Effects of a Government Shutdown on HHS Operations and Key Medicare/Medicaid Policies

Background

In the absence of a legislative agreement to fund the federal government in federal fiscal year (FY) 2026, which begins on October 1, 2025, the government will experience a shutdown until an appropriations bill is signed into law. There are also key health policy "extenders" that are tied to a funding bill that will lapse on September 30, 2025, including Medicare telehealth flexibilities and the Medicare Acute Hospital Care at Home program. This document summarizes which Department of Health and Human Services (HHS) activities will cease in the event of a shutdown, which Medicaid and Medicaid activities will continue, and the status of key health policies. HHS has provided a summary of the these activities, as well as staffing changes, on its website. A contingency plan specific to the Centers for Medicare & Medicaid Services (CMS) is available here.

Medicare and Medicaid Payments Expected to Continue

- CMS will continue to make Medicare fee-for-service payments to providers and payments to Medicare Advantage Organizations.
    - CMS will continue to make Medicare Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments.
- The federal government will continue to make Medicaid and Children's Health Insurance Program (CHIP) payments through the first quarter of FY 2026.
- Health insurance marketplace operations, such as eligibility determinations, will continue.
- Non-discretionary activities, including Center for Medicare & Medicaid Innovation (CMMI) activities and Health Care Fraud and Abuse Control Program, would continue.

Health Extenders

Telehealth

Since March 2020, Congress has waived Sec. 1834(m) limitations to Medicare payment for telehealth services. If the waivers are not extended beyond September 30, 2025, CMS must return to pre-pandemic telehealth policy; therefore, the following key changes would occur:

- **Geographic Limits**: Telehealth services will no longer be available to patients in all geographic regions. The patient must be located outside of a Metropolitan Statistical

Area (non-MSA) or within a Health Professional Shortage Area (HPSA) when receiving a telehealth service (i.e., rural areas only).

- **Originating Site Restriction**: The patient must be located at an originating site when receiving a telehealth service (e.g., medical facility or physician office). A patient's home will no longer be recognized as an originating site for Medicare payment.
- **Eligible telehealth providers**: CMS temporarily expanded the definition of eligible telehealth providers to include audiologists, occupational therapists (OT), physical therapists (PT), and speech-language pathologists (SLP) as part of the pandemic-era waivers. If the telehealth waivers are not extended, OTs, PTs, and SLPs will no longer be recognized as eligible Medicare telehealth providers for telehealth services furnished on and after October 1, 2025.
- **In-person visit:** For mental health telehealth services, beginning October 1, an initial 6 month in-person visit and subsequent 12 month (annual) in-person visit is required. However, under CMS' interpretation of the initial 6 month in-person visit required by statute, patients who received a mental health telehealth service during the waiver period are considered established patients and are not required to have an initial 6 month in-person visit retroactively.

Medicare can pay for telehealth outside of Sec. 1834(m) restrictions for:

- Services for the diagnosis, evaluation, or treatment of a mental health or substance use disorder
- Monthly ESRD related clinical assessments
- Participation in certain alternative payment models with waivers, including:
    - Shared Savings Program ACOs taking on downside risk & accepting prospective attribution
    - ACO REACH
    - Bundled Payment for Care Improvement Advanced (ending December 31, 2025)
    - Transforming Episode Accountability Model (beginning January 1, 2026)

Hospital at Home

Under the Acute Hospital Care At Home (AHCAH) program, hospitals that have received a waiver from CMS can provide inpatient care to their patients in their homes, if certain conditions are met. CMS has said that absent an extension of the Acute Hospital Care At Home (AHCAH) program, which is set to expire on September 30, all hospitals with active waivers must discharge their hospital-at-home inpatients or transfer them to the hospital. Without an extension, CMS will no longer accept waiver requests for participation in the AHCAH initiative after September 1, 2025.

Medicaid DSH cuts

Absent Congressional action delaying or eliminating Medicaid disproportionate share hospital (DSH) allotment reductions, DSH payments would be reduced by $8 billion in in FY 2026, followed by additional $8 billion reductions in FYs 2027 and 2028.

Agency Rulemaking

The Office of the Federal Register, which publishes agency rulemaking, has stated that only rulemaking and guidance that is considered "necessary for the protection of life and property" will be published during a shutdown. All other rulemaking is likely to be on hold during a shutdown. Pending rulemaking of interest that could be affected by a shutdown could include a proposed Innovation Center model related to the administration's Most Favored Nation Executive Order and guidance or rulemaking related to implementation of H.R.1 (the One Big Beautiful Bill Act, P.L. 119-21).

Agency Operations and Staffing

In a FY 2026 HHS contingency staffing plan, the agency stated it would retain 59 percent of HHS employees department-wide and furlough the remaining 41 percent of employees. Specific to CMS, HHS plans to retain 53% of CMS staff while furloughing the remainder. Staff that are "authorized by law" or considered necessary for the "safety of human life and protection of property" are generally exempt from being furloughed.

For more information on health care policy & regulatory issues, contact the AAMC's Policy & Regulatory Team at regulations@aamc.org and visit our website.