ATHENAHEALTH INC
Form 10-K
March 02, 2009

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2008

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission File Number 001-33689
athenahealth, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**04-3387530**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
311 Arsenal Street, Watertown, Massachusetts	**02472**
(Address of principal executive offices)	*(Zip Code)*

617-402-1000
Registrant s telephone number, including area code

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $0.01 par value	The NASDAQ Stock Market LLC

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No þ

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No þ

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was

required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer þ Accelerated filer o Non-accelerated filer o Smaller reporting company o
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No þ

The aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the registrant s most recently completed second fiscal quarter was $711,889,292.

Indicate the number of shares outstanding of each of the registrant s classes of common stock, as of the latest practicable date. At February 27, 2009, the registrant had 33,419,269 shares of Common Stock, par value $0.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates information by reference from the registrant s definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the close of the fiscal year covered by this annual report.

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PART I

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS AND INDUSTRY DATA

This Annual Report on Form 10-K contains forward-looking statements. All statements other than statements of historical fact contained in this Annual Report on Form 10-K are forward-looking statements, including those regarding our expectations for future financial or operational performance, product and service offerings, regulatory environment, and market trends. In some cases, you can identify forward-looking statements by terminology such as may, will, should, expects, plans, anticipates, believes, estimates, predicts, potential, or continue terms; or other comparable terminology.

Forward-looking statements are only current predictions and are subject to known and unknown risks, uncertainties, and other factors that may cause our or our industry s actual results, levels of activity, performance, or achievements to be materially different from those anticipated by such statements. These factors include, among other things, those listed under Risk Factors and elsewhere in this Annual Report on Form 10-K.

Although we believe that the expectations reflected in the forward-looking statements contained in this Annual Report on Form 10-K are reasonable, we cannot guarantee future results, levels of activity, performance, or achievements. Except as required by law, we are under no duty to update or revise any of such forward-looking statements, whether as a result of new information, future events, or otherwise, after the date of this Annual Report on Form 10-K.

Unless otherwise indicated, information contained in this Annual Report on Form 10-K concerning our industry and the markets in which we operate, including our general expectations and market position, market opportunity, and market share, is based on information from independent industry analysts and third-party sources (including industry publications, surveys, and forecasts), our internal research, and management estimates. Management estimates are derived from publicly available information released by independent industry analysts and third-party sources, as well as data from our internal research, and are based on assumptions made by us based on such data and our knowledge of such industry and markets, which we believe to be reasonable. None of the sources cited in this Annual Report on Form 10-K has consented to the inclusion of any data from its reports, nor have we sought their consent. Our internal research has not been verified by any independent source, and we have not independently verified any third-party information. While we believe the market position, market opportunity, and market share information included in this Annual Report on Form 10-K is generally reliable, such information is inherently imprecise. In addition, projections, assumptions, and estimates of our future performance and the future performance of the industries in which we operate are necessarily subject to a high degree of uncertainty and risk due to a variety of factors, including those described in Risk Factors and elsewhere in this Annual Report on Form 10-K. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

Item 1. *Business.*

In this Annual Report on Form 10-K, the terms athena, athenahealth, we, us, and our refer to athenahealth, Inc. its subsidiary, athenahealth Technology Private Limited, and any subsidiary that may be acquired or formed in the future.

athenahealth, athenaNet, and the athenahealth logo are registered service marks of athenahealth, and athenaClinicals, athenaCollector, athenaCommunicator, athenaEnterprise, athenaRules, and ReminderCall are service marks of athenahealth. This Annual Report on Form 10-K also includes the registered and unregistered

trademarks of other persons.

Overview

athenahealth is a leading provider of Internet-based business services for physician practices. Our service offerings are based on four integrated components: our proprietary Internet-based software, our continually

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updated database of payer reimbursement process rules, our back-office service operations that perform administrative aspects of billing and clinical data management for physician practices, and our automated and live patient communication services. Our principal offering, athenaCollector, automates and manages billing-related functions for physician practices and includes a medical practice management platform. We have also developed a service offering, athenaClinicals, that automates and manages medical record-related functions for physician practices and includes an electronic medical record, or EMR, platform. ReminderCall, the newest offering from athenahealth, is our automated appointment reminder system that allows patients to either confirm the appointment or request rescheduling; we plan on combining ReminderCall with test results, prescription refill, collection, and other patient communication offerings in our athenaCommunicator services suite that we expect to beta launch in 2009. We refer to athenaCollector as our revenue cycle management service, athenaClinicals as our clinical cycle management service, and athenaCommunicator as our patient cycle management service. Our services are designed to help our clients achieve faster reimbursement from payers, reduce error rates, increase collections, lower operating costs, improve operational workflow controls, improve patient satisfaction and compliance, and more efficiently manage clinical and billing information.

In the last five years, we have primarily focused on developing our proprietary Internet-based software application and integrated service operations to expand our client base. In 2005, we formed a subsidiary in India to complement our U.S.-based software development activities and to work closely with our business partners in India. In September 2008, we completed our first acquisition, purchasing the assets of Crest Line Technologies, LLC (d.b.a. MedicalMessaging.Net), a privately held company that developed ReminderCall and associated services. In 2008, we generated revenue of $139.6 million from the sale of our services, compared to $100.8 million in 2007. As of December 31, 2008, there were more than 18,750 medical providers, including more than 12,550 physicians, using our services across 39 states and 60 medical specialties.

Market Opportunity

We believe the market opportunity for our services is, in large part, currently driven by physician office collections in the United States. According to the U.S. Centers for Medicare and Medicaid Services, since 2000, ambulatory care spending increased by an average of 7.4% per year to $479 billion in 2007. As the ambulatory care market has grown, we estimate that the market for revenue and clinical cycle management solutions has grown to over $27 billion. These expenditures are primarily comprised of salary and benefits for in-house administrative staff and the cost of third-party practice management and EMR software.

Growth in managed care has increased the complexity of physician practice reimbursement. Managed care plans typically create reimbursement structures with greater complexity than previous methods, placing greater responsibility on the physician practice to capture and provide appropriate data to obtain payments. Also, despite substantial consolidation in the number of managed care organizations over the last decade, many of the legacy information technology platforms used to manage the plans operated by these companies have remained in place. As a result of this increasing complexity, physician practices must keep track of multiple plan designs and processing requirements to ensure appropriate payment for services rendered.

Physician office-based billing activities that are required to ensure appropriate payment for services rendered have increased in number and complexity for the following reasons:

Diversity of health benefit plan design. Health insurers have introduced a wide range of benefit structures, many of which are customized to unique goals of particular employer groups. This has resulted in an increase in rules regarding who is eligible for healthcare services, what healthcare services are eligible for reimbursement, and who is responsible for payment of healthcare services delivered.

Dynamic nature of health benefit plan design. Health insurers continuously update their reimbursement rules based on ongoing monitoring of consumption patterns, in response to new medical products and procedures, and to address changing employer demands. As these changes are made frequently throughout the year and are frequently specific to each individual health plan, physician practices need to be continually aware of this dynamic element of the reimbursement cycle as it could impact overall reimbursement and specific workflows.

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Proliferation of new payment models. New health benefit plans and reimbursement structures have considerably modified the ways in which physician practices are paid. For example, there is an increasing trend toward consumer-driven health plans, or CDHPs, that require a far greater portion of fees to be paid by the consumer, typically until a pre-specified threshold is achieved. Care-based initiatives, including pay-for-performance, or P4P programs, which provide reimbursement incentives centered around capture and submission of specified clinical information, have dramatically increased the administrative and clinical documentation burden of the physician practice.

Changes in the regulatory environment. The Health Insurance Portability and Accountability Act, or HIPAA, required changes in the way private health information is handled, mandated new data formats for the health insurance industry, and created new security standards. Most recently as part of HIPAA, physicians have been required to adopt National Provider Identifiers, and this has affected physician office billing and collection workflow requirements.

In addition to administering typical small business functions, smaller physician practices must invest significant time and resources in activities that are required to secure reimbursement from third-party payers or patients and process inbound and outbound communications related to physician orders to laboratories and pharmacies. In order to process these communications, physician offices often manipulate locally or remotely installed software, execute paper-based and fax-based communications to and from payers, and conduct telephone-based discussions with payers and intermediaries to resolve unpaid claims or to inquire about the status of transactions.

The Established Model

Currently, the majority of physician practices bill for their services in one of three ways: purchasing, installing, and operating locally installed practice management software, paying for use of remotely installed on-demand practice management software, or hiring a third-party billing service to collect billing-related information and input the information into a software system maintained by the service. In many instances, the solutions that are installed at the physician office or a remote location are operated by administrative personnel on staff at the office. As the complexity and number of health benefit plan payer rules has increased, the ability of locally or remotely installed software solutions to keep up with new and revised payer rules has lagged behind this trend, leading to higher levels of unpaid claims, prolonged billing cycles, and increased clinical inefficiencies. While locally or remotely installed software has been shown to provide improvement in physician practice efficiency and collections relative to paper-based systems, we believe that such standalone software is not suited for today s dynamic and increasingly complex healthcare system.

Despite advances in practice management software to address the administrative needs of the physician office, the billing, collections, and medical record management functions remain expensive, inefficient, and challenging for many physician practice groups. We believe that established locally or remotely installed physician practice management software has generally suffered from the following challenges:

Software is static. Payer rules change continuously and the systems used to seek reimbursement require constant updating to remain accurate. If it is not linked to a centrally hosted, continuously updated knowledge base of payer rules, software typically cannot reflect real-time changes based upon health-benefit-plan-specific requirements. Additionally, since most software vendors are not in the business of processing claims, they are often unaware of the creation of new payer rules and changes to existing payer rules. As a result, physician practices typically have the responsibility to navigate this complex and dynamic reimbursement system in order to submit accurate and complete claims. We believe that their inability to keep current on these rules changes is the single largest factor leading to claims denials and diverting time and resources away from

revenue and clinical cycle workflow.

Software requires reliance on physician office personnel. Physician offices have difficulty managing the increased complexity of billing, collections, and medical record management because they lack the necessary infrastructure and suffer from significant staff turnover rates. Despite attempts to automate workflow, many software solutions still require that a number of payer interactions be executed manually via paper or phone. These manual interactions include insurance product monitoring,

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insurance eligibility, claims submission, claims tracking, remittance posting, denials management, payment processing, formatting of lab requisitions, submitting of lab requisitions, and monitoring and classification of all inbound faxes. These tasks are prone to human error, are inefficient, and generally require the accumulation of rules and claims processing knowledge by the individuals involved. Given that employee clinic turnover in physician offices averages 10-25% annually, critical reimbursement knowledge can be lost.

Software vendors are not paid on results. Most established software companies operate under a business model that does not directly incentivize them to improve their client s financial results. The established software business model involves a substantial upfront license payment in addition to ongoing maintenance fees. While the goal of practice management software is to improve reimbursement and clinical efficiency, realizing these efficiencies still largely rests on the physician office s administrative staff.

We believe that traditional outsourced back-office service providers do not compensate significantly for these deficiencies of the locally or remotely installed software model. These service providers generally rely on third-party software that suffers from the same deficiencies that physicians experience when they perform their own back-office processing operations. The software often is not connected to payer rules that can be enforced in real time by office staff throughout the patient workflow. In addition, these service providers typically operate discrete databases and sometimes utilize separate processes for each client they serve, which affords limited advantages of scale, thereby conferring limited cost advantages to physician practices. Without either control over the software application or an integrated rules database, outsourced service providers cannot offer physicians the benefits of our Internet-based business service model.

The payer universe is dynamic and continuously growing in complexity as rules are changed and new rules are added, making it extremely difficult for physician practices, and even payers, to effectively manage the reimbursement rules landscape. While locally or remotely installed software has struggled to meet these challenges, the Internet has developed in the broader economy into a reliable and efficient medium that opens the door to entirely new ways of performing business functions. The Internet is ideally suited to centralization of the large-scale research needed to stay current with payer rules and to the instantaneous dissemination of this information. The Internet also allows real-time consolidation and centralized execution of administrative work across many medical practice locations. As a result, the health care industry is well suited to benefit from the efficiency and effectiveness of the Internet as a delivery platform.

Our Solution

The dynamic and increasingly complex healthcare market requires an integrated solution to manage the reimbursement and clinical landscape effectively. We believe that we are the first company to integrate web-based software, a continually updated database of payer rules, and back-office service operations into a single Internet-based business service for physician practices. We seek to deliver these services at each critical step in the revenue and clinical cycle workflow through a combination of software, knowledge, and work:

Software. athenaNet, our proprietary web-based practice management and EMR application, is a workflow management tool used in the work steps that are required to properly handle billing, collections, patient communications, and medical record management-related functions. All users across our client-base simultaneously use the same version of our software application, which connects them to our continually updated database of payer rules and to our services team.

Knowledge. athenaRules, our proprietary database of payer rules, enforces physician office workflow requirements and is continually updated with payer-specific coding and documentation information. This knowledge continues to grow as a result of our years of experience managing back-office service operations for

hundreds of physician practices, including processing medical claims with tens of thousands of health benefit plans.

Work. The athenahealth service operations, consisting of approximately 508 people in the United States, interact with clients at all key steps of the revenue and clinical cycle workflow. These operations

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include setting up medical providers for billing, checking the eligibility of scheduled patients electronically, submitting electronic and paper-based claims to payers directly or through intermediaries, processing clinical orders, receiving and processing checks and remittance information from payers, documenting the result of payers responses, and evaluating and resubmitting claims denials.

We are economically aligned with our physician practice clients because payment for our services in most cases is dependent on the results our services achieve for our clients. The positive results of our approach are seen in the significant growth in the number of clients serviced, collections under management, and overall revenue in each of the preceding eight years.

Key advantages of our solution include:

Low total cost of the athenahealth solutions. The cost of our services includes a modest upfront expenditure, with subsequent costs based on the amounts collected. This approach eliminates the large and risky upfront investments in software, hardware, implementation service and support, and additional information technology staff often associated with the established software model. We update our web-based software every six to eight weeks and add or revise over 100 rules on average each month in our shared payer knowledge base, which enables our clients to use these new features with minimal disruption and no incremental cost. Once implemented, only an Internet connection and a web browser are required to run our Internet-based practice management system and EMR and take advantage of our patient communication offerings. We believe our services-based model provides advantages to our clients based on the elimination of future upgrade, training, and extra follow-up costs associated with the established model.

Comprehensive payer rules engine that is continuously expanded and updated. We believe that we have the largest and most comprehensive continually updated database of payer reimbursement process rules in the United States. We collect health-benefit-plan-specific processing information so that the medical office workflow and the work at our service operations can be tailored to the requirements of each health benefit plan. Real-time error alerts automatically triggered by our rules engine enable our clients in many cases to catch billing-related errors immediately at the beginning of the reimbursement cycle, fix these errors quickly, and generate medical claims that achieve high first-pass success rates. Payer rules are frequently unavailable from the payers and therefore must be learned from experience. We have full-time staff focused on finding, researching, documenting, and implementing new rules, enabling our solution to consistently deliver quantifiably superior financial results for our clients. Additionally, we discover and implement even more new rules as new clients connect to our rules engine. Our other clients benefit from the addition of these new rules, and this continuous updating increases our value proposition benefiting both current and future clients.

Real-time workflow and process optimization resulting in improved financial outcomes. Our solution incorporates a large number of efficient, real-time communications between the physician practice s staff and our rules engine and service operations staff throughout the patient encounter and billing processes. These process steps begin prior to the claims submission process, and we believe that this online interaction is vital for delivering the financial performance our clients enjoy. This enables us to stay close to client needs and constantly upgrade our offerings in order to improve the effectiveness of our overall service. These elements allow us to identify and influence critical practice workflow steps to maximize billing performance and deliver improved financial outcomes for our physician clients.

Critical mass and access to superior scale and capabilities. We have taken physician back-office tasks that would otherwise be performed on a local or regional basis and have brought them together on a single national platform. Our platform was designed and constructed to enable us to assume responsibility for the completion of automated and manual tasks in the revenue and clinical workflow cycles, while providing critical tools and

knowledge to effectively assist clients in completing those tasks that must be done on-site in the physician practice. By taking on the administrative effort associated with revenue and clinical workflow, we free our clients from the burden of performing these laborious tasks in a time-consuming and expensive manner with insufficient scale to operate effectively. As a result of our substantial infrastructure, we can apply a broad array of resources (from athenahealth,

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our clients, and our off-shore partners) to address the myriad of discrete tasks within the revenue and clinical workflow cycles in a cost-effective manner. This approach allows us to deliver resources, expertise, and performance superior to what any individual physician practice could achieve on its own.

Our Strategy

Our mission is to be the most trusted business service to medical groups. Key elements of our strategy include:

Remaining intensely focused on our clients success. Our business model aligns our goals with our clients goals and provides an incentive for us to improve the performance of our clients continually. We believe that this approach enables us to maintain client loyalty, enhance our reputation, and improve the quality of our solutions.

Maintaining and growing our payer rules database. Our rules engine development work is designed to increase the percentage of transactions that are successfully executed on the first attempt and to reduce the time to resolution after claims or other transactions are submitted. We continue to develop our centralized payer reimbursement process rules database, athenaRules, using our experience gained across our network of clients.

Attracting new clients. We expect to continue with current and expanded sales and marketing efforts to address our market opportunity by aggressively seeking new clients. We believe that our Internet-based business services provide significant value for physician offices of any size. We estimate that our athenaCollector client base currently represents approximately two percent of the U.S. addressable market for revenue cycle management.

Increasing revenue per client by adding new service offerings. We only began to offer our athenaClinicals service, which we still combine with athenaCollector for sale to prospective clients, in 2007. In the future, we plan to offer athenaClinicals as a stand-alone option. We further expanded our offerings in September 2008 by acquiring the assets of Crest Line Technologies, LLC, which provided our new ReminderCall service, and we continue to explore additional services to address other administrative tasks within the physician office.

Expanding operating margins by reducing the costs of providing our services. We believe that we can increase our operating margins as we increase the scalability of our service operations. Our integrated operations enable us to deploy efficient and effective resources at multiple steps of the revenue and clinical cycle workflow.

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Our Services

athenahealth is a leading provider of Internet-based business services for physician practices. Our service offerings are based on our proprietary web-based software, a continually updated database of payer rules, integrated back-office service operations, and our automated and live patient communication services. Our services are designed to help our clients achieve faster reimbursement from payers, reduce error rates, increase collections, lower operating costs, improve operational workflow controls, and more efficiently manage clinical and billing information.

athenaCollector

Our principal offering, athenaCollector, is our revenue cycle management service that automates and manages billing-related functions for physician practices and includes a practice management platform. athenaCollector assists our physician clients with the proper handling of claims and billing processes to help submit claims quickly and efficiently.

Software (athenaNet)

Through athenaNet, athenaCollector utilizes the Internet to connect physician practices to our rules engine and service operations team. In its 2008 year-end Best in KLAS survey, KLAS Enterprises, LLC, a healthcare information technology industry research firm, reported athenaNet No. 6 in the Ambulatory and Billing Scheduling category for practices with a single physician, No. 1 in the Ambulatory and Billing Scheduling category for practice groups with two to five physicians, No. 2 in the Ambulatory and Billing Scheduling category for practice groups with six to 25 physicians, and No. 1 in the Ambulatory and Billing Scheduling category for practice groups with 25 to 100 physicians. Apart from the single-physician practice category, which was first instituted in 2008, athenaNet has been ranked in the top 5 in each of these categories

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in each annual Best in KLAS ranking since 2004. athenaNet includes a workflow dashboard used by our clients and our services team to track in real-time claims requiring edits before they are sent to the payer, claims requiring work that have come back from the payer unpaid, and claims that are being held up due to administrative steps required by the individual client. This Internet-native functionality provides our clients with the benefits of our database of payer rules as it is updated and enables them to interact with our services team to efficiently monitor workflows. The Internet-based architecture of athenaNet allows each transaction to be available to our centralized rules engine so that mistakes can be corrected quickly across all of our clients.

Knowledge (athenaRules)

Physician practices route all of their day-to-day electronic and paper payer communications to us, which we then process using athenaRules and our significant understanding of payer rules to avoid reimbursement delays and improve practice revenue. Our proprietary database of payer knowledge has been constructed based on over eight years of experience in dealing with physician workflow in hundreds of physician practices with medical claims from tens of thousands of health benefit plans. The core focus of the database is on the payer rules, which are the key drivers of claim payment and denials. Understanding denials allows us to construct rules to avoid future denials across our entire client base, resulting in increased automation of our workflow processes. On average, over 100 rules are added or revised in our rules engine each month. athenaRules has been designed to interact seamlessly with athenaNet in the medical office workflow and in our service operations.

Work (athenahealth Service Operations)

athenahealth Service Operations enables the service teams that collaborate with client staff to achieve successful transactions. Our Service Operations consists of both knowledgeable staff and technological infrastructure used to execute the key steps associated with proper handling of physician claims and clinical data management. It is comprised of approximately 508 people on our service teams in the United States who interact with physicians, providers, and clinicians at all of the key steps in the revenue cycle, including:

- coordinating with payers to ensure that client providers are properly set up for billing;
- checking the eligibility of scheduled patients electronically;
- submitting claims to payers directly or through intermediaries, whether electronically or via printed claim forms;
- obtaining confirmation of claim receipt from payers, either electronically or through phone calls;
- receiving and processing checks and remittance information from payers and documenting the result of payers responses;
- evaluating denied claims and determining the best approach to appealing and/or resubmitting claims to obtain payment;
- billing patients for balances that are due;
- compiling and delivering management reporting about the performance of clients at both the account level and the provider level;

transmitting key clinical data to the revenue cycle workflow to eliminate the need for code re-entry and to permit assembling all key data elements required to achieve maximum appropriate reimbursement; and

providing proactive and responsive client support to manage issues, address questions, identify training needs, and communicate trends.

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athenaClinicals

athenaClinicals is our clinical cycle management service that automates and manages medical record management-related functions for physician practices and includes an EMR platform. It assists medical groups with the proper handling of physician orders and related inbound and outbound communications to ensure that orders are carried out quickly and accurately and to provide an up-to-date and accurate online patient clinical record. athenaClinicals is designed to improve clinical administrative workflow, and its software component has received certification from the Certification Commission for Healthcare Information Technology, or CCHIT, under that body s 2006 standards.

Software (athenaNet)

Through athenaNet, athenaClinicals displays key clinical measures by office location related to the drivers of high quality and efficient care delivery on a workflow dashboard, including lab results requiring review, patient referral requests, prescription requests, and family history of previous exams. Similar to its functionality within athenaCollector, athenaNet provides comprehensive reporting on a range of clinical results, including distribution of different procedure codes (leveling), incidence of different diagnoses, timeliness of turnaround by lab companies and other intermediaries, and other key performance indicators.

Knowledge (athenaRules)

Clinical data must be captured according to the requirements and incentives of different payers and plans. Clinical intermediaries such as laboratories and pharmacy networks require specific formats and data elements as well. athenaRules is designed to access medication formularies, identify potential medication errors such as drug-to-drug interactions or allergy reactions, and identify the specific clinical activities that are required to adhere to pay-for-performance programs, which can add incremental revenue to the physician practice.

Work (athenahealth Service Operations)

athenaClinicals provides the additional functionality that we believe medical groups expect from an EMR to help them complete the key processes that affect the clinical care record related to patient care, including:

- identifying available P4P programs, incentives, and enrollment requirements;
- entering data about patient encounters as they happen;
- delivering outbound physician orders such as prescriptions and lab requisitions; and
- capturing, classifying, and presenting inbound documentation, such as lab results, electronically or via fax.

athenaCommunicator

As a result of our acquisition of the assets of Crest Line Technologies, LLC (d.b.a. MedicalMessaging.Net) in September 2008, we now offer automated messaging services that remind patients of appointment details and allow them to use that automated system to confirm or reschedule the appointment or to speak with a live operator. These services help to reduce no-shows and thereby increase the number of revenue-generating appointments. We have renamed these services ReminderCall and expanded their marketing to our existing clients while also offering our other services to existing MedicalMessaging clients. We envision the development of an expanded set of services,

tentatively called athenaCommunicator, which would include ReminderCall and other outbound and inbound patient messaging services relating to patient collections, patient lab result reporting, prescription refills, and other transactions. The specific packaging, pricing, and marketing plans for this new service line have not been completed. We expect to offer beta clients an initial version of these services in 2009, with broader marketing, sales, and product development efforts likely to occur in subsequent years.

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Sales and Marketing

We have developed a sales and marketing capability aimed at expanding our network of physician clients and expect to expand these efforts in the future. We have a significant direct sales effort, which we augment through our indirect channel relationships.

Direct Sales

As of December 31, 2008, we employed a direct sales and sales support force of 96 employees. Of these employees, 74 were sales professionals. Because of our ongoing service relationship with clients, we conduct a consultative sales process. This process includes understanding the needs of prospective clients, developing service proposals, and negotiating contracts to enable the commencement of services. Of this sales force, 59 members are dedicated to physician practices with four or more physicians and 15 members are dedicated to physician practices with one to three physicians. As of December 31, 2008, our sales team includes 35 quota-carrying sales representatives, of whom 20 are assigned to the groups with four or more physicians and 15 are assigned to the smaller practices. Our sales force is supported by 22 personnel in our sales and marketing organizations who provide specialized support for promotional and selling efforts.

Channel Partners

In addition to our employed sales force, we maintain business relationships with individuals and organizations that promote or support our sales or services within specific industries or geographic regions, which we refer to as channels. We refer to these individuals and organizations as our channel partners. In most cases, these relationships are generally agreements that compensate channel partners for providing us sales lead information that results in sales. These channel partners generally do not make sales but instead provide us with leads that we use to develop new business through our direct sales force. Other channel relationships permit third parties to act as value-added resellers or as independent sales representatives. In some instances, the channel relationship involves endorsement or promotion of our services by these third parties. In 2008, channel-based leads were associated with approximately half of our new business. Our channel relationships include state medical societies, healthcare information technology product companies, healthcare product distribution companies, and consulting firms. Examples of these types of channel relationships include:

the Ohio State Medical Society;

Eclipsys Corporation; and

WorldMed Shared Services, Inc. (d/b/a PSS World Medical Shares Services, Inc.), or PSS.

In May 2007, we entered into a marketing and sales agreement with PSS for the marketing and sale of athenaClinicals and athenaCollector. The agreement has an initial term of three years and may be terminated by either party for cause or convenience. Under the terms of the agreement, we will pay PSS sales commissions based upon the estimated contract value of orders placed with PSS, which will be adjusted 15 months after the date the service begins for each client, in order to reflect actual revenue received by us from clients. Subsequent commissions will be based upon a specified percentage of actual revenue generated from orders placed with PSS. We funded $0.3 million toward the establishment of an incentive plan for the PSS sales representatives during the first twelve months of the agreement and are responsible for co-sponsoring training sessions and conducting on-line education for PSS sales representatives.

Under the terms of the agreement, no later than June 2009, revenue cycle services or software from athenahealth will be the exclusive revenue cycle solution sold by PSS, and from and after the date that clinical cycle services and software from athenahealth has been CCHIT certified and is generally commercially released as a stand-alone service, such services and software will be the exclusive clinical cycle solution marketed and sold by PSS. Additionally, the terms of the agreement prohibit us from entering into a similar agreement with any business that has, as its primary source of revenue, revenue from the business of distributing medical and surgical supplies to the physician ambulatory care market in the United States. None of our existing channel relationships are affected by our exclusive arrangement with PSS, and while our agreement with PSS precludes us from entering into similar arrangements with other distributors of medical

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and surgical supplies to the physician ambulatory care market in the United States, we believe that PSS is of sufficient size so as to offer us a compelling opportunity to market our services to prospective clients that would otherwise be difficult for us to reach. According to PSS, they have the largest medical and surgical supplies sales force in the United States, consisting of more than 750 sales consultants who distribute medical supplies and equipment to more than 100,000 offices in all 50 states.

Marketing Initiatives

Since our service model is new to most physicians, our marketing and sales objectives are designed to increase awareness of our company, establish the benefits of our service model, and build credibility with prospective clients, so that they will view our company as a trustworthy long-term service provider. To execute on this strategy, we have designed and implemented specific activities and programs aimed at converting leads to new clients.

In June 2006, we introduced our annual PayerView rankings in order to provide an industry-unique framework to systematically address what we believe is administrative complexity existing between payers and providers. PayerView is designed to look at payers performance based on a number of categories, which combine to provide an overall ranking aimed at quantifying the ease of doing business with the payer. All data used for the rankings come from actual claims performance data of our clients and depict our experience in dealing with individual payers across the nation. The rankings include national payers that meet a minimum yearly threshold of 120,000 charge lines of data and regional payers that meet a minimum yearly threshold of 20,000 charge lines.

Our marketing initiatives are generally targeted towards specific segments of the physician practice market. These marketing programs primarily consist of:

sponsoring pay-per-click search advertising and other Internet-focused awareness building efforts (such as online videos and webinars);

engaging in public relations activities aimed at generating media coverage;

participating in industry-focused trade shows;

disseminating targeted mail and phone calls to physician practices;

conducting informational meetings (such as town-hall style meetings or strategic retreats with targeted potential clients at an event called the athenahealth Institute); and

dinner series seminars.

Technology, Development, and Operations

As backup to the production data housed on the systems at our Watertown, Massachusetts, and Belfast, Maine, offices, we currently operate a data center in Bedford, Massachusetts with Sentinel Properties Bedford, LLC. Our data centers are maintained and supported by third parties at their dedicated locations. In addition, in 2007 we signed a disaster recovery contract with a major provider of these services, Sungard Availability Services, LP, so that, in the event of a total disaster at our primary data centers, we could become operational in an acceptable timeframe at a back-up location. The services provided by our data center and disaster recovery service providers are generally commercially available at comparable rates from other service providers.

Our mission-critical business application is hosted by us and accessed by clients using high-speed Internet connections or private network connections. We have devoted significant resources to producing software and related application and data center services that meet the functionality and performance expectations of clients. We use commercially available hardware and a combination of proprietary and commercially available software to provide our services. Software licenses for the commercially sourced software are generally available on commercially reasonable terms. The design of our application and database servers is modular and scalable in that, as new clients are added, we are able to add additional capacity as necessary. We refer to

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this as a horizontal scaling architecture, which means that hardware to support new clients is added alongside existing clients hardware and does not directly affect those clients.

We devote significant resources to innovation. We execute six to eight releases of new software functionality to our clients each year. Our application development methodology ensures that each software release is properly designed, built, tested, and rolled out. Our clients all operate on the same version of our software, although some rules are designed to take effect only locally for particular clients. Our software development activities involve approximately 60 technologists employed by us in the United States as of December 31, 2008. We complement this team s work with software development services from a third-party technology development provider in Pune, India, and with our own direct employees at our development center operated through our wholly owned subsidiary located in Chennai, India. As of December 31, 2008, we employed 41 people in our direct subsidiary, and in 2008 this entity represented approximately 1% of our total operating expense. In addition to our core software development activities, we dedicate full-time staff to our ongoing development and maintenance of the athenaRules database. On average, over 100 rules are added or revised in our rules engine each month. We also employ process innovation specialists and product management personnel, who work continually on improvements to our service operations processes and our service design, respectively.

Once our clients are live on our service, we collaborate with them to generate business results. We employed approximately 508 people in our service operations dedicated to providing these services to our clients as of December 31, 2008. These employees assist our clients at each critical step in the revenue cycle and clinical cycle workflow process and provide services that include insurance benefits packaging, insurance eligibility confirmation, claims submission, claims tracking, remittance posting, denials management, payment processing, formatting of lab requisitions, submission of lab requisitions, and monitoring and classification of all inbound faxes. Additionally, we use third parties for data entry, data matching, data characterization, and outbound telephone services. Currently, we have contracted for these services with Vision Business Process Solutions Inc., a subsidiary of Perot Systems Corporation, to provide data entry and other services from facilities located in India and the Philippines to support our client service operations. These services are generally commercially available at comparable rates from other service providers.

During 2008, athenahealth:

- posted over $3.7 billion in physician payments;
- processed over 30.2 million medical claims;
- handled approximately 67.4 million charge postings; and
- sorted approximately 24 million pages of paper, which amounted to approximately 240,000 pounds of mail.

We depend on satisfied clients to succeed. Our client contracts require minimum commitments by us on a range of tasks, including claims submission, payment posting, claims tracking, and claims denial management. We also commit to our clients that athenaNet is accessible 99.7% of the time, excluding scheduled maintenance windows. Each quarter, our management conducts a survey of clients to identify client concerns and track progress against client satisfaction objectives. In our most recent survey, 84% of the respondents reported that they would recommend our services to a trusted friend or colleague.

In addition to the services described above, we also provide client support services. There are several client service support activities that take place on a regular basis, including the following:

client support by our client services center that is designed to address client questions and concerns rapidly, whether those questions and concerns are registered via a phone call or via an online support case through our customized use of customer relationship management technology;

account performance and issue resolution activities performed by the account management organization that are designed to address open issues and focus clients on the financial results of the co-sourcing

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relationship; these activities are intended to aid in client retention, determine appropriate adjustments to service pricing at renewal dates, and provide incremental services when appropriate; and

relationship management by regional leaders of the client services organization to ensure that decision-makers at client practices are satisfied and that regional performance is managed proactively with regard to client satisfaction, client margins, client retention, renewal pricing, and added services.

The increased burden on patients to pay for a larger percentage of their healthcare services, together with the need for providers to have the ability to determine this patient payment responsibility at the time of service, has led some payers to develop the capability to accept and process claims in real time. Under such a real-time adjudication, or RTA, system, payers notify physicians immediately upon receipt of billing information if third-party claims are accepted or rejected, the amount that will be paid by the payer, and the amount that the patient may owe under the particular health plan involved. This capability is frequently referred to within the industry as real time adjudication because it avoids the processing time that adjudication of claims by payers has historically involved. Taking advantage of this payer capability, we have designed a platform for transacting with payer RTA systems that is payer-neutral and designed to integrate the various payer RTA processes so that our clients experience the same workflow regardless of payer. Using this platform, we have collaborated with two major payers, Humana and United Healthcare, to process RTA transactions with their systems.

Competition

We have experienced, and expect to continue to experience, intense competition from a number of companies. Our primary competition is the use of locally installed software to manage revenue and clinical cycle workflow within the physician s office. Other nationwide competitors have begun introducing services that they refer to as on-demand or software-as-a-service models, under which software is centrally hosted and services are provided from central locations. Software and service companies that sell practice management and EMR software and medical billing and collection services include GE Healthcare, Sage Software Healthcare, Inc., Allscripts-Misys Healthcare Solutions, Inc., Siemens Medical Solutions USA, Inc., and Quality Systems, Inc. As a service company that provides revenue cycle services, we also compete against large billing companies such as McKesson Corp.; Medical Management Professionals, a division of CBIZ, Inc.; Ingenix, a division of United Healthcare, Inc.; and regional billing companies.

The principal competitive factors in our industry include:

ability to quickly adapt to increasing complexity of the healthcare reimbursement system;

size and scope of payer rules knowledge;

ease of use and rates of user adoption;

product functionality and scope of services;

performance, security, scalability, and reliability of service;

sale and marketing capabilities of the vendor; and