NEGOTIATING ELECTRONIC HEALTH RECORD TECHNOLOGY AGREEMENTS

Michael J Daray. The Health Lawyer. Chicago: Dec 2009. Vol. 22, Iss. 2; pg. 53, 8 pgs

Abstract (Summary)

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Full Text (6441 words)

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Introduction

In the early half of this decade, then President George W. Bush focused the spotlight on the use of electronic health record ("EHR") technology. In 2004, he issued Executive Order 1333, which had as its stated goal the "development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care" so that, by 2014, there would be an interoperable electronic health record for each U.S. resident. Creating such a record would require all physicians, practice groups and hospitals to acquire the technology required to develop such a record.

Obtaining that lofty goal, however, has proven to be difficult so far.2 Although unofficial statistics vary, anywhere from 30 percent to 70 percent of EHR deployments fail.3 In 2008, it was estimated that less than 20 percent of physicians presently used EHR in their practice.4

The economic downturn and the resulting stimulus package have, however, pushed EHR back onto the front burner, offering carrots to those physicians that adopt EHR and assessing penalties against those who do not. As a result, health law attorneys can expect more of their clients to consider adopting EHR technology.

This article examines the issues confronting physicians considering the move to EHR. First, it provides an overview of the economic stimulus package and how it will accelerate the implementation of EHR. Second, the article identifies and discusses some of the key elements of an EHR technology agreement.

HITECH-A New Driver of EHR

In February 2009, Congress adopted the American Recovery and Reinvestment Act of 2009 ("ARRA").5 Buried among ARRA's many provisions is the Health Information Technology for Economic and Clinical Health Act ("HITECH"). HITECH provides significant incentives for physicians and hospitals to adopt EHR technology over the next several years.6 The goal is the same one articulated by then President Bush: development of a nationwide, interoperable health information technology infrastructure so that by 2014 a certified health record exists for each person in the United States. ARRA allocates approximately $19 billion over five years to accomplish this goal.

One of the key components of HITECH is encouraging adoption of a qualified, certified EHR system.7 HITECH broadly defines an EHR system as "qualified" if it is able to generate an EHR that includes patient demographic and clinical health information and is capable of the following:

* providing support for clinical decisions;
* supporting entry of physician orders;
* capturing and querying information relevant to healthcare;
* exchanging electronic health information with, and integrating such information from, other sources; and
* e-prescribing.8

HITECH requires that the EHR software be certified under one or more programs recognized by the Department of Health & Human Services ("HHS").9 Presently, the Certification Commission for Healthcare Information Technology ("CCHIT"), a 501(c)(3) organization, is the sole certifying organization under HITECH.

A physician must also demonstrate that the EHR technology is being used in a "meaningful" way. Although not precisely defined in HITECH, HHS has developed some initial guidance on what constitutes "meaningful use," although final rules have not yet been adopted.10

Incentive payments and penalties under HITECH do not apply to hospital-based physicians, such as anesthesiologists or emergency physicians, who furnish substantially all of their services in a hospital setting, as it is assumed they will use the hospital's facilities and equipment, including computer equipment (although the hospital may be entitled to its own incentive payments).11 There is some question as to the intended scope of this exclusion, especially as to the level of services that must be provided in the hospital setting for the exclusion to be triggered.

Incentives

Medicare

The primary incentives offered under HITECH take the form of Medicare payments to physicians who can demonstrate meaningful use.12 The payments, which commence in 2011, are based on 75 percent of the allowable Medicare charges of a physician and are capped as follows:

* $15,000 in the first payment year (although this is increased to $18,000 if the EHR system is adopted in 2011 or 2012 but decreased to $12,000 if EHR is first adopted in 2014);
* $12,000 in the second payment year;
* $8,000 in the third payment year;
* $4,000 in the fourth payment year; and
* $2,000 in the fifth payment year.13

Incentives will not be paid after 2016.14 Those adopting EHR technology in or after 2015 would not receive any payment under HITECH.15 The payment amounts are increased by 10 percent if the provider is located in a rural health professional shortage area.16

Medicaid

HITECH provides incentives under the Medicaid program as well. The legislation authorizes federal matching funds to pay for a portion of the amounts that states pay to Medicaid providers. These matching funds may be used to defray the cost of adopting EHR technology, as well as the necessary support services and maintenance.

For individual providers, the federal match is available to non-hospital-based physicians, dentists, nurse mid-wives, nurse practitioners, and physician assistants practicing in rural health clinics and federally qualified health centers.17 These providers must have a Medicaid patient volume of at least 30 percent or, if they practice predominantly in a federally qualified health center or rural health clinic, a patient volume of at least 30 percent attributable to Medicaid patients and other needy individuals.18 Finally, these providers cannot receive both
Medicare and Medicaid incentives provided by HITECH.

If eligible, providers can receive funds up to the following amounts: (1) $21,250 for the purchase and initial implementation of EHR technology, which must occur by 2016, and (2) $8,500 per year for up to five years for the operation and maintenance of EHR.19 Pediatricians who have 20 percent (rather than the required 30 percent) Medicaid patients and who otherwise qualify for the payments are eligible for up to two-thirds of the amount of payments. No Medicaid incentive payments are allowed after 2021.20

Penalties

Physicians who do not timely adopt and use EHR technology can expect a reduction in their Medicare payments. The schedule of reductions is as follows: one percent in 2015, two percent in 2016, and three percent in 2017 and beyond.21 Further, HHS can increase the penalties beginning in 2019, although the penalties are capped at five percent.22 HHS may waive the penalties for significant hardship (e.g., rural areas without sufficient Internet access); however, this will be done on a case-by-case basis.23

Different Approaches to EHR Deployment

HITECH provides significant economic incentives to encourage EHR utilization. To effectively adopt EHR technology, however, physicians (and their counsel) need to understand the types of arrangements by which they can acquire EHR technology. There are two primary models used for the deployment of EHR software.24 Each is discussed below.

Traditional Licensing Model

Under the traditional licensing model, the physician acquires a license in the EHR software, which is then installed on the physician’s hardware (which could be a stand-alone computer or a network). A large majority of EHR vendors utilize a traditional licensing model.

The primary benefit of the traditional model is that the software usually has been developed over a number of years. This tends to result in software that has fewer bugs and more features. Another benefit is the "control" that the physician has over both the software and the information gathered using the software. The information resides on a server located within the physician’s office, which often provides confidence to a physician that the information is accessible only to the physician and the physician’s staff, but whether this is truly the case is a separate issue.25 Traditionally licensed software is also easier to customize, which may be beneficial for large practice groups or those with unique EHR needs.26

The primary drawbacks of the traditional model relate to cost. Costs tend to be fairly significant because of the hardware that is needed (such as a server, back-up equipment for redundancy, and security devices). Additionally, an IT consultant will likely be needed to assist in the deployment of the software, which adds to the expense. Ongoing software maintenance is generally required under the traditional model, and this can add significant cost above and beyond the initial start-up expense. Finally, software offered under a traditional model may not be compatible with a practice's operating system, which may require expensive upgrading.

Software as a Service

An alternative to the traditional licensing model is software as a service ("SaaS"). Under this model, the software application is made available to the customer over the Internet. Although thought of as a license, SaaS is better viewed as a subscription arrangement. A physician will be one of a number of healthcare providers who subscribes to the software, which is remotely hosted on the EHR vendor's server and accessed by multiple users as a web-based service. This form of software deployment has only recently gained popularity, so it does not have the track record that the traditional licensing model does.

The benefits of SaaS center generally around cost. A practice need not purchase a server to host the software, nor does the practice maintain the software. Because SaaS is a subscription, it provides flexibility if a practice chooses to terminate the service. SaaS proponents also tout some operational advantages. SaaS can deliver updates on an on-going basis. SaaS also promotes scalability by utilizing one set of hardware and software for multiple users. Finally, since SaaS solutions are web-based, they are usually compatible across multiple platforms and with most web browsers.
SaaS has several potential disadvantages. First, the vendor controls the server on which the software is hosted and where the patients' health information data is stored. This can create significant problems if the vendor goes out of business. Unlike traditionally licensed software, SaaS requires a reliable and fast Internet connection. A server that works on the practice's local network will almost always be faster than a connection provided by an Internet service provider. 27 Reliability is also an issue, as access to SaaS depends on an Internet connection which may be unavailable from time to time. SaaS also tends to be less flexible than the traditional software license, as software delivered via SaaS is automatically updated regardless of whether a practice wants the particular update. Finally, there is some debate over whether SaaS is less expensive in the long run. While traditional software can require large upfront investments, the monthly charges for SaaS solutions can eventually surpass the traditional model's initial cost.

Negotiating the Agreement

Once a practice has decided what its EHR needs are and which software is most likely to meet those needs, the vendor will typically put together a written quote outlining the major business terms (including the software being licensed, number of licenses/users, required hardware, and fees). However, the quote is only a stepping stone to formally memorializing the arrangement in writing.

For traditional software licenses, the documentation will usually take the form of a software license agreement and a maintenance agreement.

If software is being acquired via SaaS, a user agreement will document the arrangement.28 A service level agreement, which outlines performance parameters, may also be used in connection with SaaS. It is not uncommon, however, to find vendors that offer SaaS still using agreements that are more tailored for traditional licensing arrangements.

In almost every case, the documents provided by EHR vendors are vendorfriendly. Further, vendors often are reluctant to make changes to their preprinted contract documents. Nevertheless, counsel should press for the appropriate modifications as there is simply too much at stake for the practice.

Licensees/Users

Software licenses place limits on who may use the software. For the traditional model, this limit may be in the form of the number of computers on which the software may be installed, the number of practice locations at which the software may be used, or the number of users. It is critical that the agreement provides the practice with a sufficient number of licenses necessary for the practice to effectively use the EHR technology.

Under SaaS, the vendor typically limits the number of users that may access the EHR software. The number of authorized users may be based on the number of licensed physicians in the practice. This may not be sufficient if staff members are expected to also utilize the EHR software (which is generally the case). Further, a SaaS vendor may place limits on the number of concurrent users. That is, only a specific number of the practice group members may be able to use the EHR software at once. The practice needs to determine how many concurrent users can expect, and then make sure that the user agreement provides the practice with the right to have a sufficient number of concurrent users.

License Term

Practices should request that the agreement state the license term for the EHR software being licensed under the traditional model. A longer license term is generally preferred as renewals often require payment of renewal fees.

Regarding SaaS, a term would appear to be unnecessary as it is a pay-as-you-go arrangement that should be terminable by the practice at any time. However, user agreements often state a term, and use the expiration of the term to adjust user fees. The practice should make sure that it has the right to terminate at any time and that the termination be permitted without the payment of any termination fees.

Payment of Fees

Cost is a critical element in the deployment of EHR software. Whether in the form of a traditional license or SaaS,
EHR implementation will run into the tens of thousands of dollars. A significant portion of this cost will consist of licensing and implementation fees that the vendor will request be paid upfront.

With the reported high failure rate of EHR implementation, physicians should request that payment of fees be tied to milestones. For example, in the traditional model, rather than pay the entire licensing fee upon execution of the agreement, the physician may want to request that fees be paid as follows: 20 percent down payment, 50 percent payment after installation and testing, and payment of the balance upon acceptance. There is no bright line test of how to schedule payments; rather, the key is to try and defer payment of as much of the fees as possible until the practice has functional EHR software in place.

For SaaS, although upfront fees may be less, the concern of paying a significant amount prior to deployment and acceptance of the EHR still exists. Again, the practice should request a payment schedule tied to milestones.

Deployment Schedule

A practice is well-advised to negotiate a schedule for the deployment of the EHR as part of the agreement. Because of the complexity involved in installing and testing EHR software, it may take several months before the software is fully deployed and operational. Appropriate milestones in a written schedule may include: (1) installation; (2) training; (3) testing period; and (4) go-live date. The practice should also negotiate for penalties if the vendor fails to meet the deadlines.

Data Conversion

Often overlooked in the agreement is the conversion of existing data. If a physician acquires EHR software for the first time, the existing paper records need to be converted into an electronic format. Similarly, if a physician is switching from older EHR software, the existing data may need to be converted. Data conversion can be a source of dispute if the material terms are not properly documented. The agreement should clearly define what data or records will be converted, the cost for the conversion, any additional hardware or software requirements needed for the conversion, and the timeline for such conversion.

Termination and Access to Data

To address the possibility that a practice may need to switch EHR software, the licensing agreement or user agreement should define what the practice’s rights are upon termination. The agreement should state that the practice owns the data and should set forth the practice’s right to access that data following termination and whether additional fees will be assessed for such access. At a minimum, the practice should request access as is necessary to continue to provide care to its patients. The agreement should also state which party is responsible for the data transfer to the new EHR system. It is reasonable to request that the vendor bear that cost if the practice terminates due to the vendor’s breach of the agreement. The agreement should also provide that the data will be transferred to the practice in a format of the practice’s choosing if the vendor relies on a proprietary database to store the practice’s data.

Representations and Warranties

Most licensing and user agreements contain few warranties and representations. In many instances, they are limited to non-infringement of the intellectual property rights of a third party. However, counsel should try to negotiate the following additional representations and warranties:

1. The software is, and will remain, certified, qualifying software within the meaning of HITECH.

2. The software is and will remain compliant with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3. The software will perform in accordance with the specifications and parameters (for example, uptime) as defined in the vendor’s proposal or documentation.

4. The software is free of all worms and viruses, and has no disabling devices (which could be activated if the vendor believes the practice is in breach).
5. Any enhancements or upgrades to the software will be compatible with the practice's version of the software.

6. The vendor has good title or right to the software being licensed.

7. The software will interface with the practice's other applications.

8. The software documentation is complete and accurate.

9. The software is free of defects in material and workmanship.

Warranties and representations regarding SaaS will be generally similar. However, a practice adopting SaaS should also request warranties and representations regarding the vendor's server, such as its security and encryption of stored data.

Once the representations and warranties are agreed upon, care must also be taken to define when the warranty period commences. Typical licensing agreements often provide that the warranty period commences upon "installation" of the software. Not only is this term ambiguous (especially in the context of SaaS), a significant amount of time may elapse between the installation of the software and when the practice "accepts" it. A more practical approach is to have the warranty period commence upon execution of the agreement and continue for the defined period (whether it is six months, a year, etc.) following acceptance.

The agreement should also define the warranty term. Most software agreements will limit the warranty period from three months to up to one year. However, certain warranties, such as compliance with HIPAA and meeting the requirements under HITECH, should be indefinite. Most pre-printed licensing agreements will not provide this, so care must be taken to ensure that appropriate language is added.

Hardware

A potential expense in implementing EHR technology is acquiring the hardware needed to run the software. As noted above, this expense can be significant in the traditional model. The licensing agreement should outline in detail the hardware and operating system necessary to run the EHR software.

Some up-front infrastructure expense may also be required if software is being deployed via SaaS. Although a practice may not need a server, it may discover that its current computers and operating systems cannot access the software efficiently. Again, the practice should make sure the agreement identifies what hardware and operating systems the practice must provide.

Maintenance

A software license agreement is typically accompanied by a maintenance agreement that sets forth the vendor's obligations regarding ongoing technical support of the software. The licensee pays for this support, usually in the form of annual fees. The practice must consider several aspects of this document. First, does the software license require that the practice also purchase maintenance from the vendor? Second, what are the fees for maintenance, and what rights does the vendor have to change the fees? This is important, as maintenance fees can be quite significant. A practice should request caps on the fees, both as to the amount of any increases and their frequency.

A maintenance agreement should also require the vendor to (1) provide updated documentation as the EHR software is updated; (2) provide the practice with the source code if the vendor ceases to provide maintenance for the EHR software; (3) agree that the level of support the vendor provides under the maintenance agreement will not be less than that provided under any warranty provisions contained in the licensing agreement; and (4) specifically define what constitutes maintenance (which may be an issue if the vendor claims that an update constitutes a new version of the EHR software for which new license fees must be paid).

In the SaaS model, the counterpart to the maintenance agreement is the service level agreement ("SLA"). Because SaaS comprises software remotely hosted on an outside server, the SLA should address the following issues:

* The levels of uptime for the EHR software (i.e., when the EHR software can be used);
* Availability of support (both during and after business hours);

* The vendor's response time to complaints, with shorter response times for problems that affect the critical functions of the EHR software;

* The schedule of vendor maintenance for the software and its server;

* The practice's right to access and/or obtain an electronic copy of the practice's data if the practice terminates the subscription;

* The manner and frequency of data back-up; and

* The practice's rights if updates or upgrades degrade the operation of the EHR software.

The goal is to ensure that the parties are in agreement regarding how the software will operate and how the vendor will support it.

**Indemnification**

A critical issue in an EHR licensing or subscription agreement is indemnification, specifically a vendor's obligation to provide it. Software license agreements tend to afford licensees with a very limited right of indemnity for claims alleging the software infringes on the intellectual property rights of third-parties.

In the case of EHR software, however, a vendor's access to or storage of patients' personal health information and other non-public information rightfully necessitates broader indemnity. A practice should request indemnity for the following:

1. Claims/losses arising out of the vendor's breach of the license, user or maintenance agreement;

2. Claims/losses arising out of the vendor's breach of the business associate agreement or the vendor's obligations under HIPAA (discussed below); and

3. Claims/losses arising out of the vendor's negligence.

Although vendors will likely resist at first, the vendor should at least be willing to provide indemnity for claims arising out of its breach of its obligations under HIPAA. If it will not, the practice should re-consider whether it wants that vendor to provide the EHR software.

A word of caution is in order here: most license agreements will cap a vendor's liability under the license agreement or user agreement. Since the cap language is often drafted broadly so as to include the vendor's indemnity liability, the practice should make sure that there is appropriate language carving out the vendor's indemnity liability from the cap.

**Business Associate**

Any move to EHR technology must take into consideration the implications of HIPAA. HIPAA originally required covered entities to hold their business associates to the same requirements that the covered entities have under HIPAA with respect to maintaining the security and privacy of protected health information ("PHI"). HIPAA defines a "business associate" as a non-employee person (whether an individual or entity) that performs any function or activity on behalf of, or provides a service to, a practice that involves the use or disclosure of PHI. 35 Until recently, business associates were not directly subject to HIPAA's privacy and security provisions.

ARRA made significant changes that impact EHR vendors. It expands elements of HIPAA's "Security Rule" to apply directly to business associates. 36 ARRA also applies the privacy provisions required in a business associate agreement directly to business associates, as well as HIPAA's civil and criminal provisions. 37 These changes go into effect in February 2010.
EHR vendors will almost invariably meet the definition of business associate. In the traditional model, vendors may have remote access rights to the practice's system for upgrade/maintenance, which could involve the use or disclosure of PHI. As for SaaS, the transmission of PHI and storage on the vendor's server is sufficient for the vendor to constitute a business associate under HIPAA.

Although business associates are now obligated to comply with specific provisions of HIPAA as a matter of law (as opposed to having that obligation by way of a business associate agreement), HIPAA still requires a business associate agreement or the required business associate terms in the underlying agreement, and the practice should make compliance with such an agreement or terms one of the vendor's obligations under the license or user agreement.

Limitations on Liability/Remedies

Almost all vendors include in their agreements a limitation of liability. This limitation has two components: (1) an exclusion of various damages for which the vendor can be held liable (for example, lost profits); and (2) a cap on the vendor's total liability under the license agreement.

Few, if any, vendors will agree to remove the exclusion. However, a practice should try to have the exclusion be mutual so that the practice can rely on it if the vendor claims damages from a breach of the software license agreement or user agreement by the practice.

Vendors are also reluctant to remove the cap. The cap is normally based on the fees paid by the practice for the EHR software over a period of time (for example, fees paid by the practice in the 12-month period preceding the date of the claim). If the vendor will not remove the cap, request that the cap amount be based on a multiplier of the fees paid and have the cap include fees paid under the license or user agreement and the maintenance agreement or service level agreement. As noted above, a practice should ensure the cap excludes the vendor's indemnity liability.

Remedies available to a licensee are often quite limited under a license or user agreement. For example, agreements often provide that the sole remedy in the event of defective software is the replacement or repair of the software. The license or user agreement should provide that if such repair or replacement does not correct the problem, the practice may pursue monetary damages (although even this may not be sufficient depending upon how the agreement caps damages). Agreements are often silent on what a practice's rights are if there is a breach not related to defective software (for example, failure of the vendor to meet specific deadlines). The practice should consider requesting liquidated damages upon such breaches.

Assignment/Outsourcing

Because a practice may choose EHR software based, in part, on the qualities of the vendor offering it, a practice may want to request that the vendor not be permitted to assign the agreement without the practice's consent (although vendors will resist this). With respect to outsourcing by the vendor, the practice should insist that any subcontractors agree to be bound in writing by the same terms and conditions with regard to privacy and security of PHI that apply to the vendor (including all of the vendor's obligations as a "business associate" under HIPAA).

Information Storage

Under the SaaS model, the electronic health record resides on a server outside of the control of the practice. A practice should request that the agreement obligate the vendor to comply with HIPAA and all other applicable privacy laws with respect to the following: (1) data encryption technologies for both transmission and storage; (2) appropriate firewalls to block malware and other viruses; and (3) appropriate physical safeguards for the data center where the server is located. Additionally, the agreement should include a prohibition against relocating the server without notice to the practice, as well as provide the practice with audit rights for the server site.

Related to the security of the server is the frequency of data back-up. SaaS vendors typically have data back-up systems that track and store changes on a continual basis. The practice should request that the vendor be able to provide a HIPAA-compliant back-up log and have data centers that are redundant of the primary server. The vendor should agree in writing to all of this, as well as make available to the practice a copy of the vendor's disaster recovery plan. Finally, the practice should ensure that the vendor's data storage policies are consistent with the practice's own document retention policy.
Source Code Escrow

Source code is the human readable lines of code in a computer program that allow a programmer to edit and update the software. Depending on the amount of the investment in the software, some customers purchasing traditional licenses will ask that the source code be provided to the customer or placed in escrow and released to the customer upon the occurrence of certain events (the vendor breaching the license agreement, going out of business, etc.). Vendors, however, are typically very reluctant to place their source code in escrow. Further, even if the EHR vendor would be inclined to such an arrangement, the cost associated with a source code escrow likely makes the arrangement cost prohibitive. However, each situation stands on its own, so consideration should be given to making the request if appropriate.

Conclusion

The framework is in place for a significant increase in the deployment of EHR technology over the next few years. A practice's investment in that technology may be one of the most significant investments it makes in its infrastructure. It may also be one of the riskiest. It is therefore important that healthcare attorneys understand and effectively negotiate the key terms of an EHR arrangement.

[Footnote]

Endnotes
1 EHR and electronic medical records ("EMR") tend to be used interchangeably when describing medical records that are generated and stored by a provider in an electronic format. This article will use "electronic health record" and its acronym, EHR, to describe such records. Neither EHR nor EMR should be confused with a personal health record, which is a record generated by a patient and designed to allow a patient to manage his or her medical information.
2 Among the efforts to encourage widespread adoption of interoperable health information technology was the publication by the Department of Health and Human Services ("HHS") of two rules in 2008. The Centers for Medicare & Medicaid Services promulgated an exception to the physician self-referral prohibition ("Stark"), while the Office of Inspector General promulgated a safe harbor under the anti-kickback statute ("AKS"). The Stark exception and the AKS safe harbor both allow EHR software to be donated, provided the donation meets certain conditions. First, the EHR must be interoperable, i.e., "a certifying body recognized by the Secretary [of HHS] has certified the software no more than 12 months prior to the date it is provided to the recipient." Second, donors may not condition the eligibility, amount or form of EHR software on the volume or value of referrals or other business generated by the recipient for the donor. Third, recipients may not condition doing business with a donor upon the receipt of EHR technology. The donations of EHR technology must be made before January 1, 2014, which is when the safe harbor and exception expire. The recipient must pay at least 15 percent of the donor's cost related to the EHR software, and this amount may not be financed by the donor or shifted to any federal health care program. Finally, the EHR software must contain an electronic prescribing capability. Neither the exception nor the safe harbor permits donations of computers or other hardware. See generally 42 CFR § 1001.952 (discussing the safe harbor under AKS) and 42 CFR § 411.357 (discussing the exception under Stark). Initiatives were also launched at the state and local level to develop regional health information organizations ("RHIOs"), which are designed to promote the electronic exchange of health information across a spectrum of providers (with the ultimate goal of having the RHIOs connect to each other as part of a nationwide health information network).
3 No detailed studies have been done to determine the success rate of EHR implementation. David J. Brailer, M.D., PhD, the National Health Information Technology Coordinator under former President George W. Bush, estimated the failure rate of EHR deployment at 50 percent. In the author's experience, most deployment failures occur prior to the software "going live."
5 Pub. L. No. 111-5 § 76 seq.
6 This article focuses on the use of ARRA and HITECH on individual providers and practice groups rather than hospitals.
7 ARRA § 4101(a) (codified at 42 USC § 1395w-4(o)). HHS has established a website with some very helpful resources located at http://healthit.hhs.gov/portal/server.pt.
8 ARRA § 13101 (codified at 42 USC § 300j).
9 ARRA § 13101 (codified at 42 USC § 300j).11
10 In August 2009, the Health IT Policy Council for the Office of the National Coordinator for Health Information Technology issued its recommendations to the National Coordinator for defining "meaningful use." These recommendations, which are set forth in a matrix, outline various metrics to determine whether there is meaningful use. The matrix may be accessed at: http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_888532_0_18/FINAL%2020%20RECOMMENDATIONS%20TABLE.pdf.
11 See ARRA § 4101(a) (codified at 42 USC § 1395w-4(o)): see also ARRA § 4201(a) (codified at 42 USC § 1396b(a) and (j)).
12 ARRA § 4101(a) (codified at 42 USC § 1395w-4(o)).
13 Id.
14 Id.
15 Id.
16 Id. Rural health professional shortage areas ("HPSAs") are designated by HHS's Health Resources and Services Administration as having shortages of primary medical care, dental or mental health providers.

17 ARRRA § 4201(a) (codified at 42 USCA § 1396b). Rural health clinics are located in areas that are designated as HPSAs or medically underserved areas. Federally qualified health care centers are providers that receive grants or enhanced reimbursement under Medicare or Medicaid to promote the provision of primary care services in underserved urban and rural communities.

18 Id.

19 Id.

20 Id. HITECH provides a number of other types of assistance to encourage EHR technology adoption. For example, grants are available to public, nonprofit, and critical access hospitals, community health centers, individual and small group physician practices, and entities that serve the uninsured, underserved, and medically underserved individuals. Matching grants are available to states to help facilitate and expand electronic health information exchange. Competitive grants may also be made to Indian tribes and states to establish loan programs for health care providers to purchase and utilize certified EHR technology. HHS is also authorized to explore a program for making competitive grants to medical, dental, and nursing schools, and to other graduate health education programs, to integrate EHR technology into the clinical education of health care professionals. Finally, if the needs of providers are not being met by the marketplace, HHS is to support the development and routine updating of qualified EHR technology and make it available to providers for a nominal fee.

21 ARRRA § 4101(a) (codified at 42 USCA § 1395w-4(c)).

22 Id.

23 Id.

24 There are a number of other methods for deploying software. In the author's experience, however, these other methods are not presently being used extensively in the deployment of EHR software.

25 For example, if vendors are responsible for storing protected health information on their server, such information will usually be encrypted, while PHI stored on a provider's own server may not.

26 To ensure that the EHR software complements the way a practice operates, a practice may require different templates than those offered by the EHR software vendor.

27 In almost all instances, a local area network will offer speeds that are greater than those available from an Internet service provider, as the transmission distances are much shorter.

28 The user agreement may also be called a participation or subscription agreement.

29 There has been at least one reported instance of a vendor denying a practice access to PHI due to the practice's alleged failure to pay outstanding fees owed to the vendor. See Brian Banderon, Multiple Doctors Cut Off from Records by Dr. Notes, SOUTH FLORIDA BUSINESS JOURNAL, June 30, 2006 (http://southflorida.bizjournals.com/southflorida/stories/2008/07/03/story8.html).

30 As a practical matter, to be able to take advantage of the incentives under HITECH, the software must be certified by CCHIT, which should reduce the concern about the transferability of the practice's data. However, for the avoidance of doubt, the agreement should allocate responsibility for any costs associated with the transfer of the data to the new EHR system.

31 29 USC §1181 et seq. Although vendors will often represent that their software is "HIPAA-compliant," a practice will need to determine if that is in fact accurate. For example, the practice should ask about the security features of the software, as well as the ability of the EHR software to accommodate audit requests permitted under HIPAA.

32 Whenever EHR software is chosen needs to be integrated/interfaced with existing software, including practice management software (which is one advantage of using a single vendor for both EHR and practice management software, thereby reducing the reliance on interfaces). Although vendors will likely resist any representations and warranties regarding the EHR software's integration and interface with other products, the practice should consider such a request if the circumstances warrant.

33 "Acceptance" is that acknowledgment by the physician that the EHR software is operable in a clinical setting in accordance with the specifications for the software. It is strongly encouraged that the terms of acceptance be defined in the primary agreement and that acceptance be made in writing.

34 The Software & Information Industry Association published a white paper in 2007, "Setting Expectations in SaaS: The Importance of the Service Level Agreement to SaaS Providers and Consumers," which provides a more thorough explanation of the SLA's importance in the SaaS model.

35 45 CFR § 160.103.

36 ARRRA § 13401 (codified at 42 USCA § 17931(a)) (applying 45 CFR § 164.308, .310, .312 and .316 to business associates).

37 ARRRA § 13404 (codified at 42 USCA § 17934(a)) (applying 45 CFR § 164.504(e) to business associates).

38 ARRRA § 13423 (codified at 42 USCA § 17953).

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**Indexing (document details)**

**Subjects:** Hospitals, Agreements, Software, Adoption, Privacy, Computer centers, Physician assistants, Payments, Incentives, Fines & penalties, Data encryption, American Recovery & Reinvestment Act 2009-US, Information storage, Health facilities, Computerized physician order entry

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**Document types:** Feature

**Document features:** References

**Publication title:** The Health Lawyer. Chicago: Dec 2009. Vol. 22, Iss. 2; pg. 53, 8 pgs

**Source type:** Newsletter

**ISSN:** 07363443

**ProQuest document ID:** 1983868631

**Text Word Count:** 6441

**Document URL:** http://proquest.umi.com/pqdweb?did=1983868631&sid=2&Fmt=3&clientId=139599&RQT=309&VName=PQD

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