

# Recovery Act Signed into Law

President Barack Obama on Feb. 17 signed into law the “American Recovery and Reinvestment Act of 2009” (ARRA). The new law contains \$1 billion in funding for prevention and wellness programs, \$10 billion in research funding for National Institutes of Health and \$1.1 billion in comparative effectiveness research (CER) funding. The law also contains \$19 billion in incentives for “meaningful users” of health information technology (IT).

ARRA authorizes incentives for health IT adoption for physicians equal to 75 percent of their allowable Medicare Part B charges, subject to caps. Physicians can receive payments of up to \$18,000 for implementing certified health IT in 2011 or 2012. In subsequent years, this incentive payment drops to \$12,000; \$8,000; \$4,000 and finally \$2,000. However, physicians who do not adopt a certified health IT system are subject to penalties starting at -1 percent in 2015, -2 percent in 2016 and -3 percent in 2017.

“The ACC is excited about the passage of the Recovery Act because of its funding for prevention and wellness, research and health IT,” says ACC President **Douglas Weaver, M.D., F.A.C.C.** “The development of specific regulations regarding health IT provides an opportunity to develop a ‘business case’ for medical providers to make the time and monetary investment in implementing an EHR.”

## Comparative Confusion

Significant confusion was created regarding the ARRA section on CER. Specifically, some were concerned that a new Federal Coordinating Council for CER created by the Act would be able to limit access to health care items or services due to cost. However, the final language states that funds are to be used only to conduct CER research and are not

intended “to be used to mandate coverage, reimbursement, or other policies for any public or private payer.”

The ACC supported the health provisions of ARRA, including the final CER language, in a letter to conferees on Feb. 11. The letter states, “ACC believes the goal of comparative clinical effectiveness research should be to provide the data necessary to better inform physician/patient decision making in the future, and the final provision must not contain recommendations establishing national clinical guidelines nor contain national coverage recommendations.” The letter is available at [qualityfirst.acc.org](http://qualityfirst.acc.org).

## Recommendations

Given the many benefits of using health IT, including reduced administrative cost and medical errors, the ACC highly encourages members to take advantage of the federal funding available to implement health IT.

The ACC recommends that members who do not currently use an EHR begin the process of adoption in 2009 and implement a system no later than 2010 in order to receive the maximum bonuses available. Practices interested in implementing EHR systems should be sure that vendors provide a guaranteed upgrade path that ensures their products will meet certification criteria as established by the Department of Health and Human Services (HHS). Including this requirement will also benefit practices interested in purchasing and implementing systems in 2009.

The ACC will provide updates on the program as they become available from HHS. Visit [acc.org/healthit](http://acc.org/healthit) for an FAQ on the health IT incentives, and EHR tools and resources.



## Corrections to the ACC Coding Guide

In the February issue of *Cardiology*, the ACC included a special “Guide to 2009 Cardiology Coding and Payment Changes.” This included several improperly-numbered edits. On page 4, “remote services – codes 93294-93297 are billed once every 90-day period,” should read 93294-93296. On the same page, “a physician/practice may not report 93294-93297 if the service is less than 30 days,” should read 93294-93296. In the Remote Codes table on page 5, the final two codes should be 93297 and 93298, not 93296 and 93297. A corrected copy of the guide is available on [acc.org](http://acc.org), in the Advocacy section.