August 12, 2014

Chairman Ron Wyden
Finance Committee
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20515

Senator Chuck Grassley
Finance Committee
United States Senate
135 Hart Senate Office Building
Washington, DC 20515

Via data@finance.senate.gov

Re: **Improving Health Care Through Data Availability and Transparency**

Dear Chairman Wyden and Senator Grassley,

athenahealth, Inc. ("athenahealth") appreciates the opportunity to respond to your request for input regarding the availability and utility of health care data. Recent steps toward greater availability of health data to date have been due in large part to your leadership on this issue, and we look forward to continuing to work with your offices to continue that trend.

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 50,000 health care professionals who serve approximately 50 million patients in all 50 states. All of our providers access our services on the same instance of continuously-updated, cloud-based software. As a result, we maintain one of the largest real-time health information databases in the country. This data, and our ability to leverage it in real time, affords to us and our clients significant insights to improve care delivery and help us realize our company vision of a national information backbone enabling healthcare to work as it should.

Our clients are ambulatory practices, ranging from small groups and solo physicians to large health systems employing thousands of providers. They participate in Accountable Care Organizations ("ACOs"), pay-for-performance programs, and a variety of other payment reforms that require a focus on making high quality, cost-effective care decisions. Internal athenahealth teams use data from our 50,000 providers to improve the intelligence of our cloud-based platform on a daily basis, ensuring that the lessons learned by one client become lessons learned for all. Our team of researchers is charged with using our de-identified data to publish relevant findings, such as where flu is spiking across the country or how the implementation of the Affordable Care Act is impacting patient access. It is with this

experience in mind that we provide our perspective on the questions you posed in your June 12th letter about the availability of health care data.

1. What data sources should be made more broadly available?

The potential of health care-related data—and Medicare claims data in particular—to revolutionize our health care system cannot be understated. Physicians are increasingly held accountable for the cost and quality of care through programs such as Medicare Shared Savings, but we have a long way to go before "shopping" for affordable care options becomes routine for physicians and their patients. Releasing Medicare claims data to the public is a necessary step towards that goal.

Over the past two years, the Centers for Medicare and Medicaid Services ("CMS") have made great strides toward increasing the availability of Medicare claims data, but data release necessarily begs the question: why not release the database in its entirety, subject to appropriate restrictions on use and sanctions for misuse? Periodic releases of subsets of the Medicare paid claims database frustrate care givers, patients, and their service providers looking to make more informed care decisions. To realize our collective vision of a reformed health care system, Medicare paid claims data must be made fully available to stakeholders.

2. How, in what form, and for what purpose should this data be conveyed?

The potential benefits of 'data liberation' to individuals are only a small part of the rationale for revising current policy to allow for release of this data. The real value of public Medicare and other data will be realized through the innovation that it catalyzes. Technology developers and researchers are more likely to initially consume of this data than patients and physicians. Release by CMS of the Medicare claims data will trigger a proliferation of new technological tools to help physicians and patients make well-educated care decisions, such as apps that show patients' cost responsibility at various care providers or analytics built into health IT workflows that show complete downstream care costs. These technologies, already common in nearly every other sector of our data-driven economy, are desperately needed in health care.

The Medicare claims data released to the public to date identify providers but is de-identified at the patient level. Privacy considerations appropriately dictate that publicly released data be carefully de-identified so that patient identity cannot be reverse engineered. However, identifiable patient claims data should be released to the covered entities under the Health Insurance Portability and Accountability Act ("HIPAA") that provide care for a patient, since those entities are already legally required to carefully protect patient data. Without patient identity, Medicare claims data cannot be used to coordinate care and reduce overutilization—two necessary objectives in successful health reform. In fact, patient-identifiable claims data are released to Medicare Shared Savings Program ACOs in recognition of this reality. The same data should be released to all care providers taking on risk for their patient populations.

3. What reforms would help reduce the unnecessary fragmentation of health care data? What reforms would improve the accessibility and usability of health care data for consumers, payers, and providers?

Congress should ensure that CMS is not overly reliant on programs such as the Medicare Shared Savings Program or Innovation Center demonstrations to release claims data for the purpose of promoting

value-based care. Medicare ACOs and other physician groups in certain demonstration programs currently can access claims data for attributed beneficiaries, but limiting access to these groups excludes other providers—largely independently practicing physicians—from participating in the transition away from fee-for-service reimbursement. Paid claims data should be made available to the consultants, health IT providers, or other third parties that work on behalf of such physicians. These third party entities could act as virtual ACOs, using claims data to provide care coordination and utilization management services that today are completely out of reach for many solo physicians and small practices that still provide care to much of the nation's underserved populations. Put simply, the availability of claims data should not be limited to providers, nor should it be limited to certain programs.

athenahealth has developed a proposal for a new value-based delivery model for independent physicians that serves as an excellent example of the type of innovation that could result from broader availability of Medicare claims data. An Independent Risk Manager ("IRM") would enable independent and small group practices to leverage claims data and 21st century information technology to assume and share risk cost-effectively, empowering them to participate in 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). However, access to Medicare claims data is one of the biggest barriers to the creation of the IRM model, which is not permitted under current law. We have attached our IRM proposal to these comments for your reference.

4. What barriers stand in the way of stakeholders using existing data sources more effectively and what reforms should be made to overcome these barriers?

In releasing claims or other data to fuel innovation, it is important that Congress not draw arbitrary distinctions with respect to types of entities that are eligible to access paid claims data. The Qualified Entity program under Section 10332 of the Affordable Care Act is a positive first step toward greater data transparency, but it contains a fatal flaw in that disallows any use of CMS paid claims data other than for the provision of free public reports on cost and quality. This is a *de facto* prohibition on for-profit entities building business models around claims data analytics, a huge deterrent to the very innovation that has the potential to control costs in health care. In contemplating the release of claims data, Congress should explicitly reverse this policy and determine the best way to ensure that all entities—public or private, for-profit or not—can access the data in service of their patient and physician clients, with appropriate safeguards against and penalties for abuse of data access.

Additionally, Congress should take steps to address an inconsistency that currently exists between HIPAA and CMS policy regarding the use of claims data. When patient-identifiable claims data are released to an ACO, the data use agreement between the ACO and CMS allows the ACO to integrate the claims data into the medical record (See Section A-2 of Attachment A of the attached CMS Data Use Agreement), but it also requires that the ACO delete the CMS claims data after one year (see Section 6 of the attached CMS Data Use Agreement). However, once integrated into the medical record, HIPAA requires that PHI be maintained for six years—an explicit and irreconcilable conflict with the one year deletion requirement in the Data Use Agreement (45 C.F.R. § 164.316(b)(2)(i)). This forces data recipients in effect to choose between violation of their data use agreements or violation of HIPAA. There are significant advantages to patient care when claims data are integrated into the medical record. Care coordination can be improved by enabling providers to see how patients move through the care continuum, clinical information can be reconciled from disparate sources, and overutilization can

be minimized. Congress should ensure that this inconsistency is resolved and not perpetuated in future value-based care models.

athenahealth strongly supports your offices' ongoing data liberation efforts and appreciates the opportunity to provide feedback on how to best include paid claims data in those efforts. Data transparency is and has always been at the core of our business. We look forward to working with you in the future on these very important initiatives.

Sincerely,

Dan Haley
Vice President
Government and Regulatory Affairs

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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.

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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.

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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.

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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.