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April 30, 2015

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Submitted via https://ftcpublic.commentworks.com/ftc/examhealthcareworkshop/

Re: Health Care Workshop, Project No. P131207

Dear Secretary Clark and Assistant Attorney General Baer,

athenahealth, Inc ("athenahealth") appreciates the opportunity to provide comments to the Federal Trade Commission ("FTC") in response to its second public workshop in the series, "Examining Health Care Competition," co-hosted by the Department of Justice, Antitrust Division ("DOJ"). We appreciate FTC and DOJ's continued attention to vendor and provider organization practices that may stifle competition and interfere with consumer choice in the health information technology sector.

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 more than 60,000 healthcare professionals who serve over 60 million patients in all 50 states. We envision and work to establish a nationwide health information backbone that makes healthcare work as it should by connecting patients and care providers with the information they need to seek and provide high-quality, cost-effective, efficient care. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our clients' successes, exemplified by a Meaningful Use attestation rate more than double the national average, underscore the very real potential of health IT to improve care delivery and patient outcomes while increasing efficiency and reducing systemic costs.

The FTC has expressed concern over rapid market consolidation and potentially anticompetitive behavior spurred in part by unintended side effects of the nation's slow transition from fee-for-service to value-based care. We, and more importantly many of our care provider clients, share this concern. Well-intentioned public policy intended to foster technological modernization and information sharing in healthcare is in practice creating or enhancing financial *dis*-incentives to information sharing, and/or affording incumbent health IT vendors new mechanisms to consolidate and hold market share by controlling patient and care provider data in direct

contravention of bipartisan public policy objectives and the public interest. The competitive implications of these unintended consequences are significant.

While we are broadly interested in the entire scope of the questions presented, we limit our formal comments to two interrelated subject areas about which our clients have expressed particular concern and interest:

1) **Anti-trust waivers intended to encourage participation in value-based models impede patient choice and incentivize the adoption of closed information networks.**

On a bipartisan and bicameral basis Congress has recognized that successful care coordination requires closer relationships between care providers than might ordinarily exist in a fee-for-service world. In recognition of this truth and to enable those relationships, Congress and regulators effectively exempted Accountable Care Organizations (ACOs) from standard antitrust scrutiny.

Unfortunately, the resulting aggressive consolidation has created perverse market incentives for closed, proprietary health information technology systems that impede the sharing and availability of health information, and the purveyors of such closed systems frequently leverage those perverse incentives in ways that deprive care providers of choice. These vendors convince large care provider entities that in order to effectively coordinate care and maintain patient volume, they must adopt information systems that do not interoperate—closed networks—and use those systems to make their care networks "sticky." The often-unwritten logic runs as follows: care providers who are "on" the closed information network will be able to make and receive referrals within the care network. Those who are not… cannot. When this logic is communicated to care providers the effect can be highly compulsory. Effectively, these providers are often faced with a stark choice: abandon their preferred information technology in deference to the choice of the dominant market actor, or face a potentially devastating loss of referral volume. This not only perverts the health information technology market in a way that harms the commercial prospects of vendors that produce open systems; it impedes patient care and drives up systemic costs by depriving both patients and care providers of choice.

The end result is that a policy decision—the anti-trust exemption attendant to the federal ACO model—intended to increase information sharing and care coordination ultimately encourages the creation and maintenance of "data silos" that actively impede broad information sharing across platforms, networks, and geographies and lock providers into care environments that they might otherwise not choose, and technology platforms that do not improve patient care.

2) **Value-based models should be structured with enough breadth and flexibility to ensure that independent providers can participate.**

Many of our client providers operate in small, independent practices that for a number of reasons frequently find themselves unable under current law and regulations to keep pace with changes in care delivery and reimbursement attendant to health reform. The administrative and technological burdens associated with payment reform leave independent providers with little choice but to accept employment with a hospital or large health system, or forego participation in new value-based models. As a result, physicians are choosing employment at a rapid pace, often against their will. This problem is by no means limited to our client base: according to a

2012 report by Accenture, the number of independent physicians has decreased by one-third in the past few years.[1]

This unintended exclusion of independent and small practice care providers from current value-based models exacerbates the market consolidation, data lock-in, and reduction in patient choice described above. To correct for those unintended consequences, new value-based payment models must be developed with less of a one-size-fits-all approach. Providers must be given the flexibility to implement creative solutions that enable them to bear financial risk for the health of their patients in a way that best fits the specifics of their practice.

athenahealth has, in consultation with its clients, developed the attached proposal for an Independent Risk Manager ("IRM") model of accountable care that could be implemented if providers and technologists were afforded the necessary degree of legal and regulatory flexibility to deviate from the specific requirements of the Medicare Shared Savings ACO Program. We believe models like the one conceptualized in this proposal could address many of the FTC's concerns expressed in the present workshop. An IRM would enable independent and small group platforms to leverage 21st century information technology to assume and share risk cost-effectively, empowering them to participate in all payment reform models without forcing them into employment with large groups (which in the rural context is often not an option in the first instance). We are pleased to note that the recently-signed Sustainable Growth Rate ("SGR") repeal legislation takes significant steps toward implementation of the necessary flexibility to implement creative new value-based models, however achievement of the objectives of accountable care will require a sustained and cross-governmental focus.

We applaud the FTC and DOJ for looking into areas where payment reform has created unintended incentives to consolidate market share and to block the exchange of health information. We stand ready to assist in the next phase of this effort by answering questions and by providing any additional input. Thank you again for the opportunity to comment.

Sincerely,

Dan Haley
Vice President
Government and Regulatory Affairs

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[1] Accenture, *Clinical Transformation: New Business Models for a New Era in Healthcare,* 2012. http://www.accenture.com/sitecollectiondocuments/pdf/accenture-clinical-transformation-new-business-models-for-a-new-era-in-healthcare.pdf

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.