athenahealth

▶ **Our Vision: A national health information backbone that helps healthcare work the way it should.**

Testimony of Dan Haley

Company Description

Born 16 years ago as a women's health clinic, today athenahealth, Inc. ("athenahealth") provides electronic health record ("EHR"), practice management, care coordination, patient communication, data analytics, and related services to physician practices, working with a network of over 40,000 healthcare professionals in every state, serving more than 40 million patients. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our cloud platform affords to our clients a significant advantage over traditional, static software-based health IT products as we work to realize our company vision of a national information backbone enabling healthcare to work as it should. Simply stated, the cloud enables us to coordinate care across providers and geographies, tracking patients, curating and transmitting patient information, and providing granular data analysis—allowing our care provider clients to achieve the benefits of 21st century information technologies that are common in most sectors of the economy, but still relatively rare in healthcare.

Panelist Bio

Dan Haley is athenahealth's Vice President of Government and Regulatory Affairs, responsible for all aspects of the company's interactions with government and government officials at the federal, state, and local levels. Prior to joining athenahealth, Dan was a partner at a global law firm, where his practice focused on government and regulatory affairs and complex commercial litigation. He has held senior positions in a number of statewide political campaigns, and served as Assistant Chief of Staff to Massachusetts Governor Mitt Romney. Dan is a frequent writer, commentator, and blogger on health IT issues and broader federal healthcare policy, and a graduate of Middlebury College and Harvard Law School.

General Remarks

- Many of athena's clients express to us frequently that they want to participate in value-based payment models like Medicare ACO program, but they want to do so without having to become employed by a large health system.
    - Federal policy requirements create an environment where participation in these programs requires management by a full team of administrative and business personnel, as well as tremendous technical resources, large patient panels, and data and granular insight into patient data—not resources that a small, independent practice has.
- According to athena's 2013 Physician Sentiment Index, 78% of physicians are not optimistic about their ability to practice independently or in small groups in the future. Large systems now employ about 25% of physicians; employment of physicians has increased 30% over past few years. [source: Accenture, *Clinical Transformation: New Business Models for a New Era in Healthcare*]
- athena's Independent Risk Manager (IRM) proposal (attached) represents one possible way to fill the gap in federal policy that is inadvertently leaving small group providers behind. It would allow independent physicians to collectively share risk without forming a separate ACO entity, utilizing a health information backbone like athenaNet to outsource the administrative and technical burden of ACO programs.
- By filling this policy gap, the IRM would also address the unintended consequences of the Medicare ACO program: independent physicians sharing risk will not have the perverse incentive

that hospitals and large health systems have to consolidate market share and bring patient volumes in-house.

- Independent physicians sharing risk through an IRM or similar model will achieve cost savings for Medicare while doing well financially on their own and maintaining competition in health care.
- Filling this policy gap as essential, because if left unchecked, market consolidation by hospitals and large health systems will drive health care costs up, not down.
- The IRM is merely one example of the kind of innovative model that federal policy should enable, not impede.
- To enable such models, policymakers should focus less on prescriptive certification standards, and more on broad, outcomes-based measures to evaluate proposed new models.

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IRM: Empowering Independent Practices to Thrive Through Payment Reform

Problem: Participation in Value-based Payment Models Leads to Physician Employment with Large Health Systems, Increased Costs, and Reduced Access to Care

New value-based payment models, such as the Medicare Shared Savings Program under the Affordable Care Act, are meant to encourage new care delivery models to improve quality while decreasing the cost of healthcare. But as implemented those payment models too often incentivize aggressive drives by hospitals and health systems to employ independent physicians, consolidating market share and bringing volume in-house. Most independent physicians want to focus on what motivated them to attend medical school in the first place: caring for patients. While some are perfectly content to become *de facto* business people or employees of large, corporate entities, many prefer to remain autonomous.

The realities of current value-based payment models, however, too often take the choice out of physicians' hands. Participation in these models requires management by a full team of administrative and business personnel, as well as tremendous technical resources, large patient panels, and data and granular insight into patient data. These realities leave independent physicians with little choice but to accept employment with a hospital or large health system, or forego participation in shared savings models. As the healthcare system moves inexorably away from fee-for-service, in truth this is no choice at all; estimates show that in the past several years up to one-third of physicians have moved from independent practice to employment.[i] Physician employment has been associated with a significant drop in productivity. Hospitals lose $150,000 to $250,000 per year over the first 3 years of employing a physician and must make this up in inpatient revenue.[ii] Given the existing shortage of primary care providers, and the relative inelasticity of the nation's physician pool, this will likely ultimately lead to a reduction in access to care.

Furthermore, the law and regulatory guidance gives hospital and health-systems that form Accountable Care Organizations (ACOs) express permission to collectively negotiate contracts with payers on behalf of their members without concern for ordinary antitrust enforcement. [iii] As a result, the animating policy imperatives of care coordination and cost savings that underlie shared savings models are subordinated to the imperative to bring ever-higher volume in-house.

Unlike their health system counterparts, if enabled to participate in shared savings programs, independent physicians will be truly incented to coordinate care with high-value providers, in turn leading to reduced costs and increased quality—and fulfilling the goals of value-based reimbursement models.

Solution: Third Party Independent Risk Managers, To Enable Physicians to Stay Independent and Share Risk, Resulting in Higher Quality and Lower Cost Care

Congress and CMS should support the creation of an Independent Risk Manager (IRM) model, enabling physicians to thrive in value-based payment models without sacrificing their independence, by empowering third parties to relieve them of the administrative and technological burdens of participation in shared savings. An IRM will be an entity that is organizationally independent from healthcare providers and payers, with the IT infrastructure and expertise to provide the risk-pooling, contracting, care coordination, and care management services necessary to manage patient populations that are currently too costly for small physician practices.

IRM Guiding Principles

- **Independence**: Physicians should be empowered to transition toward value-based payment models while remaining independent if they so choose—including from the constraints of preferred referral relationships that exist within health systems. The IRM model will allow independent physicians to coordinate care along the entire care continuum, regardless of patient or provider health system affiliation.
- **Accountability**: Physicians should be accountable for delivering efficient and high quality care, in value-based reimbursement models, and there should be attainable financial benefits for successfully realizing these objectives. The IRM model will incorporate accountability standards, enabling physicians to make the right decisions clinically and financially, while remaining independent.
- **Security**: To successfully transfer from fee-for-service to a shared savings model while maintaining their independence, physicians must be—and feel—financially secure. Physician employment is on the rise at least in part because the administrative and logistical difficulty of assuming risk has physicians seeking shelter in large groups. To enable physicians who choose to do so to remain independent while holding them to accountability standards, the IRM model will offer physicians security in their financial and clinical ability to transition toward value-based payment models by relieving them of both the administrative burdens and the often-crippling up-front cost to participation in currently-available models.

In furtherance of these guiding principles, an IRM will:

1. Use claims data to identify independent physician practices caring for similar patient populations and convene those practices into networks that can collectively share risk.
2. Facilitate patient-centric clinical integration (information sharing across the care continuum) and care management among networks of physicians to enable successful risk sharing.
3. Provide the quality measurement, benchmarking, and reporting necessary to give networks of physicians and contracting payers insight into how they are performing against value-based reimbursement contracts.

An IRM will also administer a new, unique reimbursement model that specifically allows physicians to assume risk while remaining independent, being held accountable for quality and efficiency, and maintaining the professional security necessary to thrive in a value-based system.

Details: How IRMs Will Operate

1. Use claims data to identify independent primary care physician practices caring for similar patient populations and convene those practices into networks that can collectively share risk.

- IRMs will have access to CMS and private payer claims data for the patients attributed to their participating practices.
- IRMs will gather and analyze claims and other types of clinical and practice management data for participating physician practices to "match" together practices that could successfully share risk.
    - IRMs will have qualified staff (data analysts, quality managers, etc.) with expertise in measuring quality, efficiency, effectiveness, and resource use.
    - IRMs will be required to comply strictly with all applicable HIPAA data privacy and security requirements.
    - IRMs will analyze data to give physician practices a comparison of different reimbursement contracts in which they can choose to participate (such as bundled payments or shared savings).
    - IRMs may negotiate these value-based contracts on behalf of providers.

2. Facilitate patient-centric clinical integration (information sharing across the care continuum) and care management among networks of physicians to enable the utilization management necessary to successfully share risk.

- IRMs will provide patient communication technology, enabling patients to have access to their healthcare information and allowing practices to engage with patients.
- IRMs will provide platforms on which to exchange clinical data across the care continuum.
- IRM analytics will allow practices to understand external costs and utilization across patient populations.
- IRMs will facilitate the selection of the lowest cost and highest quality providers by providing insight at the point of care into downstream and secondary costs, as well as data to help practices reduce overutilization and duplication of services.
- IRMs will provide care management platforms to help providers identify the sickest and most costly patients, enroll those patients in a care management program, and deploy advanced care and disease management solutions.
- IRMs will integrate with electronic health record (EHR) and other health information technology. IRMs will be technology and vendor agnostic, enabling cross-vendor clinical integration and care coordination across participating physicians' EHRs.

3. Provide the quality measurement, benchmarking, and reporting necessary to give networks of physicians insight into their performance against value-based reimbursement contracts.

- The IRM platform will incorporate the quality metrics required by the reimbursement contracts so that the metrics can be tracked and measured in the clinical workflow of the physician practices.
- IRM analytics will allow practices to access a complete picture of quality by benchmarking physician and practice-level performance against peer groups and against targets set by reimbursement contracts.
- The IRM platform will streamline the process of reporting on quality measurements back to payers in accordance with payer requirements.

DETAILS: IRM REIMBURSEMENT MODEL

To maintain the independence, accountability, and security that physicians need, physician reimbursement in the IRM model will have the following characteristics:

- Empowering physicians to remain independent while assuming risk:
    - Physicians' current individual profits and losses will be used as a starting benchmark.
    - As in the ACO model, potential savings will be shared among the IRM risk-sharing pool of providers.
        - Gains will not be strictly shared, but rather will be distributed among IRM providers that realize savings in a given year.
- Holding physicians accountable for delivering efficient and high quality care:
    - Quality and efficiency mechanisms, such as a physician quality metric scorecard, will be used to drive behavior change among participating physicians and to hold physicians accountable to clear outcomes-based targets.
- Providing security to physicians as they assume risk:
    - Revenue will be risk adjusted so that physicians with sicker patient populations do not bear a disproportionate amount of risk.

- Reinsurance thresholds will be incorporated so that small, independent physician practices do not risk losing their practices as a result of catastrophic patient issues.

REQUIRED REGULATORY ACTION

Several legal and regulatory changes are needed to enable establishment of the IRM model:

IRM Access to CMS Claims Data

- IRMs must be authorized to access CMS claims data for beneficiaries attributed to the primary care physicians belonging to each IRM.
  - Aggregated claims data will enable IRMs to provide physicians with insight to pool risk and to understand cost and quality among their physician networks.
  - Beneficiary-identifiable data will enable IRMs to provide physicians with insight to understand and act on cost, quality, and utilization at the patient level.
- Beneficiary attribution will be prospective.

IRMs and HIPAA *Compliance*

- IRMs, and business associates of physician practices, must be explicitly and uniformly required to comply with all applicable HIPAA requirements.
  - Use of participation and data use agreements between IRMs and CMS will bolster existing HIPAA protections.
  - The new HIPAA omnibus rule, released in January 2013 to implement HITECH Act provisions, ensures that Protected Health Information (PHI) is handled appropriately and that strict penalties are enforced for breaches of PHI.
- IRMs will be health services and technology vendors that already have robust HIPAA compliance programs in place.

Stark Laws, Anti-Kickback Statute and Anti-Trust Waivers for IRM Participating Physicians

- Stark, Anti-Kickback Statute (AKS) and anti-trust waivers are needed to alleviate concerns when physicians are sharing savings and maintaining a coordinated referral network.
- It is appropriate to extend these waivers (which already apply in the ACO context) to physicians participating in the IRM payment model since they will be transitioning away from fee-for-service reimbursement and their clinical decisions regarding patient referrals will be driven by the goal of delivering high-quality and well-coordinated care.

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[i] Accenture, *Clinical Transformation: New Business Models for a New Era in Healthcare,* 2012.
[ii] Robert Kocher, M.D., and Nikhil R. Sahni, B.S., *Hospitals' Race to Employ Physicians: The Logic behind a Money-Losing Proposition,* New England Journal of Medicine 364; 19, 2011.

Additional Reading
Molly Gamble, *How Has the Rise of Physician Employment Changed Hospitals' Recruitment Strategies?*, becker's Hospital Review, Nov. 29, 2012. http://www.beckershospitalreview.com/hospital-physician-relationships/how-has-the-rise-of-physician-employment-changed-hospitals-recruitment-strategies.html
References
[iii] Federal Trade Commission and Department of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program,* 76 Fed. Reg. 67,025, Oct. 28, 2011.