FY2015 Omnibus or "CRomnibus" Appropriations
December 16, 2014

The following ACP staff analysis compares key health care provisions of the Consolidated and Further Appropriations Act, 2015 (H.R. 83), which was released on December 9, 2014, with College policy. It rolls together, through September 2015, 11 of the 12 annual appropriations bills that fund the federal government into one piece of legislation (i.e. omnibus). The 12th bill, which funds the Department of Homeland Security, is also included in the legislation, but is funded under a temporary Continuing Resolution (CR) that expires on February 27, 2015. The legislation is commonly referred to as the "CRomnibus." The House narrowly passed the measure on December 11 and the Senate did so on December 13. The President signed the bill into law on December 16, 2014.

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CRomnibus overview This bill includes funding levels for all federal health care programs, which are included as part of the Labor, Health & Human Services and Educations Appropriations component. The overall topline spending amount in the bill is $1.014 trillion in discretionary spending (spending that results from appropriations bills), $521 billion for defense discretionary and $492 billion for non-defense discretionary spending. For FY2015, this is only a $2 billion increase from FY2014's overall topline amount of $1.012 trillion. Back in December 2013, the Bipartisan Budget Act (BBA), H.J. Res 59, was enacted, which not only established this overall topline number but also restored $63 billion in discretionary spending that would have been cut under sequestration, $45 billion in FY 2014 and $18 billion in FY 2015, divided evenly between defense and non-defense discretionary spending. The Budget Control Act (BCA), as enacted in 2011, put forth instructions that if Congress could not find means to reduce the federal deficit by a specified amount over a certain time period then across-the-board cuts, known as "sequestration," would be imposed. Congress did not find the means and therefore sequestration cuts went into effect in January 2013. As noted above, partial relief from those sequestration cuts in 2013 were averted because of the BBA. Sequestration under the Budget Control Act (BCA) would have required an overall topline amount of only $995 billion for FY2015. The BCA's initial overall topline amount for FY2015 before sequestration was $1.086 trillion. The CRomnibus's FY 2015 $1.014 trillion level is $72 billion less than the BCA's original FY2015 spending level. However, sequestration could return in FY2016 as the BBA was only for two years, FY2014 and FY2015. While the BCA's overall FY2016 spending level is $1.11 trillion, with no agreement	No relevant policy. ACP acknowledges the serious financial constraints in federal spending at this time and supports bipartisan efforts to reduce funding for discretionary programs that do not achieve sufficient value. In the SNHC 2012, we state: "Congress should enact a budget package to replace the $1.2 trillion in sequestration cuts mandated by the Budget Control Act. Such an alternative should achieve equivalent or greater savings while allowing for continued and adequate funding for critical programs to provide access to vulnerable populations, fund graduate medical education, improve and protect public health and safety, prevent and control disease, train more primary care physicians, respond to natural disasters and bioterrorism, and support medical research." ACP is pleased that during a difficult fiscal environment funding for federal health programs of importance to us remains largely intact, and that sequestration cuts were averted, at least in part, thanks to enactment of the BBA. It is also very beneficial, in every sense, that 11 of 12 appropriations bills were funded through H.R. 83, which means that we do not have to endure the threat of a possible government shutdown over appropriations through September 2015. It should be noted, however, that the BBA's sequestration relief does not continue into FY2016. Sequestration under the BCA could return if Congress does not agree to stop the automatic cuts.

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in place to avoid sequestration, FY2016's spending level would be reduced to $1.016 trillion, just $2 billion more than FY2015.	
Health and Human Services (HHS) HHS is the principal federal agency charged with protecting the health of all Americans and providing essential human services. HHS is funded within the Labor-HHS-Education portion of the CRomnibus. The FY2015 CRomnibus provides $156.8 billion for the Labor-HHS-Education program, the same as the enacted FY2014 level.	ACP monitors this agency very closely with regard to appropriations because federal health care programs are funded by this department. We annually advocate for adequate funding for federal programs important to internal medicine and our priorities this year largely received increases in funding.
Agency	
Food and Drug Administration (FDA) The FDA oversees food and medical products and is responsible for assuring the safety of our nation's food and the safety and efficacy of drugs, biologics, vaccines, and medical devices. The FDA received $2.59 billion in the FY2015 CRomnibus, $37 million more than the FY2014 enacted level.	Consistent with ACP policy. ACP will work with the FDA, including supporting appropriate legislative actions to ensure that the content and purity of dietary supplements are compliant with the FDA's regulatory responsibilities for truth-in-labeling under the Dietary Supplement Health and Education Act of 1994. ACP strongly supports increased post-market surveillance of prescription drugs to ensure safety. Congress should provide adequate levels of funding for the federal food and water safety program to include enhanced surveillance systems, better prevention programs, faster outbreak response, enhanced education, and better coordinated and focused research and risk assessment activities. ACP advocates speeding the approval and encouraging the use of generic drugs. ACP also supports negotiating volume discounts on prescription drug prices and pursuing prescription drug bulk purchasing agreements under the Medicare program. ACP has proposed studying the effectiveness of prescription drug substitutes, such as lower-cost, therapeutically equivalent medications. Additionally, ACP strongly supports increased post-market surveillance of prescription drugs to ensure safety.
Health Resources and Services Administration (HRSA) HRSA is responsible for improving access to health-care services for people who are uninsured, isolated or medically vulnerable. HRSA received $6.35 billion in the FY2015 CRomnibus, $23 million more than the FY2014 enacted level.	As part of the "Friends of HRSA" coalition, ACP requested at least $7.48 billion (FY2010 level) for HRSA during the FY2015 appropriations process that began last spring. However, in this current tight fiscal environment, HRSA having received just over flat funding is likely the best that could be realistically achieved Adequate funding for HRSA was a key priority for ACP during Leadership Day 2014.
Centers for Disease Control and Prevention (CDC) The CDC's mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health—through health promotion,	ACP policy supports the CDC, and we have traditionally advocated for adequate funding for its mission. In the SNHC 2012, ACP stated "Cuts to public health programs will endanger the health of the public. Public health

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prevention of disease, injury and disability, and preparedness for new health threats. It is the disease prevention and wellness promotion agency, protecting people's health and safety, providing credible information to enhance health decisions, and improving health through strong partnerships. The CDC received $6.93 billion in the FY2015 CRomnibus, $21.4 million more than the FY2014 enacted level. Of the total amount, $6.02 billion is in discretionary funding, $161 million more than the FY2014 enacted level. The CDC benefitted from an $887.3 million transfer from the Prevention and Public Health Fund (PPHF), $56 million more than FY2014.	funding is discretionary spending in most states and is at high risk for significant cuts during economic downturns." While overall the CDC budget has an increase, this is only done through a combination of discretionary dollars and a transfer of mandatory Prevention and Public Health Fund (PPHF) dollars. Congress is backfilling and supplanting discretionary funding for CDC with use of the PPHF. CDC has received the largest portion of PPHF funds. Adequate funding for the CDC was a key priority for ACP during Leadership Day 2014.
National Institutes of Health (NIH) Medical progress and improved patient care depend on innovative and vigorous research. The NIH is the nation's medical research agency, making important discoveries that improve health and save lives. NIH is made up of 27 Institutes and Centers, each with a specific research agenda, often focusing on particular diseases or body systems. The NIH received $30.08 billion in the FY2015 CRomnibus, $149.7 million more than the FY2014 enacted level.	ACP policy supports the NIH. ACP advocates ongoing research with adequate financial support as being in the best interest of the American public. Precipitous changes in such support must be viewed with concern when they threaten to adversely affect the continuity of research efforts. ACP believes that governmental medical research funds should be allocated to categorical areas of need based on merit and, where possible, distributed rather than concentrated on a select number of investigators. FY2015 funding is below the needed amount to sustain NIH research, which means that ACP will continue to advocate for more funding for NIH. FY2008 NIH funding was at $29.2 billion, which would be about $32.8 billion in current dollars. NIH funding levels have not kept up with inflation. Adequate funding for the NIH was a key priority for ACP during Leadership Day 2014.
Agency for Health Research and Quality (AHRQ) This agency is responsible for improving the quality, safety, efficiency and effectiveness of care. AHRQ received $363.7 million in the FY2015 CRomnibus, about the same as the FY2014 enacted level (not including a $7 million transfer from the PPHF in FY2014). AHRQ is also expected to receive an additional $105.6 million in FY2015 from the Patient-Centered Outcomes Research Trust Fund (PCORTF) transfer mandated by the Affordable Care Act (ACA). AHRQ's total FY2015 funding would be $469.3 million, about $5.3 million more than the FY2014 level (again, not including a $7 million transfer from the PPHF in FY2014). Within AHRQ, the FY2015 CRomnibus provides $112.2 million for "cross-cutting" activities related to quality, effectiveness, and efficiency research, $76.58 million for patient safety research, $28.17 million for HIT research,	Consistent with ACP policy, with a slight increase for FY2014. ACP had requested $375 million for AHRQ for FY2015 in its submission to the House and Senate Appropriations Committees. However, in this current tight fiscal environment, AHRQ having received just over flat funding is likely the best that could be realistically expected. While we are disappointed the committees did not fund the agency at the requested level, we are pleased to see increased funds being appropriated over FY2014 levels (not including PPHF transfer). It is particularly positive that AHRQ's base discretionary funding ($363.7 million) was provided through budget authority and not through various taps and transfers, which are less stable and more vulnerable than using budget authority, as had been the case until this bill.

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and $11.59 million for prevention/care management (this research lost $7 million in PPHF transfer funds). No funding was provided for Patient-Centered Health Research or Value research. Within patient safety research, there is $10 million in Healthcare Delivery Systems grants that support, "a systems model approach to patient safety issues in order to identify interrelated threats, generate new ways of thinking about these threats, and establish new environments to brainstorming and rapid prototyping techniques."	ACP has been very supportive of AHRQ and its vital role in improving the quality of our nation's health. AHRQ helps physicians help patients by making evidence-informed decisions, funding research that serves as the evidence engine for much of the private sector's work to keep patients safe, making the healthcare market place more efficient by providing quality measures to health professionals, and ultimately, helping to transform health and health care. Adequate funding for AHRQ was a key priority for ACP during Leadership Day 2014. The Patient Centered Outcomes Research Institute (PCORI) will receive $105.6 million in FY2015 to carry out comparative effectiveness research. This funding is not included in the FY2015 CRomnibus, but will come through the PCORTF.
Centers for Medicare and Medicaid Services (CMS) CMS administers Medicare and Medicaid programs and also operates and manages 27 ACA exchanges. CMS received $611.43 billion in both discretionary and mandatory funds in the FY2015 CRomnibus, $70.94 billion more than the FY2014 enacted level. For running ACA exchanges, CMS received $3.67 billion for its Program Management account, the same amount as FY2014 (and FY2013). Within this account, the main program for administering the ACA, program operations, received $2.52 billion for FY2015, the same as the enacted level for FY2014. CMS will also be able to collect user fees to help run the exchanges. The FY2015 CRomnibus also appropriated $672 million for CMS's health care fraud and abuse control (HCFAC) account for program integrity and program management activities, $378.41 million more than the enacted FY2014 level. The HCFAC program detects, prevents, and combats health care fraud, waste, and abuse across Medicare, Medicaid and the Children Health Insurance Program (CHIP).	ACP supports adequate funding of ACA exchanges, and will continue to advocate for a successful roll-out. ACP recognizes the federal government's need to operate and manage the 27 federally-facilitated exchanges in states that have chosen not to run their exchanges. If Congress denied these funds, it would be difficult to implement the individual coverage parts of the ACA, which would compromise coverage for millions and the overall effectiveness of the ACA. Consistent with ACP policy, which supports efforts to eliminate waste, fraud, and abuse. The College believes that efforts should be fair as to not unnecessarily adversely affect physician practices and the ability of physicians to care for their patients. The College is encouraged by the substantial increase in funds for the HCFAC account. Congress has recognized that program integrity efforts in combating waste, fraud, and abuse are paying off and accordingly has increased funding to expand these activities.
Programs	
Health Professions & Nursing- Title VII and Title VIII The Title VII Health Professions program is critical because it is the only federal program dedicated to funding and improving training of primary care physicians. These programs are administered by HRSA. Title VII and Title VIII Nursing received $486.6 million in the FY2015 CRomnibus, $17.37 million more than the FY2014 enacted level.	Consistent with ACP policy. ACP supports increasing funding for Title VII, as it was a key priority for ACP during Leadership Day 2014. Funding levels in this bill are moderately higher than we have seen in previous years, which please ACP. The increase in Training in Primary Care Medicine almost brings it up to FY2011 and FY2012 levels. Public Health and Preventative Medicine received an increase, although not back up to the levels when it was receiving PPHF

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Title VII received $254.98 million in the FY2015 CRomnibus, $9.64 million more than the FY2014 enacted level. Within Title VII, training in Primary Care Medicine received $38.92 million, $2 million more than the FY2014 enacted level. Public Health and Preventative Medicine training received $21 million in the FY2015 CRomnibus, $2.82 million more than the FY2014 enacted level.	transfers in FY2011 and FY2012.
Rural Health Within HRSA, there are rural health programs that coordinate and analyze the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians in rural areas. These activities can include support for community organizations for healthcare delivery and network sustainability, grants to small rural hospitals, including critical access hospitals, and enhancing telemedicine efforts. These programs received $147.47 million in the FY2015 CRomnibus, $5.11 million more than the FY2014 enacted level.	ACP policy supports ensuring adequate access to health care and primary care physicians in rural and underserved areas of the country.
National Health Service Corps (NHSC) Within HRSA, NHSC helps provide primary health care through direct support of health professionals across the country. The NHSC provides scholarships and loan forgiveness to enable primary care physicians to be trained to serve underserved communities. The NHSC did not receive discretionary appropriations in either the FY2015 CRomnibus, the FY2014 omnibus nor in FY2013 appropriations. However, the ACA created a mandatory NHSC Fund at the discretion of the Secretary of Health and Human Services (HHS). With this new mandatory fund, which is not subject to annual congressional appropriations process, the Secretary may provide up to $1.5 billion to the NHSC over 5 years ($290 million for FY2011, $295 million for FY2012, $300 million for FY2013, $305 million for FY2014 and $310 million for FY2015). FY2015 is the last year that NHSC receives mandatory funding through the ACA. A FY2016 funding source for the NHSC is uncertain at this time.	ACP supports the NHSC to help address the health professionals workforce shortage and growing maldistribution. NHSC programs make an impact in meeting the health care needs of the underserved. ACP advocated an $810 million investment for the NHSC in FY2015. However, without any discretionary appropriations, NHSC funding has fallen far short of the levels anticipated after passage of the ACA. Adequate funding for the NHSC was a key priority for ACP during Leadership Day 2014. Until there is a clear source of funding for FY2016, the NHSC program is in jeopardy.
National Health Care Workforce Commission The Affordable Care Act (ACA) established a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy starting in 2010. It would be tasked with assessing the nation's workforce needs including the barriers to primary care. As in previous years, the FY2015 CRomnibus does not	ACP policy supports the Commission and its mission and we requested $3 million in funding for the Commission in FY2015. Since the Commission was established under the ACA, appropriators have not provided any funds for the commission, which means it has yet to become operational, which has been a great disappointment to ACP. Funding for the Commission was a key priority for ACP

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include funding for the Commission.	during Leadership Day 2014.
Chronic Disease Prevention and Health Promotion Within CDC, these programs engage to prevent and control chronic diseases. Through public health efforts such as data collection and surveillance, these programs monitor, prevent, delay and detect chronic disease as well as conduct chronic disease research. These programs received $1.19 billion in the FY2014 omnibus, $747.22 million in discretionary funds and $452 million from the PPHF. Overall, this is $41.57 million more than the enacted FY2014 level, $35.57 more in discretionary funds and $6 million more from the PPHF.	Consistent with ACP policy. ACP supports appropriate coverage and adequate payment for preventive services and improving prevention and wellness activities. While overall this program has seen a slight increase, this is only done through the transfer of mandatory Prevention and Public Health Fund (PPHF) dollars. Congress is backfilling and supplanting discretionary funding for CDC with use of the PPHF.
Public Health Preparedness and Response Within CDC, the Office of Public Health Preparedness and Response (PHPR) is responsible for coordinating the response to natural, biological, chemical and radiological incidents. The PHPR also supports state and local response to hazard incidents through funding for public health departments as well as technical support. The PHPR also oversees the national repository for medicines for public health emergencies. These programs received $1.35 billion in the FY2015 CRomnibus, $29.1 million more than the FY2014 enacted level.	Consistent with ACP policy that Congress should appropriate the necessary funding to support a grant program to local public health departments and hospitals to develop appropriate crisis management structures and plans for dealing with a biological or chemical attack. However, the modest increase in the FY2015 CRomnibus should be considered almost flat funding. ACP supports measures to increase pandemic influenza vaccine and antiviral medications in the Strategic National Stockpile. ACP supports the national procurement of vaccine in an amount sufficient to protect the entire U.S. population and national procurement of antiviral medications to cover 25 percent of the U.S. population. ACP believes that additional courses of antiviral medications should be procured for all public safety officers and health care workers with direct patient contact in amounts sufficient to provide prophylaxis. In the event of pandemic influenza, stockpiled vaccine and antivirals should be distributed equitably to all states' public health authorities based on the numbers of people in high-risk and high-priority groups.
Ebola Funding The FY2015 CRomnibus included $5.48 billion in emergency funding to fight the Ebola outbreak. Of that total, $2.72 billion went to the Labor-HHS-Education bill. The bulk of it, $1.77 billion, went to the CDC for both domestic and international activities. The remaining funds were strewn across various agencies: $157 million for the Biomedical and Advanced Research and Development Authority (BARDA); $576 million for the Assistant Secretary for Preparedness and Response; and $238 million for the National Institute of Allergy and Infectious Diseases (part of NIH). Bill report language also requested a detailed spending plan and a report on oversight to prevent fraud and waste.	Consistent with ACP's statement calling for government to promote infection control measures that have been shown to be both highly effective in limiting the spread of diseases, while being the least restrictive possible.
Mental Health Within the Substance Abuse and Mental Health Services Administration (SAMHSA) there are numerous mental	Under current fiscal constraints, SAMSHA's mental health programs did relatively well with a slight decrease. There were also slight decreases for two of its activities,

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health service programs. These programs include grants to the states for mental health, the homeless and children as well as national mental health programs. In the FY2015 CRomnibus, mental health programs received $1.08 billion, $9.41 million less than the FY2014 enacted level.	Programs of Regional and National Significance and Mental Health block grants. SAMSHA also received a $12 million transfer in PPHF funds for suicide prevention.
Independent Payment Advisory Board The ACA established IPAB, a 15-member panel tasked with slowing the growth in Medicare spending. Beginning in 2014, proposals for Medicare cost reductions from the Board would be required for each year when Medicare costs are projected to increase faster than the 5-year average of the consumer price index (CPI) as determined by the Centers for Medicare and Medicaid Services Chief Actuary. The Secretary of HHS would be required to implement the provisions included in the IPAB proposal, unless Congress passes an alternative proposal with an equivalent amount of budgetary savings. Medicare's trustees say the program's costs are growing so slowly on their own that the IPAB wouldn't even be triggered until at least 2015. The President hasn't nominated anyone to the board yet. Nominees have to be confirmed by the Senate, which until recently required 60 votes. Last year, the Senate passed a rule change allowing a 51-vote threshold for executive appointments, which will likely make it easier for the President to have his appointees to the board, should he choose them, approved by the Senate. According to the House Appropriations Committee, $10 million was cut from IPAB's funding level in the FY2015 CRomnibus.	ACP supports the concept of an Independent Payment Advisory Board (IPAB) to implement payment reform that promotes quality and value (and does not simply focus on cost). The College believes that an independent board of physicians and other health care experts that both informs Congress on means to effectively control the unsustainable growth of Medicare healthcare expenditures and provides an increased requirement for Congress to address this important issue would be more likely to achieve needed Medicare changes. The College further believes that the IPAB has the potential to serve this role, but requires some significant modification from the IPAB as structured under the ACA. Thus, rather than repeal IPAB, the College advocates for modifications to the current-law provision, such as allowing Congress to override IPAB recommendations with a majority rather than a super majority vote, among others.
Prevention and Public Health Fund (PPHF) The ACA established direct funding for the PPHF for prevention, wellness, and public health activities. For FY2015 there was $927 million still available, including sequestration. In 2014, unlike previous years, Congress decided to directly allocate PPHF funding in the FY2014 omnibus and has done so again for FY2015. In the FY2015 CRomnibus, the Administration for Community Living (ACL) received $27.7 million (same as FY2014), the CDC received $886.3 million ($55 million more than FY2014), and the Substance Abuse and Mental Health Services Administration (SAMHSA) received $12 million ($50 million less than FY2014). AHRQ did not receive any PPHF funds, which were $7 million in FY2014.	Consistent with ACP policy. ACP supports appropriate coverage and adequate payment for preventive services and improving prevention and wellness activities. ACP supports the PPHF; the impetus of the fund is that it is available for use by public health agencies to provide additional dollars above and beyond current baseline funding. However, in the scarce non-defense, discretionary budget environment, mandatory funds from the PPHF were being used to backfill discretionary dollars in order to further spread out the use of discretionary dollars and fund other programs, namely the ACA. Some Members of Congress objected to this use of PPHF funding for ACA purposes, namely Republicans, the majority of whom oppose the ACA. In the FY2014 omnibus, a compromise was reached where the $1 billion was still spent, but specifically allocated across ACL, AHRQ, CDC, and SAMHSA for prevention and public health functions, not ACA

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	purposes. While some media reports covering the FY2014 omnibus indicated that the PPHF had been eliminated, that is not correct. Congress chose to directly allocate PPHF funds, as it is permitted to do, instead of leaving it up to the discretion of the Secretary of HHS. Congress has chosen to continue this practice in the FY2015 CRomnibus, with $927 million available through the PPHF.
Community Health Centers (CHC) CHCs receive a total of $5.1 billion in the FY2015 CRomnibus, $1.5 billion more than FY2014. The amount includes $1.49 billion in discretionary funding through HRSA, $3.75 million less than the FY2014 enacted level and $3.6 billion in mandatory funding, $1.4 billion more than FY2014. The FY2015 CRomnibus directs HRSA to increase base grants to CHCs by $165 million and to use $350 million to open new CHCs.	Consistent with ACP policy. ACP supports funding of community health centers, as a part of providing affordable coverage to all Americans. Note that discretionary funding is just slightly down from FY2014 enacted levels. However, there is a significant increase in mandatory funding from the Community Health Center fund which ends in FY2015. There is no mandatory funding source for CHCs in FY2016.
Policy Rider	
National Health Service Corps (NHSC) Congress directed NHSC to evaluate the establishment of a demonstration project within the NHSC in which optometrists are recognized as primary health care providers for purposes of the Loan Repayment Program.	ACP supports the NHSC to help address the health professionals' workforce shortage and growing maldistribution. ACP's policy does not specify which specialties or other health professions should be eligible to participate in the NHSC and does not recognize optometrists as primary health care providers.
Centers for Medicare and Medicaid Services (CMS) Access to Home Health Care- Congress directed CMS in its FY2016 budget request to quantify and explain how requiring physicians to conduct face-to-face certifications for home health care has prevented fraud, increased access, and impacted costs to Medicare and Medicaid.	Consistent with ACP policy—the face-to-face certifications are time consuming and may not be always necessary based on patient records and reports from other health professionals. This has been an issue that we have previously addressed with CMS.
Health Insurance Marketplace Transparency- Congress directed CMS to document in detail the use of funds for the Health Insurance Marketplaces for every fiscal year since the enactment of the Affordable Care Act (ACA) as well as proposed uses for those funds in its FY2016 budget request.	Not consistent with ACP policy, which is supportive of the new insurance marketplace established under the ACA (It appears to be a request for a lot of busy-work and part of an effort to disrupt/hinder ACA implementation).
Physician Fee Schedule- Congress expressed concern that CMS did not provide the adequate opportunity to the public to comment regarding changes to surgical procedures in the annual Medicare Physician Fee Schedule (MPFS) final rule. Congress also expressed concern that the appropriate methodology has not been tested to ensure no negative impacts. Congress also stated that CMS should give additional consideration to these changes.	No comment—Do note that these changes were first offered within the proposed rule; thus, there was considerable opportunity for stakeholders to review and comment.
Risk Corridor Program- Congress prohibited CMS from using Program Management funds for risk corridor payments, requiring the program to be budget neutral and not pay out more than it collects from insurance companies over the three-year period the program is in	Inconsistent with ACP policy—the risk-corridor program protects insurers in the new insurance market place from excessive losses. Removal of this funding source could jeopardize this protection and discourage insurer participation.

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effect.	
Office of the National Coordinator for Information Technology (ONC) Information Blocking- Congress urged ONC to only certify products that meet current meaningful use program standards and that do not block health information exchange. Congress also urged ONC to decertify products that proactively block the sharing of information. Congress required a detailed report from ONC within 90 days of enactment regarding the extent of the information blocking problem. Interoperability- Congress directed the Health IT Policy Committee to submit a report to the House and Senate Appropriations Committees and appropriate authorizing committees within a year of enactment regarding the challenges and barriers to interoperability. Congress specified that the report should cover the technical, operational, and financial barriers to interoperability.	Consistent with ACP policy that supports the broader exchange of health information. However, were ONC to take an action to decertify previously certified systems, physicians who have purchased the affected systems would be severely penalized, in that they would lose their ability to attest for Meaningful Use.

Sources:
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https://www.aamc.org/advocacy/meded/176378/national_health_service_corps_nhsc.html