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## **PHYSICIANS SWITCHING EHRs**

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## **Physicians Switching EHRs**

*“Changes aren’t permanent, but change is.”*

- Neil Peart

### **I. Introduction**

Physician usage of EHRs has grown considerably over the past decade for varying reasons; however, physicians and physician practices may choose to change from one EHR to another. Changing practices, employers, or health systems is only one motivator. A desire to meet Medicare program requirements (such as those under the Medicare Incentive Payment System) may also prompt changes. Or, the practice may simply want additional or different functionality that their current EHR does not provide, including, but not limited to, switching from an EHR designed for a general medical practice to one designed specifically for a specialty practice, adding a billing component, or obtaining a program which makes the extraction of performance information and reports easier.

Whatever the reason, changing EHRs can create a host of issues. These include practical issues, such as the sheer amount of time required to research, implement, and transition to a new EHR package; loss of productivity in the process; and changes in functionality from one EHR to another, which require retraining and perhaps may lead to a loss of some functions on which the physicians counted previously.

Any change in EHRs will necessarily implicate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations, including addressing concerns with changing business associates and the disposition of protected health information (PHI), and whether records in an older EHR must remain shared with other providers. There may also be data transfer and interoperability concerns, where one EHR may not be able to “talk” to another to smoothly transfer data, or where file formats between EHRs may be incompatible. This may

lead to continuity of care concerns, if old data cannot effectively be entered in to the new software. Data ownership issues may also come into play, with some EHR vendors holding data “hostage” if the terminating practice refuses to pay demanded fees. Finally, the specific language in EHR license agreements, especially language relating to termination, must be considered in any EHR change.

This article provides a brief overview of EHR adoption and federal efforts to spur it, and why this is relevant. It examines common reasons why physicians choose to change EHRs, and common problems and concerns arising from such changes. Finally, it offers practical and legal advice on how to confront these issues. I offer language from actual software licenses that are relevant.

## **II. Historical Perspective**

For over a decade, the Federal government has attempted to spur the adoption of EHRs across the American health care system. These efforts have included a combination of carrots and sticks, such as easing of regulatory burdens, offering incentives for adopting an EHR, and imposing penalties for failing to adopt a qualifying EHR. The historical context for these Federal efforts examines their success and explores the significance of the government’s role in relation to physicians switching EHRs.

### **A. Bush Era Efforts**

The first major initiative to spur EHR adoption came during George W. Bush’s second administration, with the push to develop a “national health information network” (NHIN). In Bush’s 2004 State of the Union address, he claimed, “By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”<sup>1</sup> Shortly after this, Bush

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<sup>1</sup> <https://georgewbush-whitehouse.archives.gov/stateoftheunion/2004/>.

issued Executive Order 13335, creating the Office of National Coordinator for Health Information Technology (ONCHIT).<sup>2</sup>

In August, 2006, fraud and abuse regulations were modified to permit the donation of EHR software to physician practices.<sup>3</sup> This included the Federal antikickback statute and its regulations. Similarly, the Stark statute and its regulations prohibit physician referrals of Medicare patients for certain designated health care services (DHS) when there is a financial relationship with the referred to entity. As applied to EHRs, the concern would normally have been that a hospital providing free software to a physician practice would be remuneration for referrals. The regulatory changes put forth by the Bush-era Centers for Medicare and Medicaid Services (CMS) created a Stark exception and antikickback statute safe harbor that both permit donations meeting certain specific requirements.<sup>4</sup> This, in turn removed a significant legal barrier to the proliferation of EHR software by allowing hospitals to use their purchasing power to donate EHRs to physician practices at lower cost than the physicians could obtain them on their own.

#### B. E-Prescribing, PQRS, and Meaningful Use

Beginning in 2007, CMS implemented the Physician Quality Reporting Initiative (PQRI).<sup>5</sup> At its inception, the initiative included an electronic prescribing (E-Rx) component, although this was later separated into its own initiative in 2008.<sup>6</sup> The Patient Protection and

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<sup>2</sup> <http://www.presidency.ucsb.edu/ws/?pid=61429>

<sup>3</sup> 71 Fed. Reg. 45110, August 8, 2006; 71 Fed. Reg. 45140, August 8, 2006; 42 CFR 1001.952(y); 42 CFR 411.357(w).

<sup>4</sup> For more on the donation regulations, see Shay, Daniel, “Downstreamed Physician EHR License Agreements: Understanding the Ebb and Flow,” HEALTH LAW HANDBOOK, 2008 edition, pp. 45-76.

<sup>5</sup> See, Tax Relief and Health Care Act of 2006, Pub. L. 109-432, Section 101, Division B.

<sup>6</sup> See, Medicare Improvements for Patients and Providers Act of 2008, P.L. 110-275, Section 132.

Affordable Care Act of 2010 (ACA) transitioned both the PQRI and E-Rx systems into full-fledged “systems.”<sup>7</sup> Both PQRI (after 2010, referred to as PQRS) and E-Rx allowed for the use of EHRs, although they did not explicitly require their use. E-Rx, in particular, did not require a complete EHR, but rather an electronic prescribing function. However, many EHRs include this functionality as part of an overall software package. PQRS likewise allowed for reporting through the use of EHR software, in addition to other methods (e.g., claims submissions, or group practice reporting); although the use of an EHR to report data required that the EHR be “qualified.” Each program initially offered an incentive payment of up to a 2.0% increase to all Medicare Physician Fee Schedule payments.<sup>8</sup>

The true program that would eventually launch 1000 EHR adoptions, however, resulted from the passage of the American Recovery and Reinvestment Act of 2009 (ARRA), and specifically the Health Information Technology for Clinical and Economic Health (HITECH) portion thereof.<sup>9</sup> The “Meaningful Use” program, as it came to be known,<sup>10</sup> offered up to \$44,000 to eligible practitioners (EPs) for demonstrating “meaningful use” (within the regulatory definition of that term) of EHRs.<sup>11</sup> Regulations for the program were first published in 2010.<sup>12</sup>

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<sup>7</sup> Patient Protection and Affordable Care Act of 2010, Section 10327. For additional discussion of these systems, see Shay, “PQRS and Its Penumbra”, HEALTH LAW HANDBOOK (2012 Ed.), pp. 87-119; Shay, “To Quality And Beyond! The Present and Future of Medicare’s Physician Quality Reporting Programs,” HEALTH LAW HANDBOOK, (2016 Edition), pp. 31-66.

<sup>8</sup> Incentive payments were gradually reduced, beginning in 2011 and were discontinued altogether in 2015.

<sup>9</sup> P.L. 111-5, Title XIII, Section 13001, et seq.

<sup>10</sup> In fact, CMS referred to it in far less punchy terms as the Electronic Health Records Incentive Program.

<sup>11</sup> Depending on when an EP first successfully attested to meaningful use, he or she could be eligible for gradually decreasing incentive payments. For example, an EP who first successfully attested in 2011 and reported successfully throughout the program, would receive the full \$44,000. But an EP who began reporting in 2013 would only be eligible for up to \$39,000. See, EHR Incentive Payment Timeline, <https://www.healthit.gov/providers-professionals/ehr-incentive-payment-timeline>. Payment amounts were further reduced by 2% beginning in 2013, in response to President Obama’s sequestration order. See, [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ListServ\\_SequestrationUpdate\\_EHR\\_Program.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ListServ_SequestrationUpdate_EHR_Program.pdf).

As part of the requirements to qualify for payment, the Meaningful Use program required EPs to use certified EHRs, based on a list published by ONCHIT.<sup>13</sup>

In 2013, payment incentives for E-Rx were eliminated; PQRS incentives were axed in 2014. Beginning in 2015, PQRS, E-Rx, and the Meaningful Use program all began to change from “carrot”-based programs to “stick”-based programs, as each system began to phase out incentive payments and phase in “payment adjustments,” -- really just a euphemism for “penalties.”<sup>14</sup> PQRS and E-Rx gradually changed to imposing “payment adjustments” of -2.0% applied to all Medicare Physician Fee Schedule payments for failure to properly report. Meaningful Use payment adjustments were a 3.0% percentage reduction for all Medicare Physician Fee Schedule payments.<sup>15</sup> Of the three programs, only Meaningful Use survives today, as part of the Medicare Incentive Payment System (MIPS).<sup>16</sup>

### C. MIPS

The MIPS program was created as part of the Medicare Access and CHIP Reauthorization Act of 2015.<sup>17</sup> This program consolidates several different “legacy” programs, including both PQRS and Meaningful Use. The MIPS program also adopts a new payment

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<sup>12</sup> For more on Meaningful Use, see Shay, “PQRS and Its Penumbra”, HEALTH LAW HANDBOOK (2012 Ed.), pp. 87-119; Shay, “HIPAA and Meaningful Use Audits and The Security Risk Analysis Nexus,” HEALTH LAW HANDBOOK (2015 Edition), pp. 429-464; Shay, “To Quality And Beyond! The Present and Future of Medicare’s Physician Quality Reporting Programs,” HEALTH LAW HANDBOOK, (2016 Edition), pp. 31-66.

<sup>13</sup> Certified Health Product List search engine, <https://chpl.healthit.gov/#/search>.

<sup>14</sup> Technically, this process began in 2013, due to the two year “lag” between reporting and payment – or payment adjustments. 2015 represented the first year that payment adjustments were imposed, based on reporting data from 2013.

<sup>15</sup> 42 CFR 495.102.

<sup>16</sup> The E-Rx program itself was terminated in 2014, with PQRS terminating in 2016.

<sup>17</sup> P.L. 114-10. for more on MIPS, see Shay, “To Quality And Beyond! The Present and Future of Medicare’s Physician Quality Reporting Programs,” HEALTH LAW HANDBOOK, (2016 Edition), pp. 31-66.

system that penalizes low performing participants, and rewards high performers. Payment adjustments may therefore occur both upwards and downwards (making the term no longer a euphemism for “penalties”). For the 2017 payment year, payment adjustments are +/-4.0% to Medicare Physician Fee Schedule payments. By 2023, this figure is scheduled to change to +/-9.0%.<sup>18</sup> The program – by virtue of incorporating “Meaningful Use” – continues to incentivize the use of certified EHR technology, while penalizing the failure to do so.

D. Whether It Worked and Why That Matters.

Each of the efforts described above was either intentionally designed to spur EHR adoption, or could be viewed as part of a larger effort to encourage strongly such adoption. It appears those efforts have indeed borne fruit. The website HealthIT.gov tracks the usage of EHRs starting in 2004, up to the present.<sup>19</sup> The data varies from year to year, however, based on the type of EHR used.<sup>20</sup> Nevertheless, it is clear that adoption rates have increased, regardless of the increase is measured. In 2004, the adoption rate by office-based physicians for “any EHR” was only 20.8%. By 2006, that number had risen to 29.2%.<sup>21</sup> By 2015, total EHR adoption had risen to 77.9%. The data shows steady growth in most cases, although adoption in 2012 saw the greatest jump, from 57% in 2011 to 71.8% by 2012. This is not surprising, since 2012 was the final year that EPs could attest to “meaningful use” of certified EHR technology and still receive

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<sup>18</sup> 42 USC § 1395w-4(q)(6)(B)(iv).

<sup>19</sup> Adoption data available at <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php>.

<sup>20</sup> 2004 data only tracks the use of “any EHR.” Data from 2006 onwards tracks the use of both “any EHR” and “Basic EHRs.” Beginning in 2014, the data also includes “certified EHRs.”

<sup>21</sup> “Basic EHRs” have only achieved 10.5% adoption, however. For purposes of this study, physicians were considered to be using a basic EHR if they reported their practice performed all of the following computerized functions: patient demographics, patient problem lists, electronic lists of medications taken by patients, clinician notes, orders for medications, viewing laboratory results, and viewing imaging results. “Any” EHR includes medical or health record systems that are entirely or partially electronic, and excludes systems used solely for billing. “Certified” EHRs are those EHRs which are certified by ONCHIT for Meaningful Use. <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php>.

the full \$44,000 incentive payment. It is important not to conclude causality from correlation, but there does appear to be a correlation between the various government efforts over the past thirteen years, and the rise in adoption of EHRs.

This increased adoption, however, has created some problems of its own. Many physicians who purchased and implemented EHRs in the early days of the government's efforts have either already had to change systems, or face such changes in the near future. In essence, the rapid adoption of software also means that many practices are now using software that may be multiple years old. Functionality may not be as useful as modern EHRs; the developers may no longer support the products – if they even remain in business; or the older versions of the software may not be up to current certification requirements for use in MIPS or other government programs. The remainder of this article explores the reasons behind physicians changing EHRs, and the legal and practical implications of such changes.

#### E. Physicians Switching EHRs

While it is true that adoption of EHRs has grown steadily in the last thirteen years, not all physicians have been satisfied with their EHRs. Surveys reveal multiple reasons why physicians have opted to change EHRs. These surveys also examine problems physicians have faced in such changes, and their overall satisfaction with their new EHRs after changing.

A survey conducted in 2016 by the American Academy of Family Physicians of its members examined 305 family practitioners who had changed EHRs.<sup>22</sup> Another survey conducted by Medical Economics addressed similar issues.<sup>23</sup> The Medical Economics survey

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<sup>22</sup> Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, "EHR Switch Survey: Responses from 305 Family Physicians," Family Practice Manager, January/February, 2015, pp.13-18. Data was collected between mid-July and September, 2014.

<sup>23</sup> Bendix, Jeffrey, "Doctors Seek User-Friendliness, Interoperability from EHRs," Medical Economics, October 25,, 2017, pp.15-19, 38, 40-41.

data reported by over 3200 physicians regarding their satisfaction with EHRs. Interestingly, although 43% stated that they would not recommend their EHR to a colleague,<sup>24</sup> only 15% stated that they were considering switching EHRs.<sup>25</sup> Of all respondents in the 2017 survey, 62% had switched EHRs during their career.<sup>26</sup> In a survey conducted by Medical Economics in 2016 of over 2000 physicians, approximately 46% had used two or more EHRs, indicating that switching is now relatively common.<sup>27</sup> Still another survey conducted in 2013 found that approximately 31% of respondents were dissatisfied with their EHR software, although only 17% had a plan in place to actually change vendors within one year (and only 2% were prepared to change within 3 months).<sup>28</sup>

Among the more common reasons for switching was that the current EHR software simply was not user-friendly or lacked functionality, and the new software would provide additional needed functionality.<sup>29</sup> Another common reason was to achieve Meaningful Use,

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<sup>24</sup> Bendix, Jeffrey, "Doctors Seek User-Friendliness, Interoperability from EHRs," Medical Economics, October 25,, 2017, pp.15-19, 38, 40-41. This number actually decreased by 10% compared to the previous year. "2016 EHR Report," <http://medicaleconomics.modernmedicine.com/medical-economics/news/2016-ehr-report>.

<sup>25</sup> Martin, Keith L., "Switching EHRs Becomes More of the Norm in Healthcare," Medical Economics, October 25, 2017, pp. 24-25.

<sup>26</sup> Martin, Keith L., "Switching EHRs Becomes More of the Norm in Healthcare," Medical Economics, October 25, 2017, pp. 24-25.

<sup>27</sup> Bendix, Jeff, "The Challenges of Switching EHRs," Medical Economics, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>.

<sup>28</sup> "Electronic Health Record Sellers Face Make-or-Break Year of Client Ultimatums and Revolts, Reveals 2013 Black Book Survey," PRWeb, available at <http://www.prweb.com/pdfdownload/10416655.pdf>, February 18, 2013.

<sup>29</sup> The Medical Economics survey found 33% of respondents cited this reason for changing EHRs. Bendix, Jeff, "The Challenges of Switching EHRs," Medical Economics, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>. Similarly, the Family Practice Management survey found 60% of respondents cited this reason. Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, "EHR Switch Survey: Responses from 305 Family Physicians," Family Practice Manager, January/February, 2015, pp.13-18. Data was collected between mid-July and September, 2014. Approximately 80% of respondents cited a similar reason that "Solution does not meet the individual needs of this practice workflow," and 77% of respondents cited "Design of solution is not suited for this practice specialty/specialties" in the Black Book survey. "Electronic Health Record Sellers Face Make-or-Break Year of Client Ultimatums and

where the previous EHR was either not certified or had lost its certification.<sup>30</sup> Unsatisfactory customer support also represented a significant reason for changing EHRs.<sup>31</sup> Additional reasons included mergers of practices or physicians changing from one employer to another; the new product's ability to link to other systems (e.g., practice management or billing software); lack of specialty support; to obtain a cloud-based EHR system; and price considerations.

Because of the rapid growth in EHR adoption since 2011,<sup>32</sup> some physician practices may also be confronting EHR software packages that are now showing their age. This issue may result from problems within the software itself, or its inability to communicate with other software that the practice may have also upgraded over time. Moreover, even for physician practices who have kept their software up-to-date, the software's evolution may have taken user interfaces or other software functionality in a direction that the practice no longer finds helpful. This, in turn, may make the practice more willing to explore software from other vendors.

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Revolts, Reveals 2013 Black Book Survey," PRWeb, available at <http://www.prweb.com/pdfdownload/10416655.pdf>, February 18, 2013.

<sup>30</sup> The Medical Economics and Family Practice Management surveys found that 19% and over 40% of respondents cited this reason, respectively. Bendix, Jeff, "The Challenges of Switching EHRs," Medical Economics, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>; Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, "EHR Switch Survey: Responses from 305 Family Physicians," Family Practice Manager, January/February, 2015, pp.13-18. The Black Book survey found that 12% of respondents stated "Vendor is too focused on meaningful use achievement," and a further 16% responded that "EHR will not meet Accountable Care requirements." "Electronic Health Record Sellers Face Make-or-Break Year of Client Ultimatums and Revolts, Reveals 2013 Black Book Survey," PRWeb, available at <http://www.prweb.com/pdfdownload/10416655.pdf>, February 18, 2013.

<sup>31</sup> Twenty per-cent of Medical Economics respondents cited this reason, as well as over 40% of Family Practice Management respondents. Bendix, Jeff, "The Challenges of Switching EHRs," Medical Economics, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>; Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, "EHR Switch Survey: Responses from 305 Family Physicians," Family Practice Manager, January/February, 2015, pp.13-18. Forty-four per-cent of Black Book survey respondents cited "Vendor not responsive to requests and needs." "Electronic Health Record Sellers Face Make-or-Break Year of Client Ultimatums and Revolts, Reveals 2013 Black Book Survey," PRWeb, available at <http://www.prweb.com/pdfdownload/10416655.pdf>, February 18, 2013.

<sup>32</sup> In 2011, the percentage of physicians using "any EHR" was 57%. By 2012, that number jumped to 71.8%. See, <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php>.

Still other practices may find that their older EHR no longer is supported by the company that developed it. This could be because the company has stopped supporting “legacy products” (or some similar rationale), the company has merged with another company which has discontinued support, or the company has simply gone out of business altogether. The surveys bear this out, with the Medical Economics survey finding that 9% of respondents cited a vendor going out of business as a reason for switching; and Family Practice Management finding that 20% of respondents switched EHRs to “find a more stable vendor.”<sup>33</sup> The Black Book survey cited “vendor viability” as one of the top ten criteria (beyond functionality) for looking for a new vendor.<sup>34</sup>

### **III. Problem Scenarios**

Changing EHRs opens the door for a myriad of headache-inducing difficulties. One major hurdle is simply the amount of time required to get the new EHR up and running.<sup>35</sup> Productivity loss and length of time required to learn to use the new software have also been identified as problems.<sup>36</sup> Other issues, however, have proven significant, made all the more complicated by their legal implications.

#### **A. Data Transfer**

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<sup>33</sup> Bendix, Jeff, “The Challenges of Switching EHRs,” Medical Economics, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>; Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, “EHR Switch Survey: Responses from 305 Family Physicians,” Family Practice Manager, January/February, 2015, pp.13-18.

<sup>34</sup> Eighty-four per-cent of respondents cited this as a reason to find a new vendor. “Electronic Health Record Sellers Face Make-or-Break Year of Client Ultimatums and Revolts, Reveals 2013 Black Book Survey,” PRWeb, available at <http://www.prweb.com/pdfdownload/10416655.pdf>, February 18, 2013.

<sup>35</sup> Eighty-one per-cent of respondents to the Family Practice Management survey found this to be a problem. Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, “EHR Switch Survey: Responses from 305 Family Physicians,” Family Practice Manager, January/February, 2015, pp.13-18.

<sup>36</sup> The Family Practice Management survey found that seventy per-cent and 60%, respectively, of respondents cited these as problems in their own transitions. Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, “EHR Switch Survey: Responses from 305 Family Physicians,” Family Practice Manager, January/February, 2015, pp.13-18.

One of the greatest concerns is the issue of data transfer.<sup>37</sup> Patient demographics, billing, and other financial data that was stored in the previous software will need to be transferred to the new software. Unfortunately, this process is anything but simple. One of the persistent problems dogging EHRs and their adoption remains the issue of interoperability, even as late as 2015 as noted in a report to Congress, in which ONCHIT stated that “substantial interoperability amongst all stakeholders in American health care has not been achieved to date.”<sup>38</sup>

Many EHRs are still unable to easily transmit information from one to another. In many cases, our own clients who have changed EHRs (and those for whom we have negotiated license agreements that address data transfer) were only provided with copies of their old records in PDF format. In other words, the records were essentially nothing more than “digital photocopies” – static images (albeit with object-character recognition, usually, which enables them to be electronically searched for specific terms or phrases), which cannot themselves be changed. Instead of retaining any of the functionality that the older format may have had, they are essentially a digital version of a paper record. Although the records can still be viewed within the software itself, the only way for the old data to be useable within the new EHR in a manner that takes full advantage of the new EHR’s functionality is to manually re-enter the data – a time consuming, mind-numbing, and potentially expensive process.

Interoperability is not impossible, however. Software “bridges” can be built to take data from one system and populate it into another, different system. This technique is sometimes used between providers who need to transmit data from one system to another on an ongoing

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<sup>37</sup> Bendix, Jeff, “The Challenges of Switching EHRs,” Medical Economics, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>.

<sup>38</sup> “Challenges and Barriers to Interoperability,” Report to Congress, December 16, 2015. Available at, [https://www.healthit.gov/hitac/sites/faca/files/HITPC\\_Final\\_ITF\\_Report\\_2015-12-16%20v3.pdf](https://www.healthit.gov/hitac/sites/faca/files/HITPC_Final_ITF_Report_2015-12-16%20v3.pdf).

basis such as a diagnostic testing provider which wants to directly populate a patient report into the referring physician's EHR software. We have had diagnostic testing provider clients who have done just this. The process, however, is costly and time consuming; and such software is usually built only for the purpose of communicating with the specific provider. It is not a panacea for all potential interoperability problems. This process can be further complicated depending on the degree of customization of the old EHR. If a physician practice obtains an EHR software suite and leaves it as a "stock" model, another vendor may be able to develop a bridge to transfer data to a new EHR. On the other hand, if the old EHR has been modified or customized to suit the practice's needs, development of the bridge may be more difficult or even impossible. To the extent that it is successful, not all data may end up being transferrable, if some of the customizations to the old software prevent a full, clean transfer.

When physician practices are unable to transfer data, or even when the data remains stored as PDFs, it may necessitate creating two separate sets of data: one old, one new. Our own clients have struggled with this issue, too. One client had an EHR which was so old that it could not even produce PDFs; the only way to transfer the data was to enter it by hand. The client's other alternative was literally to have a separate laptop that could run the ancient software, and use that to access the data when needed.

In the Family Practice Management survey, respondents describing data migration have offered scathing critiques. "Data migration is an absolute joke. Old data doesn't import well into the new [software]."<sup>39</sup> Another described having two sets of data, noting that, because old data would not transfer over, it must be re-entered by the physician at the time of a patient's visit.<sup>40</sup>

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<sup>39</sup> Edsall, Robert L. and Kenneth G. Adler, MD, MDMM, "EHR Switch Survey: Responses from 305 Family Physicians," Family Practice Manager, January/February, 2015, p.18.

<sup>40</sup> Id.

Another described having essentially lost two years' worth of records, except for hand-entered information.<sup>41</sup> Perhaps the most, "Don't even bother with data migration. Just save an archived, read-only version of your old EMR. Migration is almost always a disaster."<sup>42</sup>

One of our clients, which has switched EHRs three times in the operation of its practice, graciously agreed to discuss how it handled data migration, which it too described as the biggest challenge in any EHR switch. The client noted that converting both clinical data and scheduling data proved difficult, with scheduling data being particularly tricky given the constantly changing nature of the data. Because the practice's schedule is continually being updated, any attempt at data migration (especially with a goal of starting up a new EHR seamlessly with no down-time due to the switch) is essentially an exercise in building railroad tracks in front of a moving train.

With respect to the conversion of clinical data, the client approached newer information differently from older records. The client reached back for two years to incorporate data – including height, weight, medication, dosing information, etc. – into the appropriate fields for the new EHR, so that it would actually be incorporated in the new EHR's native format. They did most of this by converting data into an XML file format, which could then be mapped into the new system; the client never used a "software bridge," due to the amount of time it would take to construct, and the fact that the client's EHR switches have usually required shorter timeframes and greater speed. Older data would be converted over as PDFs, but organized with software "tabs" to specific information, such as a "medication" tab, a "hospitals" tab, a "testing" tab, and

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<sup>41</sup> Id.

<sup>42</sup> Id.

so on. They would then make use of web-based front-end software that would allow the physicians to search for information using the “tabs.”

Much of the difficulty with data transfer between EHRs stems from the fact that there is no single data standard within the industry, from one EHR to another. A comparable situation would be to imagine if personal computers had dozens of different, idiosyncratic operating systems beyond simply Apple, Microsoft, and Linux-based operating systems; and the only way to exchange files was to convert them into read-only .TXT files.

To further complicate matters, many vendors charge for data conversion services. In some cases, the price for such conversion is specified within the license agreement itself, but this is not always the case. For example, compare the following two sections from different license agreements, addressing the return of medical records stored within the vendor’s EHR:

Example 1

*“At termination of this Agreement, we will provide you with a copy of Your Health Information in an electronic form that is accessible through commercially available hardware and software. You may have to purchase such hardware and software from third parties in order to access your data, and you may have to configure your systems in order to use your data in your practice...”*

Example 2

*“The provision of any Medical Records by [Vendor] under this Section...shall be contingent upon the payment to [Vendor] of a non-refundable fee of (i) \$500 with respect to the first request for any Medical Records pursuant to this Section...and (ii) \$5,000 for each subsequent request for any Medical Records pursuant to this Section...Subject to the requirements of this Section..., [Vendor] shall transfer the applicable Medical Records in readable pdf format or such other format as is agreed to by The Medical Practice and [Vendor]. The transferee of any Medical Records shall be responsible for the cost of any disk drives or other media used by [Vendor] for the transfer of such Medical Records as well as shipping and handling for the transfer of such disk drives or other media to such transferee. Any recipient of any Medical Records as a result of such transfer...shall indemnify and hold [Vendor] harmless from, any liability, damage, loss, cost or expense (including reasonable attorneys’ fees) arising out of or related to the transfer of such Medical Records and [Vendor] shall have the right to require any such recipient to agree*

*in writing to such requirement as a condition to any transfer of Medical Records. Notwithstanding the foregoing, after the thirty (30) day period commencing on the date of termination or expiration of this Agreement, [Vendor] shall have no obligation to maintain any copies of or provide any copies of the Medical Records, except as otherwise required by law.”*

The fee and format for the records to be returned is clearly specified in Example 2, but no fee is referenced in Example 1, nor is there any specific reference to the format in which data will be returned.

The ambiguity and breadth of the language in Example 1 can create problems. “An electronic form that is accessible through commercially available hardware and software” could mean anything from typical PDF format, to a Microsoft Word document, to a comma-delineated “flat file.” All that would be required to satisfy the provision is that it be accessible through commercially available hardware and software. Relatedly, although the vendor may later choose to impose a fee for returning the records in a given format – even if only for the cost of shipping and handling for any storage devices containing such records – this may prove a point of dispute between the practice and the vendor, since it was never addressed in the agreement.

Example 2, however, has problems of its own. Although it clearly specifies the format in which the medical records will be returned, and the cost for any data conversion, it does not explain what constitutes a “request for Medical Records.” This could be read to apply to any request for an individual’s records – such as a request pursuant to HIPAA – or might only be applied to a request for the entire database of the practice’s records. The agreement is ambiguous, and therefore the practice cannot be certain what will trigger the payment obligation. Notably, the first request costs \$500, but the second costs ten times as much! In addition, although Example 2 includes language that extends the vendor’s obligations to those “required

by law,” some vendors have ignored such requirements with respect to the return of practice data.

## B. HIPAA Concerns

For HIPAA purposes, EHR software vendors are usually considered "business associates." Vendors typically must access practice PHI to install the software and train staff, and to provide ongoing support services. In the case of cloud-based EHRs, the vendor is usually maintaining the practice's PHI on remote servers provided by the vendor. Thus, vendors absolutely transmit, receive, and maintain PHI on behalf of covered entities, placing them squarely within the definition of a business associate.<sup>43</sup> Most EHR license agreements acknowledge this fact by including a business associate agreement (BAA) as an exhibit.<sup>44</sup>

It may therefore shock readers to learn that vendors sometimes flagrantly breach their duties as business associates by effectively holding data hostage upon termination of a license agreement, usually to obtain unpaid fees or essentially to extort the practice. That this is clearly a violation of the BAA does not deter them.<sup>45</sup> In such circumstances, however, the physician practice whose data is held hostage has very limited recourse. They can sue for breach of contract, but cannot sue for a breach of HIPAA itself, since there is no private right of action under HIPAA. Alternatively, the practice can refer the case to the Department of Health and Human Services' Office of Civil Rights – the government entity responsible for enforcing HIPAA.<sup>46</sup>

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<sup>43</sup> "Business associate" definition at 45 CFR § 160.103.

<sup>44</sup> Requirements for BAAs can be found at 45 CFR § 164.504(e).

<sup>45</sup> Specifically, 45 CFR § 164.504(e)(2)(ii)(J), which requires the business associate to return or destroy all PHI received from, or created or received by the business associate on behalf of, the covered entity, and that the business associate retain no copies of the PHI.

<sup>46</sup> Complaints can be filed at <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.

The OCR has recognized that this is a problem, and has warned vendors against the practice.

*“Generally, if a business associate blocks access to the PHI it maintains on behalf of a covered entity, including terminating access privileges of the covered entity, the business associate has engaged in an act that is an impermissible use under the Privacy Rule. For example, a business associate blocking access by a covered entity to PHI (such as where an Electronic Health Record (EHR) developer activates a “kill switch” embedded in its software that renders the data inaccessible to its provider client) to resolve a payment dispute with the covered entity is an impermissible use of PHI. Similarly, in the event of termination of the agreement by either party, a business associate must return PHI as provided for by the business associate agreement. If a business associate fails to do so, it has impermissibly used PHI.”<sup>47</sup>*

However, the OCR has also stated that covered entities do remain responsible for the ultimate disposition of PHI.

*“Finally, OCR notes that a covered entity is responsible for ensuring the availability of its own PHI. To the extent that a covered entity has agreed to terms in a business associate agreement that prevent the covered entity from ensuring the availability of its own PHI, whether in paper or electronic form, the covered entity is not in compliance with 45 CFR §§ 164.308(b)(3), 164.502(e)(2), and 164.504(e)(1).”<sup>48</sup>*

The implication of this statement is that, if a physician group signs a license agreement with terms in it that permit the vendor to "hold data hostage," the group itself is out of compliance with HIPAA, as is the vendor.

Nevertheless, these issues still arise from time to time. A recent story relates to eClinicalWorks' conduct with respect to its customers. In May, 2017, eClinicalWorks entered into a settlement with the Department of Justice arising from alleged False Claims Act violations

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<sup>47</sup> <https://www.hhs.gov/hipaa/for-professionals/faq/2074/may-a-business-associate-of-a-hipaa-covered-entity-block-or-terminate-access/index.html>.

<sup>48</sup> <https://www.hhs.gov/hipaa/for-professionals/faq/2074/may-a-business-associate-of-a-hipaa-covered-entity-block-or-terminate-access/index.html>.

for falsely claiming that its software was certified for the Meaningful Use program.<sup>49</sup> As part of the settlement, eClinicalWorks was required to enter into a corporate integrity agreement which itself required eClinicalWorks to allow customers to obtain current versions of their software at no charge and to allow customers to have eClinicalWorks transfer their data to another EHR software provider without penalties or service charges.<sup>50</sup> However, some customers have disputed that eClinicalWorks has complied. Laura Williams, a practice administrator at North Spokane Women's Health in Washington state claimed in July, 2017 that eClinicalWorks has held their data hostage for a year and a half.<sup>51</sup> Williams claimed that, when the clinic requested copies of its patient data files as part of a migration to a rival EHR vendor, they were told by eClinicalWorks that they would be charged \$25,000 for the files, without any guarantee that the data would be provided in a usable format. EclinicalWorks' spokesperson denied this claim, stating that customers always own their patient data, but the clinic claimed to still have not received its data. As a result, it had resorted to using eClinicalWorks' software in "read-only" mode, until the day after the settlement with the Department of Justice, when the clinic claimed that the software simply stopped working altogether. The clinic contacted eClinicalWorks and threatened to file a complaint with ONCHIT, at which point eClinicalWorks worked to resolve the program errors; and the clinic eventually developed a workaround to access the data.

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<sup>49</sup> "Electronic Health Records Vendor to Pay \$155 Million to Settle False Claims Act Allegations," Press Release, Department of Justice, May 31, 2017, available at <https://www.justice.gov/opa/pr/electronic-health-records-vendor-pay-155-million-settle-false-claims-act-allegations>. The settlement agreement can be read in full, at <https://www.phillipsandcohen.com/wp-content/uploads/FINAL-ECW-Settlement-Agreement-FULLY-EXECUTED.pdf>.

<sup>50</sup> Corporate Integrity Agreement, p. 21, available at [https://oig.hhs.gov/fraud/cia/agreements/eclinicalworks\\_05302017.pdf](https://oig.hhs.gov/fraud/cia/agreements/eclinicalworks_05302017.pdf).

<sup>51</sup> Sullivan, Tom, "Customer Says eClinicalWorks Holding Patient Data 'Hostage'," *Health care IT News*, July 10, 2017. Available at, <http://www.healthcareitnews.com/news/customer-says-eclinicalworks-holding-patient-data-hostage>.

One of our clients faced similar circumstances. The client had decided to change EHR vendors, and contacted its old vendor to terminate the agreement and request that its data be returned. The client's license agreement simply stated that the client owned the data, and that it would be returned to the client upon termination of the agreement. Nevertheless, the vendor demanded that the client pay approximately \$800 to return the data. Certainly, the client could have sued or reported the incident to the appropriate authorities, but that would not necessarily have returned the data any sooner. Moreover, the client needed the data to treat current patients, and could not afford to enter into costly and time-consuming litigation to resolve what was essentially an \$800 dispute. The client opted to pay, reasoning that it was cheaper, faster, and more effective than trying to fight, even though the client likely would have won.

Still, both stories illustrate the difficulty that physician practices face if the vendor chooses to hold data hostage. Physicians must continue to treat their patients, and therefore need ongoing access to patient records. Without a technological work-around, appealing to the authorities will take too long to resolve the issue. Especially if the actual amount of money is small, it may be easier simply to pay and then report the violation to the authorities once the data is returned.

In one case, the Federal district court for the Eastern District of Wisconsin denied a motion by a medical provider to issue an injunction ordering an EHR vendor to restore connectivity to its medical records after the provider found itself in a dispute with the vendor.<sup>52</sup> The court ultimately held that equitable relief was available to the provider, and therefore an injunction was not necessary, thereby forcing the provider to pursue further litigation, or settle.<sup>53</sup>

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<sup>52</sup> Milwaukee Health Services, Inc. v. Business Computer applications, Inc., 2013 WL 3973222, (E.D.W.I. 2013).

<sup>53</sup> The context of the dispute involved a provider that attempted to transition from one EHR to another, but failed to complete the transition before the provider's EHR license expired. The provider also disputed the amount it owed to

Unfortunately, however, there is a relative dearth of caselaw on this point. While cases do exist relating to disputes between physician practices and EHR vendors, I was unable to find much caselaw relating to the issue of vendors holding data hostage. As discussed above, the issue undoubtedly exists and continues to plague physician practices, as evidenced by multiple stories from physician practices and the OCR's own acknowledgment of the problem. However, it appears that relatively few cases are litigated to the point of a judicial ruling. Although it is speculation, one reason for this may be that physician practices simply determine, as our client did, that it is easier to pay the "ransom" and move on than to litigate the matter. Another issue, discussed further below, is that arbitration clauses may force such disputes into private arbitration, thereby leaving no judicial record.

Another problematic scenario relating to return of PHI upon termination of an EHR license is the circumstance where data conversion or retrieval is simply not possible from a technological or practical standpoint. As part of its obligations as a business associate, a vendor that cannot return PHI to the covered entity must continue to maintain the PHI to the same degree as required under the business associate agreement during the term of the license -- which necessarily means that the vendor must continue to provide access to the PHI as well.<sup>54</sup> We have represented clients who have faced such a scenario, as well. A client was changing EHRs from a

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the vendor, leading the vendor to cut off connectivity to the software. The court, however, was unpersuaded by the provider's argument that injunctive relief was appropriate. Specifically, the court noted two things. First, the court noted that the vendor had offered to provide connectivity at a commercially reasonable rate for an additional year to effect the transfer, and that if the vendor's demands for payment were somehow wrongful, the provider would have adequate legal remedies without the need for injunctive relief. Second, the court stated "...It is a general principle of equity that 'equitable relief is denied to a plaintiff whose recklessness caused his claimed injury.' ... [The provider] got itself into this predicament because it tried to transition to another [vendor], but it couldn't complete the transition before the previous contract with [the vendor] expired. [The provider] had five years to plan for this transition, but it waited too long, then tried (and is now trying) to force [the vendor] into a short-term extension to buy more time. The contract has now expired, and [the vendor] is under no duty to comply with [the provider's] demands, just as [the provider] can refuse [the vendor's] demands, so long as [the provider] can live with the consequences." *Id.*, at \*1.

<sup>54</sup> 45 CFR § 164.504(e)(2)(ii)(J).

very old, outdated system to a new one. The old system could not transfer all of the data, even in basic PDF format. This necessitated the client to pay for a "read only" license for the software. Fortunately, the software was not cloud-based, which meant that the vendor did not need to continue maintaining the PHI on its own servers, but the vendor would have had to do so if the software had been cloud-based.

The same does not, however, apply to de-identified, aggregated data, which some vendors use for various purposes.<sup>55</sup> Some vendors use de-identified data as part of clinical decision-making tools built into their software packages. Others commercialize and sell de-identified information to third parties. Vendors may also use the information purely for internal development purposes, and others may simply not inform customers why or how they will use such data. In many cases, however, the license agreement addresses this issue, usually claiming that the vendor will own all de-identified, aggregated data, rather than the practice.

To the extent that such information was made available to the practice during the term of the agreement, the practice will lose access to the information after termination. Because the data itself is de-identified, even if it was derived from practice PHI, there is no obligation for the vendor to continue providing access to this information, depending on how the language in the agreement is worded.

Consider the following examples from EHR license agreements:

Example 1

*“[Vendor] fully acknowledges that the Client shall be the sole owner of all patient data created by the Software including all patient demographics, medical records data and all financial data. The Client hereby grants [Vendor] access to the Client’s data in any*

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<sup>55</sup> See the standard for de-identification at 45 CFR § 164.514(a) and the implementation specifications for de-identification at 45 CFR 164.514(b).

*format for data benchmarking, and similar data analysis services provide [sic] that [Vendor] shall comply with HIPAA with respect to such data.”*

### Example 2

*“7.2 De-Identified Information. In consideration of our provision of the Services, you hereby transfer and assign to us all right, title and interest in and to all De-Identified Information that we make from Your Health Information or Your Personal Information...You agree that we may use, disclose, market, license and sell De-Identified Information for any purpose without restriction, and that you have no interest in such information, or in the proceeds of any sale, license, or other commercialization thereof. You acknowledge that the rights conferred by this section are the principal consideration for the provision of the Services, without which we would not enter into this Agreement.”*

### Example 3

*“7.6 Access to Data. [Vendor] shall have access to the activity data of Client processed with the [Vendor] Software so long as such data does not allow the identification of an individual person (“blinded data”) and only to the extent permitted by law and by client’s agreements with third parties. Client hereby grants to [Vendor] an irrevocable, nonexclusive, perpetual license to use the blinded data for any purpose permitted by law, including, without limitation, comparative data analysis and the development, marketing and distribution of other products or services. In exchange for Client’s participation in this process, Client may subscribe to [Vendor]’s subscription services for value-added comparative data and other related services and products.”*

Example 1 comes from a comparatively brief agreement, which did not even include or reference a HIPAA business associate agreement or exhibit; it simply states that the Vendor will comply with HIPAA, which is inadequate for satisfying HIPAA’s regulatory requirements regarding business associates. However, the agreement does not actually give the Vendor any ownership of the de-identified data. It merely grants the Vendor access to the data for data benchmarking and “similar data analysis” (although that term, itself, is vague).

By contrast, the Vendor in Example 2 fully owns, and may do what it likes, with the de-identified data it collects from the software. This may include commercialization, or additional analysis, and the physician practice providing the data has no ability to control how the de-

identified data is used (assuming it executes the agreement with this language unchanged, of course).

Example 3 takes a kind of “half-way” approach between Examples 1 and 2, in that it has the physician practice giving a license to the de-identified (or “blinded,” in this case) data, rather than outright ownership. The key difference here is that the de-identified data can still be used by the physician practice, because the license is nonexclusive, but still gives the Vendor perpetual and irrevocable use of that data.

### C. Changing Employers and Merging Practices

When a physician leaves one physician practice for another, or -- in the age of consolidation-- a physician practice merges with a larger group or is purchased by a hospital or health system, it may necessitate a change of EHRs. Likewise, a physician group which had previously been part of a larger organization may choose to leave for a different organization, or may strike out on its own, which may also require switching EHRs. For example, a new employer may have its own EHR system, or the groups merging may have chosen to use Group B's EHR software instead of Group A's. Alternatively, a hospital may not want to support multiple esoteric EHRs, and so may require the use of the hospital's own EHR. This process can create several issues.

For a departing physician or group, the records of the care provided to patients may be incorporated into a larger EHR database. Although patients may choose to continue seeing the departing physician or being treated by the departing group, they may still be treated for other conditions by the entity the physician or group is leaving, which may make disentangling the departing physician or group's EHR data difficult or impossible. For example, if a physician leaves hospital employment to form her own private practice, the records of the patients seen by

the physician while she was employed by the hospital will likely remain in the hospital's system. This may be entirely reasonable and legal, especially if the patient maintains an ongoing treatment relationship with both the physician and the former hospital employer. As a separate matter, the physician or group will need access, at the very least, to the clinical and financial records relating to the care provided, should the physician or group need to defend itself in a malpractice lawsuit or respond to a third party payor audit.

These scenarios also raise the question of who actually owns the patient records in the first place: the former employer/hospital/system, or the departing physician or group? Unfortunately, actual ownership of patient records is not often addressed explicitly in the law. Patients generally have a right to access and obtain copies of their records under HIPAA and some state laws' "patient bill of rights"; but only New Hampshire explicitly states that patients are the owners of their records.<sup>56</sup> Health care practitioners are generally treated as the custodians of patient records. In some cases, hospitals are explicitly the owners of medical records. For example, Pennsylvania's hospital licensure regulations state that "Medical records are the property of the hospital, and they shall not be removed from the hospital premises, except for court purposes. Copies may be made available for appropriate purposes such as insurance claims, and physician review, consistent with regulations governing records confidentiality."<sup>57</sup> However, this applies to records of services rendered in the hospital itself; it does not address circumstances such as records for care provided in physician offices that are operating under a lease with the hospital or outpatient practices that are owned by the hospital.

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<sup>56</sup> The statute states in part "Medical information contained in the medical records at any facility licensed under [New Hampshire's hospital licensure laws] shall be deemed to be the property of the patient." N.H. Rev. Stat. § 151:21(X).

<sup>57</sup> 28 Pa. Code § 115.28.

These issues can create "territorial disputes" when a physician leaves hospital employment. In such circumstances, the hospital may want to assert ownership of the records, but the physician will need a copy. We represented a client who was leaving hospital employment, where the hospital wanted to ensure that the physician would not edit the records of his care after having left employment, and so insisted on transferring "read-only" copies of the records. The hospital's position was that the records were theirs, the patients were theirs (even if the physician would continue to treat the same patients), and the hospital had an obligation to protect the integrity of the records. Even if the data could have been migrated to the physician's new EHR from the old one used by the hospital, the hospital would have insisted that the data be locked as "read-only."

Consider the example of Daniel Goodman, M.D., a solo internist in the Atlanta area. Dr. Goodman obtained an EHR from the Emory Health Network in 2012. Emory then discontinued support for the EHR, which led Dr. Goodman to switch to an Emory-supported EHR. Although his patient data was transferred from the old system to the new one, errors were found (e.g., patient surnames were populated into the first name field, and vice versa). The previous EHR vendor also charged Dr. Goodman \$3,500 to transfer the data, but there was difficulty integrating the data into the new system. Much of the data had to be re-entered by hand, and other data required Dr. Goodman to continually switch back and forth between an "old data" screen and a "new data" screen when older patients presented.<sup>58</sup>

#### D. Vendor Out of Business/Dropping Support

Another problem that can plague practices is the loss of support services for their EHRs. This can generally take one of two forms: (1) the vendor itself goes out of business, or (2) the

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<sup>58</sup> Bendix, Jeff, "The Challenges of Switching EHRs," *Medical Economics*, October 25, 2016, available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/challenges-switching-ehrs>.

vendor discontinues support for the product. The two scenarios are similar, but not identical, although the end result is the same: an overall loss of technical support and additional services for the EHR software.

A vendor going out of business altogether creates significant difficulties for a physician practice. It should be noted that "going out of business" does not mean that the vendor has been purchased by or merged with another vendor; this scenario describes the vendor literally ceasing to operate altogether, with no successor entity. As such, this scenario creates legal headaches of its own. First, even if the vendor is in breach of the license agreement, the practice has no legal recourse against anyone. The entity that provided support is totally defunct, and without a successor entity, there is no way for a practice to enforce the support terms of its contract or be compensated for their loss. If the practice wishes to switch to a new, supported EHR, it will need to obtain copies of its old data (if possible) and may need to have them converted – both services that will not be provided by the old vendor, and may be required of a new vendor. If such data is stored in cloud servers, this may prove difficult, unless the now defunct vendor has an entity that continues to store and maintain such data, such as a data escrow entity. For non-cloud-based software, the practice may be able to continue using it, but without any hope of support. By contrast, if a vendor continues to exist or is succeeded by another entity, and simply opts to end support for the software, the analysis is different. The key question in each of these circumstances is what kind of support is being lost.

Generally speaking, “support” as defined within most license agreements is oriented around *technical* support for the software, designed to resolve bugs or errors that limit or harm the software’s functionality. However, the degree of specificity provided in such license

agreements can vary considerably. Compare, for example, the support services described in the following EHR license agreements:

#### Example 1

*“Remote Support provided via e-mail or telephone shall be provided to a single point of contact established at the Client site. Application Service fees do not include on-site Support services or remote Support services outside of normal business hours (normal business hours are 7:00 a.m. to 7:00 p.m. Eastern, Monday through Friday, excluding [Vendor] observed holidays). Client shall (i) maintain a support staff capable of performing problem determination prior to engaging [Vendor’s] Support services, (ii) provide access to world wide web support resources for its internal support organization (iii) provide e-mail capabilities to support personnel and (iv) perform an annual support self-assessment.”<sup>59</sup>*

#### Example 2

*“During the Term, [Vendor] may, in its sole discretion, provide updates of the Software at no additional cost to The Medical Practice. Such updates may include modifications to the Software that increase the speed, efficiency or ease of use of the Software, and may add additional capabilities or functionality to the Software. [Vendor] is under no obligation to provide any such updates. [Vendor] may offer customizations to the Software requested by The Medical Practice at an additional cost to the Medical Practice. Any such customizations shall be separately negotiated and priced. [Vendor] may also offer additional modules to the Software that may provide specific functionality or services in addition to the Software. These modules will be at an additional cost to The Medical Practice and will be separately negotiated and priced. Without limiting the foregoing, [Vendor] may determine (in its sole discretion\_ whether any specific functionality or services constitute Services or constitute modules that may be separately negotiated and priced. For the avoidance of doubt, nothing in this Agreement obligates [Vendor] to make any such modules available to The Medical Practice or to require [Vendor] to provide such modules for free or at any set price. Notwithstanding anything in this agreement to the contrary, [Vendor] may, in its sole discretion, modify, update, revise, enhance or change any aspect of the Services and/or the Software. Notwithstanding anything in this Agreement to the contrary, The Medical Practice acknowledges and agrees that [Vendor] is under no obligation to provide The Medical Practice with access to any third party software, website or service as part of the Services, through the Software or otherwise and to the extent that the Software and/or the Services provide access to any third party software, website or service [Vendor] reserves the right, without prior notice, to suspend, limit or cancel such access for any reason.”*

#### Example 3

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<sup>59</sup> The holidays observed by the vendor are not specified anywhere in the agreement.

*“Company offers Software Maintenance Services to help End Users maintain the Software it accesses and uses under the Master Agreement. Customer is not required to purchase or maintain Software Maintenance, but Customer will only receive Software Maintenance Services while Customer has a current subscription for Software Maintenance. Company’s response times and the actions it takes to resolve Software Maintenance issues is based on an assessment of the impact of the reported technical issue on Customer’s business. The more serious the business impact, the higher the assigned priority. Company’s support consultant may raise or lower priority in its reasonable discretion based on Customer’s information and/or subsequent diagnosis or remediation efforts, including the availability of a work-around pending final resolution. A workaround [sic] may include requiring customer to operate on the most current version of the applicable Company Software (including any Updates thereto) if doing so will resolve the incident. Company’s Help Desk will follow the following response timeframe objectives that are based on ticket priority*

<u>Targeted response times</u>	<u>Hours of Availability</u>
<i>Priority 1: One hour</i>	<i>24x7 support, 365 days a year</i>
<i>Priority 2: Two <u>Business Hours</u></i>	<i>8:30am-8:30pm Eastern each <u>Business Day</u></i>
<i>Priority 3: One <u>Business Day</u></i>	<i>8:30am-8:30pm Eastern each <u>Business Day</u></i>
<i>Priority 4: Two <u>Business Days</u></i>	<i>8:30am-8:30pm Eastern each <u>Business Day</u></i>

*(\*Response times commence from the time Customer has properly logged a ticket within Company’s support ticketing system.)”<sup>60</sup>*

Each example goes into varying degrees of depth in describing the nature of the technical support that will be provided, and therefore lost if the vendor goes out of business or sunsets the product. Example 1 barely describes what support will be provided, outside of referencing e-mail and telephone support, and the hours each are available. Example 2 provides considerably more detail, addressing software updates and additional services that may be provided, but does not reference the hours at which support is made available. Example 3 provides the most detail

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<sup>60</sup> The support sections further describe how ticket priority is assigned. It also notes the types of issues for which support is not provided (e.g., issues that cannot be reproduced by the Company, issues caused by modifications to the software by anyone other than the Company, etc.), outlines the Customer’s responsibilities (e.g., must apply all software updates provided by the Company, must determine if the issue has been documented and fixed in a newer version of the software, etc.). Finally, the support sections note that the Company may not provide updates for all versions of the software, noting that the Company “may choose to sunset Software product, feature, functionality or compatibility and cease to provide Updates to that product.” Although, the Company will assist with issues relating to the use and configuration of older versions of the software, even as it is “under no obligation to provide Updates to such older versions and customer’s sole remedy for an issue associated with an older version may be to upgrade to a newer version of the Company Software. Sunset versions of older versions may no longer be eligible for any form of support.”

about the technical support services offered, with the quoted language only representing one out of five total subsections in the overall maintenance and support article of the license agreement.

On their faces, the loss of support services would present the practice with varying challenges. Given the scant detail provided, the loss of support under Example 1 might not significantly impact the practice, if no important support services were ever lost. The loss of support described in Examples 2 and 3, however, could be more problematic, given that support in both cases includes updates to the software itself. In addition, the loss of the support provided in Example 3, could be more problematic, given the apparent level of attention the vendor will provide to resolve the practice's problems within two business days.

As described in Examples 2 and 3, support services include updates to the software itself. These updates may be "pushed" to the software, and are designed to improve its functionality, fix bugs, or enhance security. If support is terminated or lost for any reason, the software may function perfectly as it did throughout the period when the software was supported by the vendor, but it will no longer receive such enhancements. Depending on the nature of the software, this could present a significant legal hurdle for the practice. For example, if the software no longer receives security updates, this could expose the EHR to a higher risk of being hacked. Were this to occur, and were it demonstrable that the practice had knowingly ignored this issue, the OCR could treat the act as a violation of the HIPAA Security Rule.<sup>61</sup> On the other hand, if the updates were focused solely on things like user interface quality-of-life changes, the loss of such support may not present a risk to the security of the PHI contained in the EHR.

This scenario can also be triggered by vendor consolidation. For example, if one vendor is bought out by another, the purchasing vendor may choose to discontinue support for the old

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<sup>61</sup> 45 CFR §§ 164.301, et seq.

vendor's products, specifically to encourage users to change software to the purchasing vendor's newer models. This could be done immediately at the time of purchase, or as a gradual phase-out of the old vendor's software.

As a practical matter, however, support services should also be considered to include cloud storage, in which case the practice must consider technical issues such as whether it is feasible to store patient data on an in-house server, and whether the EHR can even access such a server. If the software can only be configured to "see" a now-nonexistent cloud server, the practice may need to transfer the records into a new EHR system altogether. This may be less of a problem in the case of a vendor merger or the vendor simply terminating ongoing support services for the software or software version, but will be a major problem for the practice if the vendor ceases operations.

#### **IV. Problem Solving**

There is no doubt that physicians face a broad range of challenges when switching EHRs. In many cases, these challenges may be merely practical, but in others they can be navigated, or at least mitigated, through legal means.

##### **A. The Devil in the Details: Agreement Provisions**

The best defense is a good offense. Within the realm of EHRs, the first point where a lawyer will become involved is in the review of the license agreement. Careful review of license agreements may be able to head off potential future conflicts.<sup>62</sup> Towards this end, it is wise for the client to inquire how the vendor will approach data transfer, and to include that information in the license agreement. Questions should include whether and how much the vendor will charge for data conversion. Similarly, the vendor should disclose what format the data will take

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<sup>62</sup> For more on EHR license agreements, see, Shay, Daniel "A Primer on Electronic Health Records License Agreements," HEALTH LAW HANDBOOK, 2006 edition, pp. 425-457.

upon (1) return to the practice, or (2) transfer or conversion to another format. Ideally, all of this should be made explicit within the text of the license itself.

For example, the license agreement could state something to the effect of: “Upon termination for any reason, Vendor shall return to Client all records then contained within the Software. Vendor shall return such data in client’s choice of: (1) a “flat” comma-delineated file format, (2) PDF format, or (3) a format mutually agreed upon by Vendor and Client. Vendor shall have no obligation to convert Client’s data into any other format.” Such language would at least make it clear in which formats the Vendor will return data, and that the Vendor will not engage in any other data conversion. In this scenario, the Client would likely have to work with its new EHR vendor to convert the data and populate it into the new EHR.

For employment agreements or lease agreements wherein a physician practice leases itself to a hospital or health system, the documents should address post-termination disposition of records. At the very least, a departing physician will need access to both clinical and financial records following his or her departure, to respond to any lawsuits or third party payor audits. We often include language similar to the following in the agreements we draft:

*“Notwithstanding this provision, after termination for any reason, Employee shall be granted access upon reasonable notice and during normal business hours, to records which may be relevant to litigation, action, claim, proceeding, investigation or inquiry or any other legitimate reason regarding Employee’s care of a patient during the term of this Agreement.”*

It is likely that the employer, hospital, or health system will assert ownership of the records. In such circumstances, it may not be worth fighting over who actually owns the records, as long as the physician or group is allowed to retain a copy of the records. However, as illustrated by our own client’s experience, these records may be provided in “read-only” format. As a separate issue, for a physician who wishes to continue using the EHR of the entity he or she

is departing, the physician may need to obtain a separate license agreement from the vendor. Depending on the software, this could prove expensive, especially if the physician's employer had a "bulk" license with a volume discount.

#### B. Due Diligence

It is important for physician practices to look beyond merely the functionality of software when considering an EHR; vendor "health" may also be relevant. Given the ongoing support requirements for many EHRs, knowing how stable and prosperous a vendor is before signing may be important. For example, a smaller vendor might offer a less expensive product, but may be less stable and more prone to either going out of business, or being purchased by a larger vendor. A larger vendor may be more expensive, but may also be less prone to going out of business or being "eaten by a bigger fish." Of course, there is nothing to guarantee that vendor health alone will determine the longevity of the products they offer and the support they provide for such products. A vendor can always choose to phase out support for software, or discontinue a software line altogether, and even the healthiest of vendors may decide to merge with another company. Still, having a sense of the vendor's financial stability can provide a valuable clue as to the future prospects for the EHR and its support.

Vendor health may be less relevant if the support services themselves are minimal, or if the software is resident on the practice's own hardware. However, given that many EHRs are now cloud-based, a physician practice may find itself relying on a vendor's continued operation to have access to the practices' own data. Ideally, however, even if the vendor discontinues service, it will still be in a position to return the data to the practice.

#### C. Dispute Resolution

As discussed above, some vendors choose to hold data “hostage” from physician practices upon termination of an EHR license agreement. When this happens, the practice has several options available. The simplest, of course, is to pay the vendor what they are asking, and get the practice’s data back. Depending on the total amount of “ransom” requested, this may be the wisest, and fastest course of action. Covered entities still retain an obligation to provide access to PHI for their patients.<sup>63</sup> Thus, if the “ransom” is inexpensive it may be better to simply pay and then fight after the fact.

A practice can also sue for breach of contract, although this depends on the language of the license agreement itself, and whether it permits the vendor to terminate support for the product. If, however, the vendor simply terminates the license upon appropriate notice, then there may be no grounds on which to sue. For example, consider the following termination language:

*“7.2 Termination with Cause.*

*(A) Material Breach by Either Party. If either Party commits a material breach of this Master Agreement, the non-breaching Party may give written notice describing, in reasonable detail, the nature and basis of the breach to the breaching Party. Except as otherwise allowed under this Master Agreement, if the breach is not cured within 30 days of the notice date, the non-breaching Party may immediately terminate this Master Agreement, in whole or in part.”*

In that example, if the vendor provides appropriate notice within the required notice period, then there is nothing to stop the vendor from terminating the contract. This does not necessarily mean that the vendor cannot offer the practice a new license for revised services or amend the existing license (e.g., continued use of the software, without any support services); it simply means that the vendor terminates the previous support services.

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<sup>63</sup> 45 CFR § 164.524.

One wrinkle is that, if arbitration language is present, the option to sue may not even be available. In other words, the practice may be required to go through an arbitration process, instead of being able to avail themselves of the court system. For example, the following arbitration language comes from the same license agreement:

*“13.4 Dispute Resolution and Arbitration. Any dispute, claim, or controversy arising out of or relating to this Master Agreement, including the determination of the scope or applicability of this clause, will be determined exclusively in Orange County, California by binding arbitration before a single arbitrator mutually agreed to by the parties. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. There shall be no right to arbitrate on a class action basis or on behalf of the general public or other group of persons similarly situated. Each party will be responsible for its own attorneys’ fees and shall split the costs of arbitration. The arbitrator shall have authority to apportion costs (other than attorneys’ fees) at the end of any such proceeding. Judgement on any award may be entered in any court having jurisdiction. Nothing in this clause shall preclude the parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.”*

Arbitration clauses are generally enforceable in the context of license agreements. For example, in Kokopelli Eye Care P.C. v. Medinformatix, Inc.,<sup>64</sup> an eye care center sued the developer of its EHR software, alleging “contractual claims,” as described by the court.<sup>65</sup> In the course of the dispute, the software developer attempted to enforce an arbitration clause, when the eye care center refused to enter arbitration to resolve the dispute. The court held that, in accordance with the Federal Arbitration Act, as long as (1) there was a valid agreement between the parties to arbitrate, and (2) the arbitration clause encompasses the dispute at issue, then the court was required to enforce the arbitration language. Because the dispute was over contractual

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<sup>64</sup> 2014 WL 12608964, (C.D.C.A. 2014).

<sup>65</sup> Id., at \*1.

terms to which the arbitration clause applied, the court was compelled to enforce the arbitration clause.<sup>66</sup>

Similarly, in Midwest Financial Holdings, LLC v. P&C Insurance Systems, Inc.,<sup>67</sup> an insurance company sued a software vendor when the vendor used the company's name and comments from its information technology officer in advertising materials without the company's permission. The software vendor attempted to enforce an arbitration clause, which stated, among other things, that "Any controversy, dispute or claim arising out of or relating to this Agreement...shall be resolved by arbitration under the Commercial Rules of the American Arbitration Association."<sup>68</sup> The court declined to apply the arbitration clause to the individual employees of the insurance company who were improperly quoted by the vendor, because the agreement and the arbitration clause did not apply to them as individuals. In its analysis of the application of the arbitration clause to the insurance company itself, the court held that "whether Midwest's claims against PCIS are subject to arbitration is itself an issue for arbitration," due to the breadth of the language in the arbitration clause, specifically the phrase "any controversy, dispute or claim arising out of or relating to this Agreement." In other words, to determine whether a claim was arbitrable, the parties had to submit to arbitration. Although the insurance company attempted to claim that such a determination was nonsensical, the court was unpersuaded and blamed the parties for allowing the language to be so broadly drawn.

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<sup>66</sup> The precise details of the case involve two separate agreements, one containing an arbitration clause, and the other that lacked such a clause. The plaintiff asserted that the second agreement – which lacked the clause – was the applicable agreement, but the court found that the two agreements were, in fact, interdependent, and therefore part of a single transaction. *Id.*, at \*3-4.

<sup>67</sup> 2007 WL 4302436, (C.D.I.L. 2007).

<sup>68</sup> *Id.*, at \*2.

The implications of cases such as these are first, that arbitration clauses in the context of software license agreement are likely to be enforced by courts if they are valid and touch upon the agreement itself, and second that the precise wording of arbitration clauses can have profound effects on future disputes. It is also unlikely that an EHR vendor will agree to modify or narrow the scope of its arbitration language, since such language has likely been included on purpose to protect the vendor.

Dispute resolution can be further complicated by the fact that, as noted above, there is no private right of action under HIPAA, so the practice cannot sue the vendor for a violation of HIPAA. Instead, the practice may refer the incident to the OCR or ONCHIT. A referral to ONCHIT may result in the revocation of the vendor's certification for meaningful use, but otherwise will carry no legal impact. The OCR may enforce under HIPAA against the vendor if, for example, the vendor's discontinuation of support violates the Privacy Rule requirement to provide access to PHI.<sup>69</sup> However, there are two things to bear in mind when referring the case to the OCR. First, the practice will likely see no financial benefit from doing so; it is not as if any settlement between the vendor and OCR will result in payment to the practice. At best, the vendor may -- like eClinicalWorks -- be required to transfer its customers' data to other EHR systems (essentially mandating return of PHI). The practice, however, will not receive any damages or share of any recovery in a settlement. Second, the process for investigation by the OCR may prove extremely slow.

By way of example, we represented a physician practice that was investigated by the OCR for an alleged violation of HIPAA. After submitting responses to the OCR's inquiries, along with supporting documentation, the OCR went silent for the following six months. The

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<sup>69</sup> 45 CFR § 164.524.

OCR had to be prompted to even respond with an estimated timeline for completion of its investigation, which was said to be likely to occur a total of nine months after the date the supporting documentation was turned over.

Finally, with respect to the issue of dispute resolution, physician practices may consider demanding that provisions for injunctive relief be included in their license agreements. The current trend in the EHR industry is towards license agreements which are drafted to favor vendors. These agreements include arbitration provisions, disclaimers of warranties and liabilities, and generally are structured to protect the vendor, potentially at the expense of the physician practice. Particularly on the issue of continued access to data and data conversion, physician practices – indeed, all health care providers -- should consider trying to change this paradigm by demanding that EHR license agreements include specific language granting injunctive relief to preserve access to the provider’s medical records, regardless of the grounds for disputes. Continued access to medical records is not simply a matter of contract law and principles of equity; patients’ lives depend upon their health care providers having access to information about the patients. A payment dispute between a provider and an EHR vendor which leads to the vendor cutting off access to such information, or even rendering it “read-only” so that the provider cannot update the information to reflect a patient’s current status, should not be possible. Towards this end, language granting the provider injunctive relief with respect to records access should be included in EHR license agreements, and providers should consider refusing to sign EHR license agreements that lack such protections.

E. Enhanced Interoperability?

There is some glimmer of hope that interoperability between EHRs is improving. Vendors are well aware that customers want better interoperability, and that the Federal

government has been pushing for it over the years. Increased interoperability would solve many of the headaches related to transitioning between EHRs. Data transfer would be greatly simplified, and vendors would find their ability to hold physician data for ransom much diminished (although vendors could still certainly charge for data transfer services). Likewise, the transition from employment in one setting to another would be simpler, since the employee could simply be provided electronic copies of patient records and claims data to incorporate into the EHR of the practice the physician was joining.

Some vendors, recognizing its commercial value, have begun to trumpet their own commitment to enhancing interoperability. For example, athenahealth noted in the wake of an industry report on interoperability that it had scored highly.

*“According to a 2015 national survey, 95 percent of physicians felt near unanimous frustration over their inability to share and access electronic health information across the care continuum. Beyond frustration, physicians cited experiencing delay and difficulty delivering medical care because patients’ health records were not accessible,” said Jonathan Bush, CEO and president, athenahealth. “While we’re thrilled to be recognized as the vendor that is chipping away at interoperability, we believe that our industry’s work has only just begun.”<sup>70</sup>*

Cerner has also been on the frontlines of promoting its commitment to interoperability. At least three separate webpages for Cerner advertise the fact that it is attempting to build greater interoperability into its software. For example, it maintains what it describes as an “Interoperability Ticker” that tracks its current efforts towards interoperability.<sup>71</sup> This page can be accessed from another page discussing Cerner’s interoperability efforts with respect to physician practices.<sup>72</sup>

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<sup>70</sup> <http://globenewswire.com/news-release/2016/10/11/878537/0/en/athenahealth-Positioned-as-a-Healthcare-Information-Sharing-Leader-in-KLAS-2016-Interoperability-Report.html>.

<sup>71</sup> See, <http://cernerhubcloud.cernerworks.com/>.

<sup>72</sup> <http://www.cerner.com/page.aspx?pageid=2147485132>. The page notes, among other things, “Removing data-sharing boundaries optimizes the quality of care and resource expenditure of your organization. Cerner’s clinical

Similarly, a major effort between two major industry groups of EHR developers, Carequality and CommonWell, is underway to enhance interoperability.<sup>73</sup> Carequality includes developers such as Epic, E Healthcare, Surescripts, eClinicalWorks, and athenahealth. CommonWell includes Cerner, Allscripts, McKesson and Sunquest. All of this suggests that enhanced interoperability could be possible in the future. Whether it will come to pass, however, remains to be seen.

## V. **Conclusion**

Switching EHRs can be a harrowing experience for physician practices. Data migration can be a headache-inducing and time-consuming experience which may not even yield productive results. Following migration, data may be segregated into “old” or “new” data, in some cases even requiring the continued use of an EHR that could not convert any of the data. Data may be endangered by the shuttering of a vendor’s business, or the termination of support services for a particular EHR product. In the worst cases, EHR vendors may hold data “hostage” by refusing to allow the practice access to the information. This issue presents a real conflict between principles of contract law (wherein the vendor might be justified in withholding access to data or services if the practice has not paid or there is a dispute about such payment) and requirements under HIPAA and state licensure laws.

Certainly, enhanced interoperability would solve many of these problems. Were there a universal standard (or at least some kind of “universal translator” for EHR data), data conversion would be much simpler, and the process of switching EHRs would be easier. Of course, this

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data exchange capabilities support your health organization’s physician connectivity strategy by improving referring physicians’ experience with your organization.”

<sup>73</sup> [https://wire.ama-assn.org/practice-management/interoperability-breakthrough-5-things-physicians-should-know?utm\\_source=BHCListID&utm\\_medium=BulletinHealthCare&utm\\_term=121516&utm\\_content=MorningRounds&utm\\_campaign=BHCMessageID](https://wire.ama-assn.org/practice-management/interoperability-breakthrough-5-things-physicians-should-know?utm_source=BHCListID&utm_medium=BulletinHealthCare&utm_term=121516&utm_content=MorningRounds&utm_campaign=BHCMessageID).

would not stop all of the problems discussed in this article. A vendor could still bar access to the practice's data, or go out of business, and the loss of support services could still implicate HIPAA.

Nevertheless, physician practices must accept that switching EHRs will become a fact of life for them, if it has not already. The difficulties these practices face are not likely to go away in time, although efforts towards greater interoperability offer some hope for an easier road to travel in switching EHRs. Time will tell whether these efforts bear fruit, but in the meantime, physician practices will need the assistance of effective health care legal counsel to help them navigate these transitions.