American Hospital Association™
Advancing Health in America

Member Advisory

October 1, 2025

UPDATED: Implications for Hospitals and Health Systems During a Government Shutdown

Day 1 of government shutdown; CMS releases telehealth guidance

STATUS ON CAPITOL HILL

Government funding and certain health care programs and waivers expired at midnight Sept. 30 as congressional leaders were unable to reach an agreement to keep the government funded. This is a full government shutdown as no fiscal year (FY) 2026 appropriations bills have been signed into law.

On Sept. 29, top Senate and House leaders on both sides of the aisle met with President Trump to discuss government funding; however, no agreement was reached.

On Sept. 30, the Senate failed, for a second time, to reach the sixty votes needed to pass the House-passed continuing resolution (CR), which would have extended government funding and health care waivers until Nov. 21. Sens. Catherine Cortez Masto, D-Nev., John Fetterman, D-Pa., and Angus King, I-Maine, sided with Republicans in favor of the bill, while Sen. Rand Paul, R-Ky., voted against it, along with most Democrats. The Senate also failed to pass an alternative CR offered by Democrats to extend funding through Oct. 31 and permanently extend the Enhanced Premium Tax Credits, among other things.

Additional legislative activity is expected in the Senate on Wednesday, Oct. 1, and throughout the weekend if needed.

AHA TAKE

The AHA will continue to advocate that priorities important to the field be included in a funding package. This remains a fluid process, and the AHA will continue to provide more updates as more information becomes available. **This Advisory, which was originally issued Sept. 25 and updated Sept. 28, has new and updated information in red.**

On Oct. 1, CMS issued guidance on how they will be handling the expiration of telehealth waivers, and that update begins on page three of this advisory.

The information below is based on information currently available, but may shift as agencies begin implementing their shutdown plans, depending on the duration of the shutdown.

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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 mandatory entitlement program, but its appropriations differ from Medicare because it does not have a trust fund or indefinite appropriations and thus relies on annual appropriations. As is customary, the Full-Year Continuing Appropriations and Extensions Act of 2025 included an appropriation for expenditures for federal Medicaid payments to states for the first quarter of FY 2026. The Centers for Medicare & Medicaid Services (CMS) has confirmed there is sufficient funding for Medicaid through the first quarter of the fiscal year. However, continuation of payments is not a certainty if the funding lapse were to continue for more than a calendar quarter.

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 reviewing applications and administering the program. As of the publication of this Advisory, CMS has not released further guidance on whether a lapse in government funding will impact the current timeline for program implementation.

On Sept. 24, the Office of Management and Budget (OMB) issued initial guidance to federal agencies regarding a potential lapse in appropriations and reductions in force. On Sept. 27, the Department of Health and Human Services (HHS) and (CMS) published contingency plans to guide the agencies through a federal funding lapse through appropriations. Information on those plans starts on page 6 of this Advisory. **The AHA will continue to provide updates as additional information becomes available.**

IMPACT ON HEALTH EXTENDERS

The authorizations for critical health care programs expired Sept. 30 and will require congressional action to extend them further.

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[1] Necessarily Implied Exception (Anti-Deficiency 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

On Oct. 1, CMS issued guidance that "directs all Medicare Administrative Contractors (MACs) to implement a temporary claims hold. This standard practice is typically up to 10 business days and ensures that Medicare payments are accurate and consistent with statutory requirements. The hold prevents the need for reprocessing large volumes of claims should Congress act after the statutory expiration date and should have a minimal impact on providers due to the 14-day payment floor. Providers may continue to submit claims during this period, but payment will not be released until the hold is lifted."

Below outlines other program-specific updates we have received.

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.

The AHA has been working with CMS leadership to explore and urge any potential options for continuing the hospital-at-home waiver in the event of a government shutdown.

Regrettably, on Sept. 26, CMS confirmed that the guidance on the CMS hospital-at-home website continues to stand. "For all hospitals with active [Acute Hospital Care at Home] waivers, all inpatients must be discharged or returned to the hospital on September 30, 2025, in the absence of Congressional action to extend the initiative. CMS will no longer accept waiver request[s] for participation in the AHCAH initiative after September 1, 2025."

As of Oct. 1, we don't anticipate any change in the CMS guidance on hospital-at-home programs as it relates to Medicare beneficiaries. **We will provide additional updates as more information or clarity is provided.**

Telehealth Waivers

Currently, there is a patchwork of temporary statutory waivers for telehealth services that have now expired. 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. As a reminder, CMS has issued temporary regulatory telehealth waivers that, without further action, will expire on Dec. 31, 2025. For more information, please refer to this fact sheet.

On Oct.1, CMS issued guidance on how it will address the lapse in authorization of COVID-era telehealth flexibilities. Excerpts of that guidance are included below and can also be found online here.

"The statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 Public Health Emergency will take effect again for services that are not behavioral and mental health services. These include prohibition of many services provided to beneficiaries in their homes and outside of rural areas and hospice recertifications that require a face-to-face encounter. In some cases, these restrictions can impact requirements for meeting continued eligibility for other Medicare benefits."

"Practitioners who choose to perform telehealth services that are not payable by Medicare on or after October 1, 2025, may want to evaluate providing beneficiaries with an Advance Beneficiary Notice of Noncoverage. Practitioners should monitor Congressional action and may choose to hold claims associated with telehealth services that are not payable by Medicare in the absence of Congressional action. Additionally, Medicare would not be able to pay some kinds of practitioners for telehealth services."

CMS notes that the "Bipartisan Budget Act of 2018 allows clinicians in applicable Medicare Shared Savings Program Accountable Care Organizations (ACOs) to provide and receive payment for covered telehealth services to certain Medicare beneficiaries without geographic restriction and in the beneficiary's home. There is no special application or approval process for applicable ACOs or their ACO participants or ACO providers/suppliers. Clinicians in applicable ACOs can provide these covered telehealth services and bill Medicare for the telehealth services that are permissible under Medicare rules during CY 2025, irrespective of further Congressional action."

(Quick links: CMS Telehealth Overview, CMS Telehealth Factsheet, CMS All Fee-for-service Providers Guidance)

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 is scheduled to go into effect on Oct. 1, unless Congress acts. **Because DSH payments are made quarterly, it is possible that states may not impose cuts on Oct. 1. 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.**

We will provide updates as more information becomes available.

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 have experienced lapses in authorization in recent years but were later retroactively extended. During that time, CMS issued guidance to Medicare Administrative Contractors to reprocess affected claims and apply the correct LVA or MDH payments for discharges occurring during the lapse.[2]

Medicare Rural Ambulance Add-on Payments

CMS considers these payments to be temporary, subject to legislative extensions.

As stated at the top of this section, on Oct. 1, CMS issued guidance that "directs all Medicare Administrative Contractors (MACs) to implement a temporary claims hold. This standard practice is typically up to 10 business days and ensures that Medicare payments are accurate and consistent with statutory requirements. The hold prevents the need for reprocessing large volumes of claims should Congress act after the statutory expiration date and should have a minimal impact on providers due to the 14-day payment floor. Providers may continue to submit claims during this period, but payment will not be released until the hold is lifted."

Workforce Extenders

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[2] https://www.cms.gov/files/document/mm12970-extension-changes-low-volume-hospital-payment-adjustment-and-medicare-dependent-hospital.pdf

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 has expired.

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 prolonged government shutdown.

In FY 2026 contingency plans, the **Health Resources and Services Administration (HRSA) states 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."** No additional information has been provided on what "limited amount of time" means now that the government has shut down.

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. 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:[3,4]

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.

[3] OMB Memorandum, *Agency Operations in the Absence of Appropriations*, Nov. 17, 1981.
[4] Legal precedent of "necessarily implied" exception allowed by the Anti-Deficiency Act.

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.

DETAILS ON PRIOR GOVERNMENT SHUTDOWNS

The federal government has seen three long shutdowns.

2018-2019: A 35-day partial government shutdown occurred from Dec. 22, 2018, to Jan. 25, 2019, because of a dispute over funding for border security. During the shutdown, HHS continued to operate as its funding had been previously enacted. The government reopened with full-year funding adopted for all remaining departments and agencies in February 2019.

2013: A 16-day full government shutdown unfolded from Oct. 1-17, 2013, because of a dispute over defunding the Affordable Care Act. Congress passed full-year spending for all departments and agencies in January 2014.

1995-1996: A 21-day partial government shutdown occurred from Dec. 15, 1995, through Jan. 6, 1996, during a confrontation over balancing the budget. The partial shutdown affected HHS. Congress and the administration negotiated full-year funding for all affected departments in March 1996.

AGENCY CONTINGENCY PLANS

On Sept. 30, OMB issued a memo saying agencies "should now execute their plans for an orderly shutdown." OMB says it will provide additional guidance as needed.

On Sept. 24, OMB issued initial guidance to federal agencies regarding a potential lapse in appropriations and reductions in force. Here are some key takeaways:

- Programs with mandatory funding will continue.
- Programs that rely on discretionary funding (i.e., funding through the annual appropriations process) are at risk if they meet the following criteria:

    - Discretionary funding lapses on Oct. 1.
    - Another source of funding (such as mandatory funding) is not available.
    - Not consistent with the president's priorities.
- OMB has directed agencies to use any lapse in discretionary funding as an opportunity to make reductions to the federal workforce through Reduction in Force (RIF) notices. These reductions would be in addition to the customary practice of furloughing federal workers during a shutdown.

On Sept. 27, HHS and its operating divisions released their FY 2026 contingency plans, which describe staff to be furloughed, how specific programs will be impacted and other pertinent details. These contingency plans, which are now in effect, may continue to be updated depending on the length of the shutdown and available funds. **AHA will continue to provide additional updates as needed.**

Below are highlights from the existing FY 2026 contingency plans.

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.
    - The Food and Drug Administration would continue core functions to handle and respond to emergencies — such as outbreak monitoring and response related to foodborne illness and the flu, supporting food and medical product recalls when products endanger consumers and patients, pursuing criminal and certain civil investigations when public health is at risk, screening the food and medical products that are imported to the U.S. to protect consumers and patients from harmful products, and addressing other critical public health issues.

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 reports that of the 8,742 staff to be furloughed, approximately 1,563 are in RIF status. (CDC)
- All Food and Drug Administration (FDA) activities related to imminent threats to the safety of human life or protection of property would continue. This includes detecting and responding to public health emergencies and continuing to address existing critical public health challenges by managing recalls, mitigating drug shortages, and responding to outbreaks related to foodborne illness and infectious diseases. (FDA)
- 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)

NON-HEALTH CARE RELATED ITEMS OF NOTE:

- Social Security benefit payments will continue because they are mandatory funding, but the Social Security Administration (SSA) may experience other administrative delays. (SSA)
- VA Medical Centers, Outpatient Clinics, and Vet Centers will be open as usual and providing all services. VA benefits will continue to be processed and delivered, including compensation, pension, education and housing benefits. (U.S. Department of Veterans Affairs)
- The United States Postal Service (USPS) will continue to operate as normal, as it self-funds its operations through the sale of postage and services rather than federal funding. (USPS OIG)
- House and Senate offices on Capitol Hill will remain open to the public.
- The Smithsonian Museums, including the National Zoo, have announced they have enough available funding to remain open until Oct. 6.

FURTHER QUESTIONS

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