athenahealth

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Federal Trade Commission
Office of the Secretary
Room H-133 (Annex X)
600 Pennsylvania Ave NW
Washington, DC 20580

Submitted electronically via https://ftcpublic.commentworks.com/ftc/healthcareworkshop

Re: **Health Care Workshop Project No. P131207**

To whom it may concern;

athenahealth, Inc. ("athenahealth") appreciated the opportunity to provide oral testimony during the recent Public Workshop, "Examining Health Care Competition," as part of the "Advancements in Health Care Technology" panel.[1] These comments reiterate and expand upon that oral testimony.

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 healthcare 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. 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. 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 Commission asks, "[t]o what extent are information technology vendors and health care providers sharing patient health information? Are there significant impediments to the useful flow of patient health information to improve health care coordination and policy?" The answers to these questions are: (a) in 2014, nearly half way through the second decade of the 21st century, the state of information sharing in healthcare lags woefully behind information sharing in virtually every other sector of our economy; and (b) yes, there are significant impediments to information flow in healthcare—many of them the unintended consequences of well-intentioned public policy decisions.

Indeed, if there is a theme to these comments it is this: in important and impactful ways, well-intentioned public policy intended to foster technological modernization and information-

[1] Video and transcript of the panel available here: http://www.ftc.gov/news-events/audio-video/video/examining-health-care-competition-workshop-part-3

sharing in healthcare is in practice creating or enhancing financial *dis*-incentives to information-sharing, and/or affording incumbent industry actors new mechanisms to consolidate and hold market share by controlling patient and care provider data. The competitive implications of these unintended consequences are significant. Specific examples of this phenomenon are not difficult to find:

1. **The Meaningful Use ("MU") program as currently structured impedes information sharing by subsidizing technologies that do not share information.**

To-date, approximately 24 billion federal dollars have been spent under the auspices of the MU program administered by the Office of the National Coordinator for Health Information Technology ("ONC") to subsidize the adoption and "meaningful use" of health IT by care providers. The most common question we are asked by policymakers is why, in light of this very significant expenditure, are so few care providers able to share patient information?

There is a very simple answer to that question: too many of those federal dollars have subsidized the adoption of systems that either cannot or deliberately do not interoperate outside of proprietary vendor platforms, perpetuating the non-interoperable status quo that the program is intended to change. There are legitimate market demands for closed information networks in healthcare (discussed further below). If, however, an overriding objective of federal health IT policy is to foster data fluidity and information sharing in healthcare, then at a minimum federal dollars should not be spent to subsidize the acquisition and use of technologies that cannot or do not enable providers to share information outside of proprietary networks. Indeed, the same arm of government that disburses those subsidies is now defining as a "hardship" the use of some of the very systems that have been subsidized, to allow providers a mechanism to avoid scheduled reimbursement penalties for failure to successfully attest to "meaningful use" due to vendor failings. To say that fact is a glaring indictment of current MU policy is an obvious understatement.

Actual interoperation (as distinguished from the mere capability of "interoperability") should be a baseline prerequisite for MU certification. Until it is, the federal government will continue to pay for systems that impede one of the few bipartisan, bicameral objectives of health care reform. More to the point for present purposes, existing policy artificially distorts the EHR marketplace, providing a taxpayer-funded subsidy for technology platforms that do not meet the basic standards of 21st century information technology, and that absent that market distortion would more quickly be phased out by ordinary market competition.

2. **The pending one-year MU attestation period will exacerbate vendor lock.**

Beginning in 2015, providers participating in the MU program will no longer have the current option of a 90-day attestation period. This means that participating providers will have to attest to meaningful use of an EHR over the entirety of a 12-month period.

There has been much industry media attention of late to prognostications of a pending "great EHR switch" in the course of which, the theory goes, providers currently using inferior, non-interoperable platforms will upgrade to modern, interoperable ones. This expectation has been heightened recently by the inability of many vendors to prepare their clients for MU stage 2, resulting in the "hardship" exemptions noted immediately above.

Perversely, the imposition of a 12-month attestation requirement will inhibit this much-needed collective upgrade. When subject to a full year attestation requirement a provider currently desiring to upgrade to a new EHR platform will be forced either to forego the ability to attest to meaningful use, or forego the upgrade.

This is another example of well-intentioned policy having the unintended, anti-competitive effect of shoring up market share of current incumbents, despite underperformance issues that would in an undistorted market contribute to the long-foreseen "great EHR switch." To correct for this unintended consequence, providers switching EHRs during an attestation period should be afforded either the option of a shorter period, or the ability to aggregate attestation data from both their replaced EHRs and their new EHRs.

3. **Anti-trust waivers intended to encourage participation in value-based models impede information sharing and enable closed information networks.**

The federal government has long since recognized that successful care coordination, correctly (in our view) thought necessary to improve outcomes and reduce costs in healthcare and progress beyond fee-for-service, require waivers and safe harbors against enforcement of laws enacted to prevent unfair competition and/or fraud and abuse in the fee-for-service system. Safe harbors from enforcement of the Stark Laws and the Anti-Kickback Statute are necessary to enable the inter-provider relationships required to form and maintain an Accountable Care Organization, for example. So, too, is the statutory exemption from ordinary anti-trust scrutiny attendant to the ACO model.

Unfortunately, this anti-trust waiver is also indirectly an impediment to information sharing in healthcare. Across the country, large care provider entities form ACOs and take advantage of the much lesser degree of antitrust scrutiny to consolidate market share with an aggressiveness that would not withstand ordinary antitrust analysis. They then adopt non-interoperable information systems—closed networks—and use those systems to make their care networks "sticky." Care providers who are "on" the closed information network are able to make and receive referrals within the care network. Those who are not… are not. As a result, those "sticky," non-interoperable networks are used (a) as a tool to pull providers into network (and often into employment relationships), and (b) as a means to lock both providers and patients into the network.

The end result is that policy decisions intended to increase information sharing and care coordination ultimately enable creation of "data silos" that enable those behaviors within very tightly-circumscribed confines, but actively impede broader information sharing across

platforms, networks, and geographies. One way to correct for his unintended consequence is to extend the safe harbors and waivers that currently apply only in severely limited contexts more broadly, in recognition of the general move away from fee-for-service and the need to enable care coordination broadly, not just within closed networks.

4. **Legal impediments to ordinary market dynamics in healthcare impede information sharing.**

In most every functioning marketplace across the economy, high-quality, curated data is treated as the valuable commodity that it is. Market participants in need of data are able to pay fair market value for that data. And those payments are used, in part, to build and maintain the necessary technological infrastructure to enable the efficient, secure exchange of both information and value. This is true everywhere from the banking and online trading systems to the national information network that enables the tracking and exchange of after-market auto parts.

In healthcare, however, because the transfer of patient data occurs most frequently in the context of a care referral any accompanying transfer of value is deemed illegal remuneration under the Stark Laws and/or the Anti-Kickback Statute. As a result, in healthcare the owner/curator of quality data is obligated to assume the cost of electronic transfer of information to a recipient. The beneficiary of the work and the infrastructure investment necessary to curate that data and enable its secure and efficient transfer—the recipient—is literally legally prohibited from paying fair market value for that work and investment. This paradigm, which forces the curator of data to pay for the privilege of sending it electronically to a recipient, operates as a very effective economic disincentive to information sharing in healthcare.

Worse, the paradigm is often used to perpetuate the closed information systems described earlier in these comments. Vendors whose platforms service those closed networks often impose per-transaction charges on care providers for information sent outside of the proprietary network. Hence, even where the technological capability exists to send information outside of network, vendors and their clients are able to create economic disincentives to information sharing. Further, they are able with a straight face to claim that the law obligates them to create those disincentives, since in point of fact someone must bear the cost of the infrastructure and data curation associated with electronic information transfer.

Again, the solution to this problem is straightforward: policymakers must recognize that laws intended to prevent fraud and abuse in a fee-for-service world, written before the age of information technology, are in current practice overbroad in their application and actively impeding desired information sharing in healthcare.

Thank you again for the opportunity to participate in the recent panel discussion, and to submit these further comments. We are of course willing to discuss these issues further at your convenience.

Sincerely yours,

Dan Haley
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