.edu>
Sent: Thursday, December 22, 2011 8:36 AM
To: Aoun, Joseph T. <jta@ntalaw.com>; Gene Michalski <GMichalski@beaumont.edu>; Nick Vitale <NVitale@beaumont.edu>; Dennis Herrick <dherrick@beaumont.edu>
Subject: RE: Blue Cross LOU term

Joe's cautions are all strong points. And don't misunderstand, I think a 3-4 year term is preferable. However, as the world changes, if we have a strong argument for terming the LOU early, we make it and move forward. Three years, four years, or five, our next talks with the Blues will be contentious. And if we have to return $2M of the signing bonus, that is part of the equation when we consider an early termination. As far as the existing LOU language, I don't think they'll catch it, but if they do and try to change it, we are the ones that cry foul, and get back to the table.

From: Aoun, Joseph T. [mailto:jta@NTALAW.com]
Sent: Thursday, December 22, 2011 8:12 AM
To: Douglas Darland; Nick Vitale; Dennis Herrick; Gene Michalski
Subject: RE: Blue Cross LOU term

I concur with Doug's reading of the clause, but would note that even if you had a right to term early, the Blues would probably "cry foul," thus making negotiations after the end of year 3 or 4 contentious. They are likely to take the position that they understood there was a five year deal and that they made concessions (e.g., 5M signing bonus) on account of that. So while legally the Hospital may be able to term the LOU, the effect of such action may as a practical matter make future negotiations more difficult. The Blues will also be able to say to the Big Three and others that Beaumont terminated the deal mid-term.

There is also a risk of proceeding with this understanding and, while the LOU is finalized, its terms change. The Blues could say that this clause was an error and needs to be corrected. At that point, the hospital may have conceded the 5 year issue and will not be able to object to the change.

I think the hospital is better off re-writing the LOU to be the way the hospital wants it. Change the term clause; provide that when the LOU ends, so does the PHA; insert the necessary terms to get the economic arrangement desired; and eliminate the MFN. I think the leverage grows in the hospital's favor with each day. Joe

****
Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
2001 Commonwealth Blvd., Ste. 300
Ann Arbor, MI 48105
734-372-4106 (direct)
734-372-4100 (general)
734-372-4101 (fax)
jta@ntalaw.com
www.ntalaw.com

From: Douglas Darland [mailto:Douglas.Darland@beaumont.edu]
Sent: Thursday, December 22, 2011 7:45 AM
To: Nick Vitale; Dennis Herrick; Gene Michalski; Aoun, Joseph T.
Subject: Blue Cross LOU term

We all agree a five year term is too risky. However, in looking at the draft LOU they provided it is not really a "binding" term. There is a 120 notice period required to terminate the LOU without cause. This is an oversight on their part, and one we can take advantage of. It is similar to many old LOUs, but in recent years they were changing the language so you could only terminate a LOU prior to its end date if there was a breach of some sort.

The LOU may be terminated by either Party with one hundred twenty (120) days written notice unless both Parties agree to a date sooner than one hundred twenty (120) days, or unless there is a material breach, that is capable of cure, which remains uncured after 30 days notice to the breaching Party.

The point is, IF (big if) Sue is open to actually negotiating some things to get this done, it may not be critical that we insist on a 3-4 year term. We will still have the option to end the contract early if desired. We should still work for a 3-4 year term, but if we can get some additional consideration for the 5th year, the risk is not as great.

Joe, do you agree with my assessment? Thanks. - Doug

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Checked by AVG - www.avg.com
Version: 2012.0.1890 / Virus Database: 2109/4696 - Release Date: 12/22/11

EXHIBIT B

NUYEN, TOMTISHEN AND AOUN, P.C.
640 Griswold Rd.
Northville, Michigan 48167
248-449-2700

June 2, 2004

FROM THE DESK OF:
Joseph T. Aoun

TO: Kevin Seitz

I enclose for your files a copy of the letter summarizing the deal with Michigan Hospital Group.

I wanted to thank you again for your efforts in bringing this matter to a conclusion.

Thanks

JA

RECEIVED
JUN - 4 2004
KEVIN L. SEITZ

LAW OFFICES

NUYEN, TOMTISHEN AND AOUN, P.C.

640 GRISWOLD
NORTHVILLE, MICHIGAN 48167
248-449-2700
FAX: 248-449-8775

Joseph T. Aoun
248-735-6920 (direct)
jta@ntalaw.com (email)
Admitted in Michigan and Florida

June 2, 2004

Mr. Mark Johnson, CPA
Vice President
Provider Contracting and Quality Assessment
Blue Cross Blue Shield of Michigan
600 Lafayette East - J744
Detroit, MI 48226-2998

Re: Michigan Hospital Group, Inc.

Dear Mark:

Thank you again for meeting with me and the senior management of the participating hospitals in Michigan Hospital Group, Inc. on Thursday, May 27, 2004. We are grateful that we were able to resolve our negotiations concerning payment rates, and I am writing to summarize the key terms of the settlement. As I mentioned, some of the hospitals need to present this proposed settlement to their respective Boards, and as a result, this settlement is subject to Board approval in those cases.

1. **Payment Increase.** The overall increase to the four Michigan Hospital Group participating hospitals (Community Health Center of Branch County, Gratiot Community Hospital, Memorial Medical Center of West Michigan and Pennock Hospital) will be $2.8 million.

2. **Allocation of Increase.** The increase will be allocated among the participating hospitals pursuant to the allocation percentages that we had previously furnished to you in our December 19, 2003 letter: Community (37.7%); Gratiot (27.7%); Memorial (14.5%); and Pennock (20.1%).

3. **Effective Date.** The increase will be effective March 1, 2003. In lieu of revising payment rates for each hospital's 2003 fiscal year, Blue Cross will make a prorated cash reconciliation payment to each hospital based on the period beginning March 1, 2003 through the end of that hospital's 2003 fiscal year. The payment will be made within two weeks of the execution of each hospital's Letter of Understanding, as described in paragraph 8 below. With respect to each hospital's 2004 payment rates, Blue Cross will revise those payment rates effective on the first day of

each hospital's 2004 fiscal year. The $2.8 million increase for 2004 will be built into the inpatient and outpatient payment rates for both the Traditional and Trust products on a proportional basis using the most recent claims volume activity. Although not discussed, we assume that Blue Cross will make an appropriate adjustment to interim payments to reflect the increase as well.

4. **PPO Differentials.** Each hospital's inpatient PPO differential will be established at 90% of the Traditional inpatient rate. The overall annual impact of such adjustment is expected to result in an increase in payment to the hospitals in the amount of approximately $180,000 annually. This increase is included within (not in addition to) the $2.8 million increase discussed in paragraph 1 above. Accordingly, in order to ensure that the hospitals receive the full value of the $2.8 million increase effective March 1, 2003, the impact of the change in PPO differentials will also be effective March 1, 2003.

5. **Most Favored Nation.** Each hospital will covenant that the payment rates which it has with Blue Care Network, Blue Cross Traditional and Blue Cross Trust are at least as favorable as the payment rates which it has established to any other commercial HMO, PPO or insurer (excluding any commercial HMO, PPO or insurer in which the participating hospital is an owner and excluding arrangements where the participating hospital has assumed financial risk). To verify compliance with the foregoing, a third party auditor will be used. Comparison of rates will be made on an overall basis and not on a specific service line basis, such as comparing only inpatient rates. In the event of a breach of this obligation, an appropriate reconciliation adjustment will be made.

6. **Duration.** The arrangement described above will apply through each hospital's 2006 fiscal year. With respect to the 2004 rate development (and the development of rates for subsequent periods), the standard rating methodologies applicable to the Traditional and Trust products (such as the application of incentives and Reimbursement Committee update factors) will be applied. Blue Cross has indicated that it is in discussions with the Michigan Health and Hospital Association about possibly changing payment policies or rates with respect to rural hospitals. You have indicated that if any of those changes would result in additional payment to the participating hospitals, those changes would be made during the term of this arrangement. In other words, the understandings reached herein do not prevent the hospitals from

NUYEN, TOMTISHEN AND AOUN, P.C.

participating in further rate or payment improvement that may arise from the Blue Cross/MHA discussions.

7. **Appeals.** As we have discussed, one or more of the hospitals may pursue appeals of the wage index classification. You have indicated that any appeal rights which the hospitals may exercise will continue notwithstanding this arrangement, and this arrangement will not be used against the hospitals in the event such appeals are pursued.

8. **Letters of Understanding.** The parties will work in good faith to complete specific Letters of Understanding for each of the four hospitals.

I trust the foregoing accurately summarizes our discussions. If you concur, please execute this letter below and return a signed copy to me. If you believe that this letter does not reflect our understandings, please advise me immediately.

Thank you again for your cooperation.

Very truly yours,

Joseph T. Aoun

ACCEPTED AND AGREED TO: 6/2/04

Mark Johnson, Vice President

JTA/grp

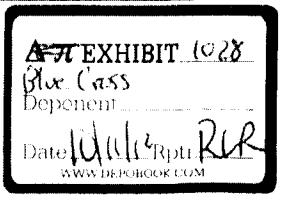
N0018833

EXHIBIT C

Transcription of Telephone Conference Call with DOJ
December 20, 2010

Participants: Joseph Aoun (Attorney), Connie Downs (Pennock Health), Tom Salisbury (Pennock Health), and Ryan Danks (DOJ)

Speaker:	
Ryan	How long have you been with the hospital?
Tom	Not all that long. About eight months.
Ryan	Okay. And where were you each at before you joined Pennock?
Connie	I was with Sturgis Hospital.
Tom	I was with Holland Hospital.
Ryan	Oh, is that in Holland, Michigan?
Tom	It is.
Ryan	Okay, I grew up in Pelham.
Tom	Sister cities.
Ryan	Sister cities, yes. More tulip times than I care to remember.
Tom	Yes, oh man, I am so glad not to be in Holland any more at tulip time.
Ryan	You'll have to explain to these folks some other time just what kind of pain could be associated with wearing wooden shoes for any length of time.
Tom	I still have a pair that I very memorably wore one day all day long at work.
Ryan	Wow, you're a braver man than I am. I have nightmares of ---- they used to put us in them when we would march in school parades and whatnot and there's just no way to get comfortable.
Tom	Yeah
Ryan	Well, so anyway, okay. Enough old home week or old home afternoon. I understand that at one point, the hospital was a part of the Michigan Hospital Group which was a joint venture among several independent rural hospitals to kind of try and consolidate some administrative and contracting work. Are you still a part of the MHG?



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Speaker:	
Connie	We are. I'm going to let Joe kind of talk to this because he helped us to organize it. We are … it is still alive. It's not very active though. There's not much going on due to mergers and consolidations of other organizations.
Ryan	Okay, and so do you—does MHG still have a role in terms of negotiating your contract with Blue Cross or is that something that you're doing directly now?
Connie	No, I don't think it's actively involved with the negotiations at all.
Ryan	Okay. Give me, just again, ballpark estimates are fine, a sense of how the reimbursement rates for your commercial payers—where they're set at now?
Connie	For which commercial payers?
Ryan	Well, for, I'm sorry for the large ones. Blue Cross, Priority and Cofinity.
Connie	Okay. The discount rates for Blue Cross are currently running at 58.7% of charges; the Priority…go ahead…
Ryan	I'm sorry. Is that a discount of to 58.7% or is that a discount of 58.7% so they're actually paying 42% of charges?
Connie	Right, they're actually paying 42% of charges. And then Priority Health, we have a discount rate of about 40% of charges.
Ryan	Okay, so they're paying about 60%?
Connie	Right, and Cofinity is paying 91% of charges and so are all the other commercial payers that we contract with.
Ryan	Okay, how have those….I know you've only been around for a couple years, three years now, Connie, so maybe…I don't know if you'll be able to answer this or not but do you have any sense of how those numbers have changed over time, in particular, if they've changed at all since the first contract that was signed with Blue Cross in 2003?
Connie	I don't have information all the way back to 2003 although 2007 is the oldest date I have. It looks like the discount rate was roughly 55% back then.
Ryan	Okay
Connie	And it's closer to 3% higher now. And that's with standard hospital rate increases.

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Speaker:	
Ryan	In other words the charge master rate has gone up by some amount and then the discount has varied between 55 and 58%?
Connie	Right
Ryan	Okay. How about with respect to Priority and Cofinity? Have their numbers changed at all since 2007?
Connie	Not significantly. They're really just getting about the same discount rate they were getting then.
Ryan	Okay. Are you familiar with the LOU that was signed in 2005 between Pennock and Blue Cross?
Connie	I am.
Ryan	Okay. I'm sorry, it was signed in 2006, I think maybe a little bit [_____05:14:7]. I understand that that LOU contained a Most Favored Nations clause, does that sound right to you?
Connie	Yes
Ryan	Okay. Do you know anything about…let me back up and ask…is that LOU still the one that was signed in 2006, is that the one that still governs the relationship today?
Connie	No, there's a, another LOU that modifies what Blue Cross uses as their reimbursement model
Ryan	Okay
Connie	So it takes their model and modifies it slightly and that's in effect at this point.
Ryan	Okay. And when did that one come into effect?
Connie	2000 … For fiscal year 2007.
Ryan	Is that related to the changes that they were making to their overall model—peer group model reimbursements?
Connie	Right, yes
Ryan	Okay.

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Speaker:	
Joe	Yeah, it's not actually a side letter or Letter Of Understanding. The hospital just signed onto the new model in the new Participating Hospital Agreement and by doing so, it essentially terminates the Letter Of Understanding.
Ryan	Okay. And does the new agreement with Blue Cross have—the one that's currently in effect—have any kind of MFN clause or MFN guarantee in it?
Connie	No, not
Joe	Not for the Peer 1 through 4 hospitals. They're on the standard participating hospital agreement, Ryan, that does have a MFN for Peer 5 hospitals.
Ryan	Sure, but there's nothing in that contract that creates an MFN obligation for Pennock.
Joe	Right, what I'm saying is they're just on that standard agreement, you know, the boiler plate. They don't have any side letter any longer. If I'm incorrect, Connie, please let me know.
Connie	No, I think you're right.
Ryan	Okay, so, there is no, and do you remember, Connie, or do you know in the course of transitioning from the LOU—the 2006 LOU to the standard PHA whether Blue Cross made any efforts to secure an MFN with Pennock?
Connie	I'm not aware. I wasn't here then.
Ryan	Okay. And your predecessor didn't leave you a note in the file or anything like that, that would?
Connie	Nothing that would lead me to that conclusion. Joe, do you know, given that you were involved with those discussions.

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Speaker:	
Joe	No, what happened, Ryan, just by way of background is that when they developed the new Participating Hospital Agreement, the new agreement was using 2004 as the base year and then the rates were effective, I believe October 1, 2006, and under the revised—under the new Participating Hospital Agreement, Pennock's rates would go up and so there was a financial incentive for them to go to the new model if you will and tear up the side letter and they ended up doing that and negotiating some other technical changes. There were some questions about whether certain costs were properly being picked up by Blue Cross when it calculated the rates so they went through the process of working on the technical calculation of the rates under the new model and then went to the new model and since that just required the hospital to sign the standard Participating Hospital Agreement, there was not any discussion about an MFN at that time.
Ryan	Okay, and Blue Cross didn't express any concern about the fact that they were moving from a contract that had an MFN to one that didn't?
Joe	No, no, that never came up. The only issue that did come up is that the new model was supposed to be effective October 1, '06, and Pennock wanted these technical changes made and so there was some fighting over the effective date of the technical changes but there was not anything relating to the MFN or we would agree to go retro to October 1 if you'll agree to the MFN—there was never that type of negotiation.
Ryan	Do you know, and I'll say you writ broadly to be either Connie or Joe know if the MFN that was in place between 2003 and 2007 ever had an impact on the rates that Pennock was negotiating with any of the other commercial payers?
Connie	Well, on an overall basis, Blue Cross' agreement with us was a pretty important one because of the fact that the reimbursement rate was so low so we were discussing with our payers all along, and continue to discuss with our payers because of the reimbursement rate, improvement in reimbursement from their perspective but specifically, I haven't used or we haven't negotiated anything since I've been here related to the MFN specifically.
Ryan	Okay, when folks say things like "specifically" to lawyers, it makes us want to ask the question "well what about generally?" Are there any...and I say that a little bit tongue in cheek but I am sincere about if there are any sort of general or more background type things where this has come into play, or come into your thinking, I would be happy to hear about those as well.

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Speaker:	
Connie	Joe, jump in whenever you feel like you need to but basically, what I'm saying is we have a policy at Pennock Hospital that payers don't get a discount from us unless they can demonstrate a significant amount of volume that comes to the hospital and we've had to hold that clause pretty firmly in order to sustain bottom line. In some cases, haven't done very well at that, in order to continue operations in certain areas. I mention the outreach centers and physician offices that we subsidize as well as services right in the hospital that we subsidize and we can't allow discounts to be much higher than the 19% because we don't get paid very well from, you know, Blue Cross which is a major commercial payer for us. So to some extent, the agreement in and of itself, because it exists, and the reimbursement is what it is and we're not allowed really a level playing field to negotiate on with Blue Cross because we are such a small payer or a small provider, we have to be stronger with those payers in our community that aren't as prominent and that's difficult for them and it's difficult for us.
Ryan	So let me see if I'm understanding...is what I'm...am I understanding you correctly to be saying that because Blue Cross is paying you such a low rate, it forces you to have to be even tougher than you might be otherwise with the other commercial payers because you have to be able to make your money somewhere and you can't—they don't have the leverage in the negotiations that Blue Cross does?
Connie	That's pretty, pretty accurate.
Ryan	Okay
Joe	Ryan, I just wanted to mention that I did work pretty closely with Connie's predecessor who was the Chief Financial Officer during that time period that you were asking and I was not aware of any situation where the hospital was having to change the rates it had with other commercial payers because of the Blue Cross MFN clause in the side letter—I was not aware of that, in fact I never—just so that you're aware, I was never aware of that becoming an issue for any of the Michigan Hospital Group hospitals that had agreed to that clause.
Ryan	Okay, and then, just for the record, that included Community Health Center?

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Speaker:	
Joe	Yes, there were four hospitals that were part of the negotiation within the Michigan Hospital Group. The Michigan Hospital Group included I think three or four other hospitals but only four were part of the Blue Cross negotiation. And the four were Pennock Hospital, Gratiot Medical Center which is now a part of Mid-Michigan and I think that you or your colleagues—we've been on some calls with them. The other hospital was Community Health Center in Branch County which is in Coldwater, Michigan, and then Memorial Medical Center of West Michigan, which I believe is in Manistee.
Ryan	Okay
Joe	Those are the four hospitals.
Ryan	Most of the topics I wanted to cover this afternoon, would you give me just one second while I look through my notes? Are there—well actually, one of the things we were just talking about, was it Mr. Nicks that you were working with? Was that your predecessor, Connie?
Connie	Yes, Wade Nicks.
Ryan	Do you know where he is now?
Connie	He's retired now.
Ryan	Okay.
Connie	I don't know where exactly his residence is though. I think he spends part of his time in another state?
Ryan	Maybe one south of here?
Connie	Yes
Ryan	That wouldn't be the first time I've heard that. I think we have hit the parts I wanted to cover. Is there anything else kind of in terms of your contract, your relationship with Blue Cross or with other commercial insurers that you think is particularly notable or that you'd like to bring to our attention?

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Speaker:	
Connie	You know, I think I'd just reiterate part of what I mentioned before is that, you know, Blue Cross is really not, it's not a negotiation. We're given the rates that we're allowed to be paid and reimbursed for and we're really not given a flat level playing field because we're not very big in their eyes—we don't serve enough of their participants and it becomes more of just a dictated this is what it's going to be and that, that, in my opinion, is not a negotiation—it's more of a one-way discussion. And it is causing—has caused—some significant issues financially for Pennock Hospital as well as my predecessor, Sturgis Hospital, and so I've seen it more than once now, with the size hospital Pennock is, we're not large enough to make a difference for Blue Cross and we're not small enough to get the advantages of Peer Group 5. We're in this size range that puts us in a bad financial situation for contracting with them and that just creates real difficulty in being able to serve the communities that we practice in and so that's I guess what I'd just like to add.
Ryan	Okay, I appreciate that. Is Blue Cross, in your view, covering its share of the hospital's operating expenses?
Connie	Not in my opinion.
Ryan	Is that a point of dispute with Blue Cross?
Connie	Well, the model that they base our prices on is something that we've referred to before and there's lots of points of difference between what the hospital thinks is their fair share and what Blue Cross thinks is their fair share and, frankly, rural community hospitals our size—again—have to do a lot of things, especially with anesthesia services and with outreach clinics that larger urban centers don't have to do—the costs are not something they have to incur. And Blue Cross is unwilling to participate in sharing those costs and part of it is bringing services to their participants so we've had lots of points of discussion about anesthesia costs associated with overhead and clinic overhead and I don't think we've ever effectively won the discussion in any way, shape or form so...the other thing that they fall short on is their portion of the bad debt—the patient's portion that doesn't get paid to the hospital. You know if they're going to pay us at reimbursement rates that approximate Medicare, when Medicare provides for those reimbursements, Blue Cross should be willing to participate in their fair share of it and it's just not, in my opinion, happening.

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Speaker:	
Joe	The thing that's a big difference is the Medicare and Medicaid losses. You know, hospitals that are the small rural hospitals that are large are too large to be critical access really don't fare well under the Medicare program—they tend to have significant losses under Medicare whereas a critical access hospital is guaranteed reimbursement that's 101% of cost and so the small rural hospitals tend to have—that aren't critical access—tend to have significant losses on Medicare and then on top of that there's Medicaid losses because the state doesn't really fund the Medicaid program enough to cover costs and so half of the payer mix of the hospitals paying below cost it means in order for the hospital to have a bottom line it needs to shift to the commercial payers and the Blues won't recognize any of that. It will recognize the Medicare and Medicaid loss for Peer 5 hospitals, basically saying yeah that's a component of your financial requirements—we recognize it—we'll pay our share but then when it comes to Peer 1 through 4 hospitals, Blue Cross doesn't do it and to me that's pretty big issue especially as these programs, Medicare and Medicaid, continue to pay below cost, and the statute that Blue Cross is regulated under in which, you know, in their, I've been reading this Motion to Dismiss that they filed—it actually requires them not to cover their share of hospital costs but their share of hospital financial requirements and so I think that the previous financial requirements is more expansive and could include things like the underpayment from Medicare and Medicaid so I think it's more than just a difference in words...other parts of that statute that they're regulated under, when they're talking about how you evaluate payment to providers other than hospitals, they refer to the provider's cost but when they talk about how to evaluate payment for hospitals, they use the phrase "financial requirements" so you know it is a substantive difference for hospitals and that's the real problem with whether the Blue's payment is fair or not is that their refusal to recognize any of that results in this disproportionate level of cost shifting to the other payers and then the other payers are rendered uncompetitive so that's just some additional thoughts that I have, especially after reading this motion that they filed.
Ryan	That...we're reading it with great interest too, I assure you.
Joe	Well, you know, I should go through my files because I once did a FOIA to the insurance commissioner's office asking for the Participating Hospital Agreement and the exhibit which lays out the reimbursement model and as you know the exhibit for Peer 5 hospitals have the MFN clause and they sent me the Participating Hospital Agreement without the exhibit and I requested the exhibit and they said that they don't have it on file and of course the side letters aren't on file so how is it pervasive subject—you know—it's pervasively state regulatory scheme when the very documents aren't on file?
Ryan	I think those are fair questions.

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Speaker:	
Joe	I'm ready to do the *amicus*. I just need to find a client that will pay me.
Ryan	Well you know, if you get nominated and confirmed to the bench before the end of January, let me know.
Joe	Okay
Ryan	No, well, thank you all. I appreciate you taking the time out to talk with me this afternoon. Again, Joe, thanks for setting this up in terms of handling the logistics and I'm not sure—there will be many twists and turns as the case proceeds, I have no doubt, and we may need to get back in touch at some point and if so, we'll give Joe a call and see if we can get you on the phone, Connie.
Connie	That would be great.
Ryan	In the meantime, I appreciate you taking the time and I hope you have happy holidays.
Connie	Yes, same to you
Ryan	Okay
Joe	Ryan, one quick question, Ryan, before we hang up. Do you know what the status is on protective orders for, for dealing with the hospital and the disclosure of data?
Ryan	I don't know the status beyond saying its in progress, I don't, but I don't have a sense of what the timing will be. I will check in with that and if we have anything definite we can share definite with you either I'll give you a call or David or Barry or somebody will, but it may be, at this point it may be after the holidays before we know anything with certainty.
Joe	You know, we're concerned—I've shared this with David that you know the Blues are trying to make requests also of hospitals and, you know, we'd just like to make sure that we get something in place so that, you know, also we've got these tag-along suits so...
Ryan	Sure, yeah, well I mean I would expect there—I have every reason to think that there will be something in place, that's pretty standard operating procedure for our cases but, I just, in terms of what it's going to be, and everything else, it's still in progress and so when we have something to share, we will definitely be in touch.
Joe	Okay, well, thank you and happy holidays to everyone over there.
Ryan	Okay, thanks a lot. Take care.

Transcription of Conference Call with DOJ
December 20, 2010

Speaker:	
Connie	Bye bye

Maybe I don't know how to read a tape recorder.

EXHIBIT D

Health Reform and Leveling the Playing Field

Michigan Association of Health Plans

Joseph T. Aoun, Esq.
Nuyen, Tomtishen and Aoun, P.C.
2001 Commonwealth Blvd., Ste. 300
Ann Arbor, Michigan 48105
(734) 372-4100
jta@ntalaw.com
www.ntalaw.com

July 2012

Context

- **ACA-related Amendments:** The Insurance Code, including the HMO provisions in Chapter 35, and Public Act 350 will need to be amended to address the ACA provisions affecting health plans
- **Exchange Legislation:** New enabling legislation is needed to implement the Exchange
- **What else should Michigan be doing to promote a level playing field and robust competition?**
  - ACA-related amendments and Exchange enabling legislation do not address the goal of leveling the playing field
  - Michigan has unique market characteristics

Dimensions to Improve a Level Playing Field

- Provider Payment Rates
- Premium Rates
- Product Distribution
- Transparency

Provider Rates

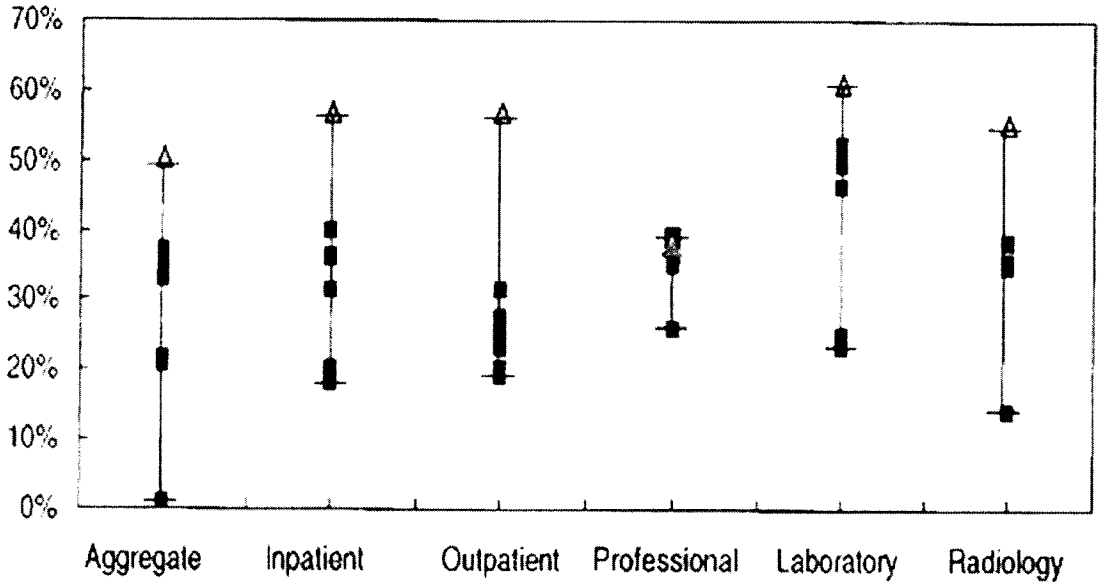
- ACA does not address provider payment rates for commercial business, but ACA requires commercial carriers to offer comparable (essential health) benefits and follow the same underwriting rules (e.g., guarantee issue; no pre-existing conditions)
  - **If all health plans are essentially insurers of last resort, how will they compete if they do not have insurer of last resort provider rates?**
- Reducing unmerited variation in payment to providers is essential to ensuring a competitive market both within and outside of the Exchange

BCBSM's has greater discounts than all competitors except in professional

△ BCBSM discount

■ Competitor discount

Spread of discounts by competitor and discount type
Percent



	Aggregate	Inpatient	Outpatient	Professional	Laboratory	Radiology
Unit cost gap (BIC/next best)*	-22%	-28%	-37%	4%	-21%	-28%
Unit cost gap (Market Avg.)*	-25%	-34%	-41%	0%	-26%	-32%

Provider Rates – Strategies to Level the Playing Field

- **Risk adjustment** – needs to ensure that provider rate differentials are appropriately taken into account
  - Even if a dominant health plan's members are 10% sicker than average, given the unit cost advantage, it should not receive positive risk adjustment

- **Rate Parity** - Evaluate ability to implement commercial rate parity within Exchange
  - May need to apply outside of Exchange given ACA requirements
  - CMS Innovations Center may test all-payor rate setting under ACA

Provider Rates – Strategies to Level the Playing Field

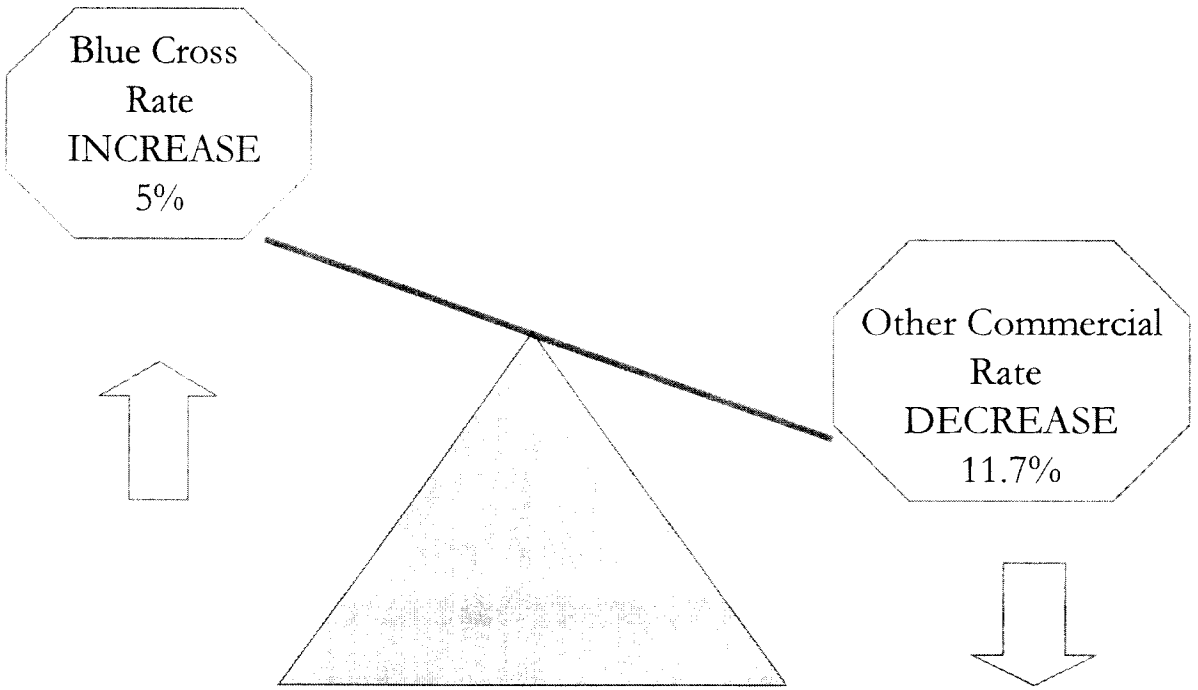
- **Hospital Financial Requirements** - Obligation to pay fair share of hospital financial requirements so that the costs are not disproportionately shifted to other health care purchasers
  - If hospital financial requirements are **130.9%** of cost and BCBSM pays 109%, then other carriers end up paying **182%** of cost
  - **Increased government shortfalls** expected as Medicaid enrollment grows and Medicare payment cuts under the ACA are implemented
- **Hospital Appeals to OFIR or Third Party** – An appeal process for hospitals that believe their financial requirements are not being paid

Provider Rates – Strategies to Level the Playing Field

- **Most Favored Nation Clauses** - Should be prohibited
  - Status of current litigation against BCBSM

- **Provider Association Roles** - Determine scope of role, if any, of hospital and physician trade associations relative to development of standard contracts (Participating Hospital Agreement) and reimbursement models
  - ***Not limited to BCBSM, but all payors***

Multiplier Effect on other Commercial Rates of Raising Blue Cross Rates



Premium Rates

- **Avoid predatory pricing (both within and outside of Exchange) by dominant health plans**
  - Consider requirement to price rate increases at least equal to trend
  - Consider requirement for increased OFIR auditing of actual rate increases to ensure rates charged are consistent with the rates that have been filed and approved
- **Other Rating Considerations**
  - Determine whether a separate rate review process is appropriate given dominant health plan market share

Premium Rates

- **AMA 2011 Analysis** of health plan concentration

	BCBSM	Other
Ann Arbor	80%	7% (HAP)
Detroit-Livonia-Dearborn	55%	26% (HAP)
Flint	68%	16% (HealthPlus)
Grand Rapids-Wyoming	65%	22% (Priority)
Jackson	85%	7% (Aetna)
Kalamazoo-Portage	74%	15% (United)
Lansing-East Lansing	67%	12% (PHP)/12% (Priority)

- **Defining dominance:** More than **50%**?

Premium Rates

- **Other Rating Considerations**
  - Politics and rate hikes
    - AG settlement with BCBSM artificially depresses Medicare supplement rates, thus weakening competition in the **Medicare supplement** and **Medicare Advantage** markets
  - Establish standards for experience rating plans to promote ability of experience rated customers to switch carriers without incurring penalties or losing accumulated credits

Product Distribution

Chamber and Association Agreements

- Consider prohibiting dominant health plans from compensating chambers and associations unless non-exclusive, i.e., chamber and association must offer competing health plans in order to receive any remuneration from a dominant health plan

Agent Relationships

- Require disclosure of agent commission and override arrangements
- Address risk that agent compensation will be structured to avoid enrolling unhealthy, e.g., less broker commission for higher metal plans

Product Distribution

- **License Agreements and Territorial Restrictions**
  - Require disclosure of license and territorial restriction agreements, such as BCBSA licensing agreement, and remuneration paid to/by other health plans under same agreement

Transparency

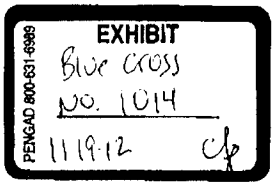
- Increase appropriate **regulatory disclosures**
- Examples of what is **not** reported today:
  - In-state versus out-of-state enrollment
  - Group enrollment where Medicare is primary
  - Stop loss enrollment
  - Claims processed by BCBSM and paid by other Blues' plans
  - Utilization statistics, such as admissions and days/1000
  - Agent compensation & Chamber arrangements

Transparency

- **Self-Funded Health Plan Reporting:**
  - Require full disclosure of all access fees and other administrative fees
  - Consider prohibiting access fees based on percentage of paid claims
  - Consider prohibiting access fees based on a single class of providers (e.g., charging access fee on hospital claims only)

EXHIBIT E

From: BRUCE HILL [BHILL@healthplus.org]
Sent: Tuesday, January 31, 2012 11:24 PM
To: Richard Murdock
Subject: RE: Summary of Meeting with Governor's staff



Rick-

Thank you for the summary. Very helpful. Sounds like the team did as good as could be expected. Also sounds like the administration was receptive. Thank you and the team for your advocacy for a Competitive Michigan market.

Bruce

From: Richard Murdock [mailto:RMurdock@mahp.org]
Sent: Tuesday, January 31, 2012 4:42 PM
Cc: 'Kathy Kendall'; Paul Duguay; 'Aoun, Joseph T.'; 'steve mitchell'
Subject: Summary of Meeting with Governor's staff

TO: MAHP CEOs and Executive Committee and Board Alternates

Attached and below a summary and information provided at today's meeting with the Governor's senior staff on "Competitive Environment". (The agenda was distributed last night—the appendices you may have seen in partial form in the package for last week's meeting).

1. **Attendance:**

Governor Office:

i. Dick Posthumus, Senior Advisor and Director of Office of Legislative Affairs

ii. Sally Durfee, Deputy Director of Office of Legislative Affairs

iii. John Nixon, State Budget Director

iv. Steve Hilfinger, Director of Department of Licensing and Regulatory Affairs, LARA

v. Kevin Clinton, Insurance Commissioner, (OFIR)

vi. Nick Lyons, Deputy Director, MDCH

MAHP:

i. Kathy Kendall, MAHP Board President

ii. Rick Murdock, MAHP Executive Director

iii. Paul Duguay, MAHP Deputy Director

iv. Joe Aoun, MAHP Consultant

v. Steve Mitchell, MAHP Consultant

2. **Overview.** The meeting lasted just over 1 hour and began with conversation with John Nixon, regarding issues related to BlueCaid/Wayne County. I will have a separate communication tomorrow regarding this topic and status, but we took the opportunity to make sure he was well aware of the MAHP position on the timing of any rebid of the Medicaid Program. Mr. Nixon then left the meeting and Dick Posthumus set the stage for the rest of the meeting by referencing his presentation to our MAHP Board. Our presentation was to review the agenda items (making sure we left enough time to discuss the "recommendations", but taking the group through the various attachments in the appendix. I also took the time to thank the Governor's office of having such a meeting as the previously administration didn't permit this discussion.

3. **Specific Comments/Observations by Governor's staff (appendices):**

Appendix 1 (draft Vision)—no specific comments, but indication that was the position they were seeking

Appendix 2 (ASO)—Commissioner Clinton asked some pointed questions to determine if we had asked for this previously, he affirmed the competitive edge this provides and could be one area to address

Appendix 3 (exclusive marketing agreements with chambers and associations) was for awareness purposes to illustrate the pervasive reach of BCBSM and was an "eye opener" for several in the room, regarding the magnitude of the reach and how those relationships work back into the legislative process.

Appendix 4 (Litigation summary)—again was to highlight for the group the numerous challenges raised by customers as well as the Federal and state government—opportunity was taken to provide more detail on some of the cases

Appendix 5 (status of competition)—again was education/awareness...We showed the most recent compilation of the HHI index by region and it clearly shown everyone the dominant position of BCBSM....several questions were raised on the formula for HHI. Appendix 5 also highlighted a quick summary of the past five years.

Appendix 6 (PA 350 provisions)....this was to acknowledge that the provisions of PA 350 do not address the bulk of current BCBSM enrollment due to vast expansion of self insured and nontraditional plans since the origin of the act. There was significant discussion on the provider class issues and it was noted that MAHP would submit commentary on OFIR's request for comments on the provider class requirements and would encourage members as well. Discussion also took place regarding the opportunity to seek information from Hospitals (or which hospitals have already provided) that would demonstrate the inequity of payments relative to charges of BCBSM compared to other payers and how that was inconsistent with the principle embedded in PA 350 that no portion of BCBSM fair share of hospital financial requirements be borne by other heath care purchasers.

4. Recommendations.

At the outset, we attempted to be very clear that the recommendations were both our initial thinking and that should be taken as a group—in other words, if the administration were to seek a "pay down of assets" but not take any other action, then competitive environment would have not been addressed.

It was clear that there was significant advanced thinking regarding the ending of the "insurer of last resort" –as there was no question that currently this was a very limited role they play—due to the federally subsidized HIP program and medicaid –there were questions regarding potential payout of assets—we were asked potential uses of those dollars. Our recommendations on exclusive arrangements and cost shifting were understood, given discussion on the information in the appendices—the pitch was made that while we don't believe new regulations are necessary in the marketplace, the administration should look at appropriate actions in these areas when a carrier exceeds the threshold of monopoly (using the HHI index as example)

The meeting ended with discussion on how the administration should not take off the table there key leverage points for creating the competitive environment---the same arguments used with John Nixon at the start of the meeting regarding the inappropriateness of rebidding Medicaid before 2014 was again discussed and with the context of the various other pieces of information clearly make impact with those in the room—that is—why would you reward BCBSM who has demonstrated a clear history of monopolistic behavior by given them the keys to Medicaid—the only current market in Michigan that is competitive.

5. Conclusion of meeting and follow up

Our meeting ended with Steve Mitchell driving home the points of BCBSM history in IMR and their claims vs. actual and placing that in the context of a vision for competitive environment. We agreed

to stay in communication –that follow up on Medicaid issues will take place with Nick Lyons (copied to others)—we will continue to work cooperatively on exchange legislation (our activity was noted and we were thanked). There is a similar meeting with BCBSM on Thursday, and the Administrations' position will then evolve—how quickly is yet to be determined.

Footnote: We had a separately scheduled meeting with Nick Lyons already in place after lunch today. Our original agenda was deferred and we discussed the debriefing of what was heard—part of the conversation was on Bluecaid/Wayne county and Nick indicated he will follow up with me tomorrow to address the issues raised by John Nixon—I will forward a separate memo on that time. However, one piece of information he shared was that the "administration's current position on rebidding the Medicaid program" appears to be solely related to the recently discussed strategic plan presented by Olga Dazzo to John Nixon of steps needed to get ready for 2014....and that John Nixon was not likely wedded to that position if we could persuade Director Dazzo of its inappropriateness at this time. More tomorrow on this as well.

The MAHP Team were very focused and I believe the message we intended to bring to the Administration was well received and will be considered.

If there are any questions on the above or attachments, please give me a call (517-371-3181) or message at rmurdock@mahp.org

Rick

Rick Murdock

Executive Director

Michigan Association of Health Plans

327 Seymour Avenue

Lansing, Michigan 48933

517-371-3181 (office)

517-482-8866 (fax)

Rmurdock@mahp.org

www.mahp.org

EXHIBIT F

UNEDITED, UNPROOFREAD, UNCERTIFIED ROUGH DRAFT

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UNITED STATES DISTRICT COURT

121213RUF.txt
EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD
OF MICHIGAN,

Defendant.

The Confidential Videotaped Deposition of
MARK GRONDA,
Taken at 4960 Towne Centre Road,
Saginaw, Michigan,
Commencing at 10:08 a.m.,
Thursday, December 13, 2012,
Before Rebecca L. Russo, CSR-2759, RMR, CRR.

APPEARANCES:

MITCHELL H. GLENDE
U.S. Department of Justice
Antitrust Division

450 5th Street, NW
Suite 4100
Washington, DC 20001
202.353.3863
mitchell.h.glende@usdoj.gov
Appearing on behalf of Plaintiff
United States of America.

LAURA M. ALEXANDER
Cohen Milstein
1100 New York Avenue, NW
Suite 500, West Tower
Washington, DC 20005
202.408.4617
lalexander@cohenmilstein.com
Appearing on behalf of Plaintiffs in
Case Nos. 10-cv-14360, 10-cv-14886, and 11-cv-10375.

MATTHEW P. ALLEN
Miller Canfield Paddock and Stone PLC
840 West Long Lake Road
Suite 200
Troy, Michigan 48098
248.267.3259
allen@millercanfield.com
Appearing on behalf of Aetna, Incorporated.

TODD M. STENERSON
Hunton & Williams LLP
2200 Pennsylvania Avenue, N.W.
Washington, DC 20037
202.419.2184
tstenerson@hunton.com
Appearing on behalf of Blue Cross Blue Shield of Michigan.

PAUL L. FABIEN
Honigman Miller Schwartz and Cohn LLP
660 Woodward Avenue
2290 First National Building
Detroit, Michigan 48226
313.465.7346
pfabien@honigman.com
Appearing on behalf of Covenant HealthCare and the Witness.

ALSO PRESENT:
Rachel Bierl - Video Technician

Saginaw, Michigan
Thursday, December 13, 2012
10:08 a.m.

VIDEO TECHNICIAN: We are now on the record. This is the videotaped deposition of Mark Gronda, being taken on Thursday, December 13th, 2012. The time is now 10:08 a.m.

We are located at 4960 Town Centre Road, Saginaw, Michigan.

We are here in the matter of United States of America, et al, versus Blue Cross Blue Shield of Michigan. This is Case Number 10:cv:14155.

This matter's being held in United States District Court, Eastern District of Michigan, Southern Division.

My name is Rachel Bierl, video technician.

A. That's what it says.
MR. ALLEN: Objection, form, foundation.
BY MR. STENERSON:
Q. And how did that compare how did that increase compare to what you were seeking?
A. It was far less than we had hoped for.
Q. What would you say to somebody, sir, who suggested to you that Blue Cross paid you too much even in Gronda 2?
MS. ALEXANDER: Objection, form.
MR. ALLEN: Form, incomplete hypothetical?
A. If someone told me Blue Cross paid us too much.
Q. Hmm-hmm?
A. I'd say they're crazy.
Q. Why?
A. Because I don't believe they do pay too much. Especially as it pertains to the other payers and --
Q. Do you believe that, what would you say to someone, sir, who says that Blue Cross should never give you a rate increase because every time it does so the cost of health care simply just gets higher?
MR. ALLEN: Objection, form.
MS. ALEXANDER: Objection, form.
A. I would say there's not a direct correlation between the premium increases and the rates that the hospitals

negotiate and I've seen charts to that effect.
BY MR. STENERSON:

Q. I was about to ask you what's the basis for that claim?
A. Charts that Joe Aoun put together that I've seen.
Q. And whose Mr. Aoun?
MR. FABIEN: Again, at this point I'm going to object to the extent we're getting into legal advice. If it's business advice, it's a different matter, but to the extent we're talking about legal advice from Mr. Aoun --
A. This wasn't legal advice. This wasn't a document for Covenant, per se. It's one he put together. I think he actually testified at the MHA or Lansing here recently.
Q. And I'm not intentionally trying to elicit answers of privilege, and so to the extent I do ask questions that call for privilege just tell me and we won't have you answer.
My original question is who is Mr. Aoun?
A. He's a lawyer that we've utilized through the PHO for legal services.
Q. And do I understand Mr. Aoun also provided business consulting beyond legal services?
A. Yes.

Q. And on what topics has he provided business consulting advice to Covenant?
A. The structure that we negotiated with HealthPlus and he's given us some advice on the Blue Cross negotiations, both legal and some that would be considered business.

Q. And has Mr. Aoun ever told you that he has an attorney-client relationship with Aetna?

MR. ALLEN: Objection, form.

A. Not that I recall.

BY MR. STENERSON:

Q. You had mentioned earlier, sir, that it was your understanding that Blue Cross had always had an MFN? Did I understand that testimony correctly?

A. That was my recall, that that was not anything new, that most favored nation clause was pretty standard.

Q. Okay. And I just want to test your memory a little bit and make some distinctions between Blue Cross getting the best price and Blue Cross having a contractual clause for the best price, okay?

A. Okay.

Q. Do you know if Covenant -- well, strike that.

Prior to Gronda 2, have you ever negotiated a contractual clause with Blue Cross for the best price at a Michigan hospital?

A. Me personally?

Q. Yes, sir.

A. No.

Q. Prior to Gronda 2, do you know whether Covenant has ever had a written agreement with Blue Cross that contained a contractual guarantee of the best price?

A. My understanding was that we did.

Q. And what is the source of your understanding?

A. Just from conversations back at the time with the individual who was leading those negotiations, but I

competition? Yes.

Q. And so if that's true, sir, if everybody else's rates at Covenant stay the same but Blue Cross' rates to Covenant go up, what would you expect that to do to competition for health insurance in or around Saginaw?

MS. ALEXANDER: Objection, foundation.

A. If Blue Cross' rates went up? I assume that would be beneficial to the competitors.

BY MR. STENERSON:

Q. And do you think -- strike that.

Let me hand you what I'm going to mark as 1307, Blue Cross.

MARKED FOR IDENTIFICATION:

BLUE CROSS EXHIBIT 1307

4:54 p.m.

BY MR. STENERSON:

Q. Blue Cross 1307 is an email correspondence from is it Mr. Albosta?

A. Correct.

Q. To you? And there's a -- I'd like to direct you to the top email. It's dated October 15, 2009. I

believe you're the author, but that's my first question, if you could read -- I can't tell -- and maybe I'll just ask this, if you would read the opening paragraph and tell me if you can --

A. Where are we?

Q. Very top of the page, 1307?

A. Albosta's email to me.

Q. That's my question. Do you think that's an email from

him to you or you to him?
A. That's in Kevin to me.
Q. Okay. So when he says Jerry and I talked to about this yesterday you believe that's a reference to Jerry and Kevin?
A. I'm just, I'm trying to figure out why my name is at the bottom that's confusing but --
Q. That's the source of my question?
A. Yeah. Yeah, Jerry is in Kevin's department so I'm sure that that's the reference they were making.
Q. Okay. So Mr. Albosta continues: I think they might have taken care of some of the issues, but are we comfortable with Joe Aoun's issue of how much market share do we want to give the Blues. Do you see that?
A. I do.
Q. Do you know what that's a reference to?
MR. FABIEN: Objection to the extent we're

seeking, you know, to reveal any legal advice from Joe Aoun. To the extent it's business advice, it's a different matter, but.
BY MR. STENERSON:
Q. Was Mr. Aoun providing business strategy advice to Covenant at this time?
MR. FABIEN: With respect to this issue?
MR. STENERSON: Well, more generally, my question first, and then second was going to be this issue.
A. Could you state it again, please?
Q. Sure. In or around October of '09, was Mr. Aoun

providing business strategy advice to Covenant?
A. I think typically when he gets involved in these contracts he ends up kind of wearing two hats some legal advice and some business.
Q. Okay, let me ask this question and just it's a short answer to the first question so we can listen to your counsel's objection. Do you know, yes or no question. Do you know what this sentence is referring to?
A. I believe I do.
Q. Okay. Second question, on that line, do you believe this issue relates to the business advice that Mr. Aoun was giving you as opposed to legal advice?
A. The second one I'm thinking is simply business advice.

Q. Okay, and by the second one you mean?
A. Reference to market share.
Q. Okay. So what does that refer to?
A. Market share?
Q. No, the specifically the issue Joe Aoun's issue of how much market share do we want to give to the Blues, to what does that refer?
A. By signing a Medicare Advantage contract we're only increasing Blue Cross' market share presence and dominance.
Q. And how is that an issue, was that an issue that you had discussed with Mr. Aoun?
A. Not a legal issue it was just the reality of what we've been talking about all along in terms of wanting to create more competition if Blue Cross not have such a dominant position that kind of flies in the face of

that I guess I don't see that as legal advice.
Q. I agree with you. So had you had conversations with Mr. Aoun about whether or not Covenant should sign a Medicare Advantage PPO agreement with Blue Cross?
A. You're back in this time frame?
Q. Yes, sir.
A. I think we did get some legal advice from Joe as --
MR. FABIEN: Again, just objection to the extent we're talking about legal advice we don't want

to talk about any other legal advice that we may have received.
A. So we did receive legal advice.
BY MR. STENERSON:
Q. Does Mr. Aoun currently provide business consulting advice to Covenant?
A. He provides legal services for the PHO which includes legal advice on contracting.
Q. Okay, so let's go to what has previously been marked as Aetna Gronda 1.
A. Is that the one I have that's not marked?
Q. Yes, sir. So the Bates Number in the bottom corner 566913?
A. Okay.
Q. Specifically, if I could ask you to look at the second page, which is Bates numbered 914.
A. Okay.
Q. And I'm going to try ask the question specifically so I don't elicit an answer about legal advice. If I fail in that regard please tell me and I'm sure your

counsel will not want you to answer those.

MR. FABIEN: Correct.

BY MR. STENERSON:

Q. So in or around December of 2009 you were discussing a favored pricing provision with Blue Cross, correct?

A. Correct.

Q. And ultimately did a favored pricing provision get included in Gronda 2, the LOU that was being negotiated at this time?

A. Yes.

Q. And am I correct in understanding that you executed Gronda 2 on behalf of Covenant?

A. I did.

Q. Okay. And do I also understand that you would not have agreed to any pricing provision that you thought was illegal?

A. Correct.

Q. And I think one of the other lawyers you asked this but at any time since signing the -- strike that.

Okay, so then going back to Aetna Gronda 1, am I correct in understanding that you on behalf of Covenant sought two legal opinions regarding the potential terms of the favored pricing provision with Blue Cross in or around December of '09?

A. Correct.

Q. And one of those legal opinions was from Mr. Aoun?

A. Yes.

Q. And the other was from is it Mr. Forsyth?

A. Jim Forsman.

25 Q. Jim Forsman who at the time was a lawyer at Miller

1 Canfield?
2 A. Correct.
3 Q. And those are the two legal opinions you were
4 referring to in Aetna Gronda 1?
5 A. I am.
6 Q. And in the last sentence of the first paragraph, you
7 state: While they had some concern with the fifteen
8 percent aggregate spread, I am willing to maintain
9 language to that effect. Correct?
10 A. That's what it says.
11 Q. And am I correct in understanding that that fifteen
12 percent aggregate language ultimately did appear in
13 the favored pricing provision?
14 A. It did.
15 Q. In the final agreement?
16 A. Yes.
17 Q. And then prior to that you objected, you know, quote,
18 especially as it relates to the second bullet
19 regarding not altering any other commercial payer
20 contracts. Is that right?
21 A. Yes.
22 Q. And am I correct in understanding that that clause did
23 not appear in the final pricing provision that is
24 represented in Gronda 2?
25 A. That's my recollection.

1 Q. Well, lets particular a look at it, because I want you

to --
A. I that knowledge I know what the second bullet was that's my confusion.
Q. Oh, I see. What do you think the second bullet was.
A. Should I speculate.
MR. FABIEN: Don't speculate.
BY MR. STENERSON:
Q. Well, no, don't speculate but if you have a reasonable belief.
A. I believe it was related to what I said earlier, that the most favored nation clause not only had the aggregate spread, but would have prevented me from contracting at lower rates with any payer regardless of whether they were at 99 percent of charges and I wasn't going to agree to that.
Q. Okay well let me do it this way Mr. Gronda. Separate and I part from whether you specifically remember exactly what the issue was, are you confident that whatever that issue was you were successful in negotiating it out of the agreement?
A. Yes.
Q. And I believe you had testified earlier that you weren't going to give in on it and ultimately Mr. Darland did?

A. That's what I said.
Q. And that's what gives you the confidence that even if your memory is not perfect as to the exact language you were objecting to you're certain that the language you didn't want in was negotiated out Al.