athenahealth

May 16, 2013

The Honorable John Thune
United States Senator
511 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Richard Burr
United States Senator
217 Russell Senate Office Building
Washington, DC 20510

The Honorable Lamar Alexander
United States Senator
455 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Tom Coburn
United States Senator
172 Russell Senate Office Building
Washington, DC 20510

The Honorable Pat Roberts
United States Senator
109 Hart Senate Office Building
Washington, DC 20510

The Honorable Mike Enzi
United States Senator
379A Russell Senate Office Building
Washington, DC 20510

Submitted electronically via HealthIT_CommentPeriod@thune.senate.gov

Re: Response of athenahealth, Inc. to "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT"

Dear Senators:

athenahealth, Inc. ("athenahealth") appreciates the opportunity to provide comments on the adoption of health information technology ("health IT") and the development of standards to accelerate health information exchange. Your white paper, "REBOOT: Re-examining Strategies Needed to Successfully Adopt Health IT," ("REBOOT") represents much needed federal recognition of some of the failures of health IT policy and, in candor, of our own industry. We are eager to engage with you actively in this important conversation. We have begun to reach out to each of your offices, and will be pleased at your convenience to meet with your staff either individually or collectively to discuss these issues in greater depth.

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 nearly every state. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our cloud platform affords to us and 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. It is also the differentiator that explains many of the distinct points of view that we hold on the important topics raised REBOOT as compared to many other members of our industry.

Our platform has enabled us to take an active role in assisting our clients to achieve clinical and financial success. For example, we partner with our clients and monitor their progress against the

Meaningful Use ("MU") program measures in real time, resulting in attestation rates significantly above industry norms (fully 96% of our participating providers successfully achieved meaningful use in Stage 1, as compared to a national average below fifty percent). Additionally, our care coordination service creates incentives for us and our clients to ensure that the right health information gets to the right point of care at the right time.

We agree emphatically with many of the core points raised in REBOOT, most especially this: current government policy emphasizes adoption and payment of incentive dollars over actual progress toward the supposedly universal goal of interoperability, and in the process may be inadvertently perpetuating the non-interoperable status quo. At athenahealth, we believe that interoperation is an absolute prerequisite for true "meaningful use" of health HIT and, further, that the best way for government to encourage and advance true meaningful use of health IT is by removing existing impediments to interoperability and health information exchange ("HIE") in current policy, regulation, and law. Government is no better able or equipped than the private sector to predict the evolution of technology and innovation, or to prescribe and/or mandate specific means and conditions to enable the eventual seamless exchange of information in healthcare. Instead, government rules and actions should be focused much more on desired outcomes—including actual interoperation between vendor platforms—and less on specific prescriptions as to how those outcomes are to be met.

In our view there are three actions that government stakeholders could take in short order to make significant progress towards the shared goal of truly "meaningful use" of health IT:

(1) Focus and realign MU incentives and tighten the definition of "meaningful use" to end de facto government subsidies for technologies that do not (and often cannot) help achieve those goals.

Taxpayer dollars that enable the purchase of obsolete technology that cannot interoperate or contribute to cross-platform HIE, and that must be replaced in few years, are wasted taxpayer dollars. Taxpayer dollars that subsidize the purchase of cutting edge technology that is deliberately designed to be unable to interoperate with other platforms are, likewise, wasted dollars (if interoperability is in fact the goal motivating the expenditure). Surely no policymakers intended the MU incentives program to subsidize technological dinosaurs with federal dollars, just as nobody intended MU dollars to fund proprietary information silos, locking doctors, patients, and information into closed systems and driving up costs. But as the REBOOT paper properly recognizes, both of these unintended consequences are happening, and both are impeding progress toward interoperability. CMS and ONC should focus the impact of subsidies by tightening the definition of "meaningful use" to require actual interoperation (an outcome, as opposed to merely theoretical "interoperability") between vendor systems, while avoiding specific prescriptions that could inadvertently hamper innovators as they work to achieve this goal.

We disagree with REBOOT, however, on the advisability of repeated delays in implementation of the successive stages of the MU program. In our view, government should resist calls made by technological laggards and those using technology to consolidate market share to slow MU timelines and lower standards. To advance interoperability and achieve HIE exactly the opposite—aggressive timelines and high, outcomes-focused standards—are necessary. The REBOOT paper suggests that MU requirements should not be the same for all providers and that even Stage 1 of MU included unachievable aims. However, the experience of athenahealth providers supports a much different conclusion.

Last year, 96% of athenahealth clients that enrolled in the MU program successfully attested, compared to the national average of only about 40%. athenahealth's data, which closely tracks each attestation metric to ensure actual achievement, shows that practices of all sizes, whether solo doctors or large multi-specialty groups, are equally successful in attesting for MU (in fact, the small practices tend to outperform the larger ones). Approximately 30% of athenahealth clients who have attested to MU to date only began using athenahealth's EHR the same year in which they were successful. As these numbers demonstrate, the current MU measures are in fact relatively easy to meet, assuming the correct technological tools are leveraged. Virtually anyone who has visited a doctor or a hospital will confirm that health IT lags years behind the rest of the information economy, and in most contexts the best tools are not yet used. Slowing down is not the way to catch up.

Of course, any one-size-fits-all environment must ensure that the one size is the right size. Unfortunately, the current MU program is entirely focused on functionality-based measures, as opposed to measuring true outcomes, and the program will therefore continue to be in some ways a waste of taxpayer funds until fundamental changes are made.

We applaud REBOOT's authors for recognizing that money spent on MU incentives is not an accurate measure of success of the MU program; it may, in fact, be exactly the opposite. athenahealth believes in the power of free markets. We do not advocate for government action intended to disadvantage our competitors in the health IT marketplace. If, however, the over-arching goal of federal health IT policy is to spur creation of a framework for true interoperation in healthcare, then at a minimum government should stop subsidizing technologies that either cannot support achievement of that goal or—worse—that deliberately undermine the likelihood of its achievement.

(2) Support modernization of the Anti-Kickback Act and the Stark Laws to encourage payment reform and to enable a true, functioning market for the exchange of health information.

Policymakers frequently acknowledge the fact that in order for a major sea change in any learned behavior to occur, there needs to be a financial incentive for that behavior to change. What are federal incentive payments to spur EHR adoption, after all, if not acknowledgement of that truth? But temporary, targeted incentives can only motivate so much change. And as the REBOOT paper correctly notes, government cannot (and should not) subsidize behaviors in perpetuity.

To incentivize systemic, lasting health information exchange, government must enable a functioning market for health information by allowing the custodians/curators of data to charge a fair market fee to deliver to recipients exactly the information that is needed, in the form requested. Where a functioning market for information exists, standards for the interoperable exchange of that information follow—in finance, insurance, even auto parts—but not in healthcare.

Like the industry's prevalent technology, the current conception of market dynamics in healthcare remains far behind the times. Under laws intended to prevent self-dealing in referrals, specifically the Anti-Kickback Act and the Stark Laws, a fee paid for quality information could be deemed a "kickback." As a result, virtually nobody curates the vast stores of electronic patient data that we are steadily amassing (including in government-supported Health Information Exchanges (HIEs), and nobody leverages the power of that data to reduce costs, increase efficiency, and improve care—because nobody is allowed a financial incentive to do so. That needs to change.

Today, though referring providers have a supply of patient health information and providers receiving referrals have a demand for that information, lack of clarity under the Anti-Kickback and Stark laws discourage transaction-based payment models for care coordination between referring and receiving providers.

As a result of the legal prohibition on paying for the value inherent in curated information, referring providers have no incentive to send curated information regarding the patient to the receiving provider. This makes it more likely that the receiving provider will duplicate tests and services (or hand the patient a clipboard) that could have been eliminated if previous data and test results were shared through electronic information exchange.

If transaction-based payment models were expressly permitted by law the development of an open and sustainable market for HIE would follow, allowing providers to pay for the benefit of the information they receive. The success of such models has been demonstrated in other spaces, such as finance and the internet, where standards for information exchange developed quickly once an open market for exchange was established. Again, health IT lags the rest of the information economy; government should remove impediments to catching up.

A functioning, two-sided market for HIE would not only spark a revolution in such exchange, it would also fund itself with nary a taxpayer dollar required, much less wasted.

(3) Promote technologies, such as web-based platforms, that can help to quickly realize the goals of health reform.

There exists a common misconception that the imperatives of innovation and other policy goals, such as quality, efficiency, safety, and security, must be balanced, as if these objectives were mutually exclusive. To the contrary, athenahealth believes that innovation must be promoted to achieve higher levels of safety and security within health IT. For that reason, we encourage government to promote innovative technologies, such as web-based platforms, while simultaneously ending its subsidy of outdated technology that cannot deliver the levels of innovation needed to realize the goals of health reform, or that deliberately contravene those goals.

Outdated, static software based technologies simply cannot achieve the goals of the MU program or the broader aims of health reform. Innovative technologies, such as web-based platforms, have the power to truly transform our health care system in the same way that they have revolutionized information technology and fueled an explosion in the seamless, secure sharing and exchange of information across the rest of our economy.

When every user of an information network is on the same cloud platform, there are significant advantages with respect to interoperability, data security, and patient safety, and even fraud detection:

- Because uniform interoperability standards do not yet exist, cloud platforms create economies of scale for users. The same interface infrastructure can be used across entire client bases, whereas static software requires that separate interfaces be built between every installed instance of that software—a costly proposition that, again, is obsolete in most other segments of the economy.

- This economy of scale principle also applies to data security, because cloud vendors extend the benefit of world class data security experts and infrastructure to every user of their system, allowing even solo doctors to have the same data security as large health systems.
- Because changes can be made to web-based software and implemented across thousands of users instantly, cloud vendors can be much more responsive to patient safety issues than vendors of static software.
- The data collection and analysis that is an inherent characteristic of a cloud-based platform provides cloud vendors with real time insight into client billing patterns that simply cannot be achieved by static systems. We disagree with the notion that technologies designed and implemented to create efficiencies and reduce administrative workload can or should properly be blamed for deliberate misuse by human beings who are, in the end, responsible for deliberate acts of fraud whether committed using a pen and paper or a sophisticated billing application. However, we strongly believe that information technology can be used to detect and prevent irregular billing or outright fraud.

We are fully committed to achieving true, widespread interoperation between vendor platforms, which is why even as we work to achieve our corporate vision of a national health information backbone, we are a founding member of the CommonWell Health Alliance, an independent, not-for-profit trade association focused on creation and promotion of standards to support cross-platform interoperation.

In closing, we at athenahealth are extremely appreciative of the thoughtful analysis and constructive criticisms set forth in REBOOT. We agree that there are serious and costly deficiencies in the current MU program, but also that the program is achieving worthwhile results and should be improved rather than ended. The prescriptions set forth above are the result of months of internal analysis of our own results, conversations with countless of our care provider clients, and dozens of interactions with policymakers (including staff in your offices). We look forward to continuing to engage with you on these important issues, and appreciate the opportunity to provide our comments.

Sincerely,

Dan Haley
Vice President, Government and Regulatory Affairs
athenahealth
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