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Member Advisory

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Implications for Hospitals and Health Systems as Partial Government Shutdown Looms

Specific government agency funding, including programs within the Department of Health and Human Services, is set to expire at midnight Jan. 30. Without legislative action, this will result in a partial government shutdown. Congressional leaders are continuing negotiations to keep the government funded. As part of those discussions is the continuation of the vital health programs also set to expire at the end of the month.

The House of Representatives Jan. 22 voted 341-88 to pass the Consolidated Appropriations Act of 2026 (H.R.7148), which contains conferenced legislation for the Departments of Defense, Homeland Security, Labor, Health and Human Services, Education, Transportation, and Housing and Urban Development. Additionally, it includes a bipartisan health package with extensions of key health care programs, many of which have been advocated for by the AHA. See the AHA Legislative Advisory for a detailed summary of provisions important to hospitals and health systems.

The Senate is set to take up consideration of H.R. 7148 this week. However, ongoing discussions regarding the Homeland Security Appropriations bill may prevent Congress from meeting its funding deadline. Any changes the Senate makes to the bill would require another House vote. With limited legislative days remaining this week, the likelihood of a partial government shutdown has increased. To date, only six of the 12 appropriations bills have been enacted.

AHA TAKE

The AHA will continue to monitor the progress of government funding negotiations. This is a fluid process, and we will provide updates as more information becomes available in the coming days. We have provided information below on what is likely to happen if there is a partial government shutdown.

IMMEDIATE IMPACT ON HOSPITALS AND HEALTH SYSTEMS

In general, Medicare payments to hospitals are mandatory and not subject to the annual appropriations process, and therefore, they are unaffected by a government shutdown.

Medicaid is a federal entitlement program, but it is considered an appropriated entitlement, as it does not have a dedicated trust fund or indefinite appropriations and thus relies on annual appropriations to continue operating. During the October 2025 shutdown, the Centers for Medicare & Medicaid Services' (CMS) contingency plan stated they had sufficient funding for Medicaid to fund the first quarter of fiscal year (FY)

2026. AHA will provide updates as CMS provides updated information for the second quarter of fiscal year 2026.

Guidance on payments to **Medicare contractors** is more ambiguous and is an area where there could be disruptions during a prolonged shutdown. Payments to contractors are typically viewed as a "necessarily implied exception," which allows activities to continue during a shutdown, even if they spend money.[1] However, if all appropriations are exhausted, actual payments to contractors would not be made until new funds are appropriated.

Funding for the **Rural Health Transformation Program is mandatory funding and therefore not impacted by a lapse in government funding**; staff furloughs could create delays in administering the program. As of the publication of this Advisory CMS has not released further guidance.

The Department of Health and Human Services (HHS) and (CMS) previously published FY 2026 contingency plans to guide the agencies through a federal funding lapse through appropriations. **The AHA will continue to monitor any updates made to these documents in the event of a lapse of funding and authorizations of key health care programs set to expire on Jan. 30.**

IMPACT ON HEALTH EXTENDERS

The authorizations for critical health care programs expire Jan. 30 and will require congressional action to extend them further. These programs include:

- Medicaid Disproportionate Share Hospital (DSH) payment cuts.
- The enhanced low-volume adjustment (LVA) and the Medicare-dependent hospital (MDH) programs.
- Medicare telehealth waivers and hospital-at-home program extensions.
- Work Geographic Practice Cost Index (GPCI).
- Medicare rural ambulance add-on payments.
- Workforce extenders (Community Health Centers, National Health Service Corps and Teaching Health Centers Graduate Medical Education).

As a reminder, during the October 2025 shutdown, CMS issued a series of guidance that directed all Medicare Administrative Contractors (MACs) to implement temporary claims hold for services affected by the expired statutory provisions. They did not hold all Physician Fee Schedule (PFS) claims. Providers could continue to submit these

[1] Necessarily Implied Exception (Antideficiency Act) — exception pertains to government functions funded through annual appropriations, which must continue to make possible the lawful continuation of other activities, like making Medicare benefit payments. This exception allows the activities to continue, thus incurring new federal fiscal obligations. https://trumpwhitehouse.archives.gov/wp-content/uploads/2020/12/FAQ-Lapse-12-18-2020.pdf

claims, but payment would not be released until the hold was lifted. Each expiring program was retroactively extended at the end of the shutdown.

As of Jan. 28, CMS has not issued any updated formal guidance in the event of another lapse in authorization. The AHA will provide updates as soon as more information becomes available.

Acute Hospital at Home Program

For hospitals and health systems to effectively and efficiently respond to the COVID-19 pandemic, CMS provided waivers and flexibilities that eased several Medicare restrictions and requirements. Specifically, it waived §422.23(b) and (b)(1) of the Medicare Conditions of Participation, which require nursing services to be provided on premises 24 hours a day, seven days a week, as well as the immediate availability of a registered nurse for the care of any patient. To learn more, see the AHA fact sheet.

CMS' website states that in the absence of congressional action, all hospitals with Acute Hospital Care at Home waivers must discharge or return all inpatients to the brick-and mortar hospital on Jan. 30.

Telehealth Waivers

Currently, there is a patchwork of temporary statutory waivers for telehealth services that, barring further action, will expire Jan. 30. These include removing eligible geographic and originating site restrictions, allowing audio-only services, permitting different types of providers to administer telehealth services, and continuing tele-behavioral health visits.

Medicaid DSH

The Medicaid DSH program provides essential financial assistance to hospitals that care for our nation's most vulnerable populations, including children and people who are disabled and elderly. Congress reduced Medicaid DSH payments in the Affordable Care Act, reasoning that hospitals would care for fewer uninsured patients as health coverage expanded. However, those coverage increases have not yet been fully realized. To learn more, you can read the AHA fact sheet.

The Medicaid DSH cut for FY 2026 is $8 billion and will go into effect on Jan. 31, unless Congress acts. **Because DSH payments are made quarterly, it is possible that states may not impose cuts right away. However, this decision is ultimately made by each state's Medicaid agency, and some states may impose cuts on their own schedule if they believe a shutdown will continue indefinitely.**

Rural Extenders

Low Volume Adjustment and Medicare Dependent Hospital Programs
Congress established the LVA program in 2005 to help isolated, rural hospitals with a low number of discharges. Currently under the enhanced program, they must be more than 15 miles from another inpatient prospective payment system (IPPS) hospital and have fewer than 3,800 annual total discharges. These LVA hospitals receive a payment adjustment based on a sliding scale formula to ensure the patients and communities these hospitals serve continue to have access to care.

Congress established the MDH program in 1987 to help support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. MDHs are small, rural hospitals where at least 60% of their admissions or patient days are from Medicare patients. MDHs receive the IPPS rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. To learn more, see AHA's fact sheet.

Both the LVA and MDH programs experienced a lapse in authorization during the October 2025 government shutdown but were later retroactively extended.

Medicare Rural Ambulance Add-on Payments
CMS considers these payments to be temporary, subject to legislative extensions. If the law lapses, **CMS may revert to the standard Ambulance Fee Schedule.**

Workforce Extenders

Community Health Centers (CHCs) and National Health Service Corps (NHSC)
While CHCs and NHSC have been permanently authorized in statute, the funding authority for these programs is set to expire.

Teaching Health Centers Graduate Medical Education (THGME)
THGME is a temporary program and receives discretionary funding through the annual appropriations process; therefore, these payments could be disrupted by a government shutdown. During the October 2025 shutdown, the Health Resources and Services Administration (HRSA) said that **"for a limited amount of time, they will continue to oversee certain direct health services and other activities with carryover balances such as Health Centers, Teaching Health Center Graduate Medical Education, and the National Health Service Corps."**

Additional Expiring Programs

Work Geographic Practice Cost Index (GPCI)
While the GPCI is a permanent part of the Medicare Physician Fee Schedule, without the extension of a 1.0 floor, **localities could see their Medicare payments reduced if their work GPCI falls below 1.0.**

KEY REMINDERS ON GOVERNMENT SHUTDOWNS

When Congress fails to pass a funding bill, federal agencies can only perform limited government functions. The Office of Management and Budget (OMB) plays an important role in guiding agencies through this process. Federal agencies and departments lacking appropriations generally shut down all nonessential operations and furlough nonessential employees. Historically, the limited government functions that are allowed to continue despite an absence of government funding are as follows:[2,3]

1. Provide for national security, including the conduct of foreign relations essential to national security or the safety of life and property.
2. Provide for benefit payments and the performance of contract obligations under no-year or multi-year or other funds remaining available for those purposes.
3. Conduct essential activities to the extent that they protect life and property, including:
    a. Inpatient and emergency outpatient medical care.
    b. Public health and safety, including safe use of food, drugs and hazardous materials.
    c. Air traffic control and other transportation safety functions, as well as transport property protection.
    d. Border and coastal protection and surveillance.
    e. Federal lands, buildings, waterways, equipment and other property owned by the United States.
    f. Prisoners and other persons in U.S. custody.
    g. Law enforcement and criminal investigations.
    h. Emergency and disaster assistance.
    i. U.S. money and banking system, including borrowing and tax collection activities of the Department of the Treasury.
    j. Power production and power distribution system maintenance.
    k. Research property protection.

AGENCY CONTINGENCY PLANS

In the coming days, we anticipate HHS and CMS to release their updated contingency plans to guide agencies and stakeholders on operations impacted in the event of an appropriations lapse. Those typically describe plans for the staff to be furloughed, how specific programs will be impacted and other pertinent details. **As of Jan. 28, there are**

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[2] OMB Memorandum, *Agency Operations in the Absence of Appropriations*, Nov. 17, 1981.
[3] Legal precedent of “necessarily implied” exception allowed by the Antideficiency Act.

no updated contingency plans posted for FY 2026. AHA will provide updates as soon as they become available.

While we await updated guidance, below are highlights from the FY 2026 contingency plans that guided agencies through the October 2025 shutdown, which may or may not be applicable pending additional directives from OMB.

HHS FY 2026 Contingency Plans

- HHS would retain 59% of staff and furlough the remaining 41%.
- Staff who have a "direct service component" would be retained. HHS provides the following examples:
    - The National Institutes of Health Clinical Center would continue to care for patients and admit new patients for whom it is medically necessary.

CMS FY 2026 Contingency Plans

Programs that would continue:

- The CMS Medicare Program would continue during an appropriations lapse.
- Other non-discretionary activities, including Health Care Fraud and Abuse Control Center (HCFAC) and the Center for Medicare & Medicaid Innovation (CMMI) activities, would also continue.
- CMS will have sufficient funding for Medicaid to fund the first quarter of FY 2026 based on the advance appropriation provided for in the Full-Year Continuing Appropriations and Extensions Act, 2025.
- CMS would maintain the staff necessary to make payments to eligible states for the Children's Health Insurance Program (CHIP).
- CMS would continue Federal Exchange activities, such as eligibility verification, using Federal Exchange user fee carryover.

Activities that would not continue:

- Health care facility survey and certification activities would focus on complaint investigations alleging the most serious incidents of resident or patient harm. Other survey activities, such as recertification surveys, initial surveys and less serious complaint investigations, and all surveys by federal staff would be suspended.
- CMS payment rule development and other policy decisions would depend on the funding source and duration of a lapse in appropriation. With limited staff to review and provide operational support, the agency would expect delays in rule-making and other policy development.

- Under a lapse, CMS would be largely unable to provide oversight to many of its major contractors, including the Medicare Administrative Contractors, the Medicare Call Center and other IT contractors.
- Many national and community outreach and education activities performed by CMS would cease or slow down during a lapse. This could include local and national engagement activities, mailings and other beneficiary-facing activities.
- CMS beneficiary casework services would be largely suspended during a lapse in appropriations.

HRSA FY 2026 Contingency Plans

Programs that would continue:

- HRSA would continue to oversee activities funded through mandatory funding, advanced appropriations, prior year carry-over funds and user fees.
- For a limited amount of time, HRSA would continue to oversee certain direct health services and other activities with carryover balances.
- HRSA would continue to oversee the National Practitioner Databank using existing user fee balances.

Activities that would not continue:

- Vaccine Injury Program, IT and administrative contracts would be delayed.
- Drafting and posting FY 2026 Notice of Funding Opportunities (NOFOs) and reviewing applications for discretionary funded programs would be impacted.
- Limited ability to staff activities related to certain litigation.
- Limited staff to support the development and promotion of high-priority programs in maternal health, health workforce and behavioral health.

Other Noteworthy Items in the FY 2026 Contingency Plans

- There will be no federal oversight and management of cooperative agreement programs such as the Hospital Preparedness Program, Regional Disaster Health Response System, Hospital Associations and others. Reviewing progress reports, reviewing performance measure data, conducting technical assistance calls, site visits and processing any approval to redirect funding, lift conditions of award and funding restrictions to allow recipients access to cooperative agreement funding would cease. (Administration for Strategic Preparedness & Response)
- The Centers for Disease Control and Prevention (CDC) will use the full extent of the authority under the Anti-Deficiency Act to protect life and property under a lapse in appropriations. CDC would not be able to provide communication to the American public about important health-related information. (CDC)

- The Indian Health Service (IHS) received advance appropriations for FY 2026; therefore, the majority of IHS-funded programs will remain funded and operational in the event of a lapse of appropriation. (IHS)
- The National Institutes of Health (NIH) activities will continue to be largely centered on the ongoing operations at its biomedical research hospital, the NIH Clinical Center, to maintain the safety and continued care of its patients. There are many NIH activities that will not continue, such as issuance of new awards, programs/grants management activities, training of graduate students and postdoctoral fellows at NIH facilities, and more. (NIH)
- Most Substance Abuse and Mental Health Services Administration (SAMHSA) grants awarded in the prior year will have funds that remain available to be spent by the grantee, including, for example, the 988 and Behavioral Health Crisis Services program, the State Opioid Response Grant program, and the Mental Health and Substance Use Block Grants. A shutdown of less than one month would have a limited impact. A shutdown would adversely impact potential FY 2026 grant applications throughout the agency, as the release of new NOFOs would be delayed. (SAMHSA)

FURTHER QUESTIONS

If you have further questions, contact Rachel Jenkins, AHA's senior associate director of federal relations, at rjenkins@aha.org.