Preparing for a potential government shutdown

Introduction

If Congress does not pass legislation funding the government for fiscal year (FY) 2026 or a stop-gap measure such as a continuing resolution (CR) by midnight on September 30, 2025, the federal government will shut down. Lawmakers are seeking to avoid that outcome, but it cannot be ruled out, given the intense partisan political climate. As the September 30, 2025, deadline approaches, the outcome of House and Senate negotiations on the 12 annual appropriations bills remains uncertain.

This document explores the government shutdown process, potential legislative possibilities (including a full shutdown), and anticipated impacts on the US Department of Health and Human Services (HHS) and its various agencies and programs. We also include an overview of health programs that will expire at midnight on September 30, 2025, if Congress does not extend them.

Shutdown Basics

The Office of Management and Budget (OMB) traditionally provides instructions to executive branch agencies on how to prepare for and operate during a shutdown in a document known as Circular No. A-11 that is revised annually (most recently in August 2025). The policy set forth in this document permits agency heads, in consultation with their general counsel, to decide which agency activities are excepted or otherwise legally authorized to continue during a lapse in appropriations.

The Antideficiency Act prevents federal agencies from entering into obligations in the absence of appropriations, with certain exceptions. For example, a September 2, 2025, Congressional Research Service report provides that “employees whose duties involve the safety of human life or the protection of property may be told by an agency to come to work during the period in which funds are lapsed or unavailable.” The report stresses that programs funded by laws other than annual appropriations bills might not be affected by a lapse in appropriations.

While many programs and staff are funded through annual appropriations, others are supported by alternative funding sources such as entitlement programs, user fees, and appropriations from previous legislation that carry over year to year. For example, the Affordable Care Act appropriated $10 billion to support all Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) staff and models. Because CMMI staff, programs, and models are not supported by annual appropriations, they are unaffected by a lapse in appropriations and can continue during a government shutdown.

In the case of a shutdown, each federal agency submits a plan for OMB review and approval that lays out the staff to be furloughed and the staff and programs that

are excepted either because of necessity (*e.g.*, they involve safety of human life or protection of property) or because they are funded by another source.

The first Trump administration saw two government shutdowns. The first was brief and mostly fell over a weekend, January 19 – 22, 2018. The second, from December 22, 2018, through January 25, 2019, was the longest in US history at 35 days. It was a partial shutdown, given that five of the 12 annual appropriations bills had already been enacted. The shutdown only impacted agencies whose funding was part of the seven unenacted bills, including HHS.

Potential legislative outcomes

While lawmakers are working to avoid a shutdown this year, the range of possible scenarios is broad:

- **Full-year appropriations passed.** Although highly unlikely, Congress could enact all appropriations bills for FY 2026 before the deadline. This would fully fund the federal government and avoid any disruption in services.

- **Continuing resolutions.** If Congress cannot agree on full appropriations, it may pass one or more CRs to temporarily extend funding. A CR would extend funding at current levels, but it could also include anomalies, such as targeted increases or decreases for certain programs, or one-time appropriations for disaster relief. A CR delays a shutdown but doesn't resolve the underlying budget disputes, and it can apply to all agencies or just a subset. CRs also can fund the government for varying lengths of time, ranging from a few days to an entire fiscal year. Recent CR examples include the following:
    - The Continuing Appropriations and Extensions Act, 2025 (H.R. 9747), extending temporary funding from September 30, 2024, through December 20, 2024.
    - The American Relief Act, 2025 (H.R. 10545), extending temporary funding from December 21, 2024, through March 14, 2025.
    - The Full-Year Continuing Appropriations and Extensions Act, 2025 (H.R. 1968), extending funding from March 14, 2025, through the rest of FY 2025.

- **Partial shutdown.** If Congress enacts some but not all of the 12 annual appropriations bills, a partial government shutdown would occur. Only the agencies funded by the approved appropriations bills would remain fully open. Others would scale back operations to align with their OMB-approved plan.

- **Full shutdown.** If no appropriations bills or CRs are enacted by midnight on September 30, 2025, a full government shutdown would occur. This would significantly scale back

operations across all federal agencies in accordance with their OMB-approved plans.

HHS impacts

The most recent publicly available HHS contingency staffing plan is from the Biden administration. HHS planned to furlough 45% of its staff and retain 55%, with varying percentages among HHS's operating divisions. How the Trump administration will plan and execute shutdown operations, taking into account the impact of Department of Government Efficiency layoffs, is not yet known.

Regulatory process

Beyond day-to-day agency operations, a shutdown could impact the regulatory process. CMS releases the final calendar year (CY) Medicare payment rules on or around November 1 (60 days prior to the start of the next calendar year). The CMS staff who work on these rules, along with the OMB staff who review the regulations before they are released, could be furloughed in the event of a shutdown. Recent impact examples include the following:

- After a 16-day shutdown in October 2013, CMS released the CY 2014 Physician Fee Schedule final rule almost four weeks late, on November 27, 2013. CMS waived the requirement for the final rule to be published 60 days in advance of the calendar year because it "would be contrary to the public interest to delay the effective date" of the rule.

- The partial shutdown of late 2018 and early 2019 may have impacted the timing of the annual CMS payment rules. Because CMS releases the FY rules before the CY rules, the FY 2020 Inpatient Prospective Payment System proposed rule fell within a typical release window, on April 23, 2019. However, the CY 2020 Physician Fee Schedule and Outpatient Prospective Payment System proposed rules, which are typically released in early- to mid-July, were not released until July 29, 2019, and the delay may have been the related to the shutdown.

HHS operating divisions

HHS historically has provided details on which staff will continue work as funded through prior year appropriations, mandatory appropriations, and user fees or other reimbursements of non-lapsed appropriations. Information on staff who will continue to work is typically broken into two categories: "authorized by law" and "safety of human life and protection of property."

To determine activities related to the safety of human life and the protection of property, HHS has traditionally relied on previous US Department of Justice guidance. The second category, "authorized by law," includes:

- Employees who are exempt from furlough because they are not affected by a lapse in appropriations.
- Officers appointed by the president, including all presidential appointments with Senate confirmation or presidential appointment officials and members of the uniformed services (Commissioned Corps).
- Staff performing activities authorized by necessary implication.

Below is a breakdown of how various HHS operating divisions have been affected during previous shutdowns. Shutdown operations under the new Trump administration could look quite different.

- **CMS**
  - **Medicare** continues during a lapse in appropriations. Any impact on providers may occur in stages based on how long a shutdown continues. For both Medicare fee-for-service (FFS) and Medicare Advantage (MA), a shutdown of a month or less typically does not affect timing of payments to providers or health plans. A shutdown of more than a month can delay the timing of payments under Medicare FFS by Medicare Administrative Contractors (MACs). Payments to health plans that participate in Medicare Advantage are not affected.

    - **Medicare FFS** payments to providers are made by MACs that operate regionally. Each MAC has a contract with CMS to handle Medicare FFS claims (Medicare Part A and Part B). The contracts are funded by the CMS discretionary program management account that Congress appropriates annually. MAC contract periods do not always align with the government FY (October 1 – September 30). However, when a MAC runs out of funding and needs additional funding from the new FY appropriation, it can hold back payments until the funding is received (once funding is received, the claims are paid in full). Therefore, any payment delay to providers depends on how each MAC's contract is structured and how long the government shutdown lasts. If the government shutdown lasts longer than 30 days, there is a greater likelihood that at least some MACs could run out of funds.

    - **MA** plans are paid a monthly risk-adjusted capitated payment on around the first of every month. The payments, which come directly from the Treasury, are mandatory and must always be made. Therefore, a government shutdown, regardless of its length, will have no impact on Medicare Advantage payments to health plans.

- **Medicaid** may have sufficient funding depending on the length of a shutdown, based on previous advance appropriations. A shutdown that goes beyond the quarter could result in delayed payments to states, although that is unlikely (as noted above the longest shutdown was 35 days). CMS is unlikely to approve state plan amendments and waivers during a government shutdown, although review can occur in the background.

- **Healthcare fraud and abuse control** activities have historically continued.

- **Center for Medicare & Medicaid Innovation** activities are funded by a separate appropriation and have historically continued.

- **The Children's Health Insurance Program** has historically continued.

- **Federal Exchange activities**, such as eligibility verification, have historically continued, funded by user fee carryover.

- **Telehealth Provisions,** the continuation of Medicare's telehealth flexibilities is different than other Medicare services. The current flexibilities are extended via statute. However, the statutory provision expires on September 30, and needs to be extended by legislation (not regulation), these flexibilities would end if a government shutdown occurs. Pre-pandemic limitations for Medicare telehealth coverage and payment would return. These include waivers to geographic and originating site restrictions, expansions to the list of eligible practitioners, authorization of telehealth via audio-only telecommunications, use of telehealth for required face-to-face encounters prior to hospice care recertification, and the delayed in-person visit requirement for tele-mental health services. It is unclear how Congress or the Administration might address any lapse in these flexibilities.

- **Administration for Community Living**
  - The Administration for Community Living has historically continued activities funded through carryover funding under the healthcare fraud and abuse control account and from the Medicare Improvements for Patients and Providers Act. These activities include the Senior Medicare Patrol Program and related Medicare program integrity activities and Medicare beneficiary outreach activities.
  - Staff has historically continued to perform reimbursable work related to managed care consumer information and assistance.

- **Health Resources and Services Administration (HRSA)**
  - HRSA has historically continued activities funded through mandatory funding, advanced appropriations, prior year carryover funds, and user fees.

  - HRSA has historically continued to oversee many direct health services and other activities funded through carryover balances, such as the Ryan White HIV/AIDS Program Parts A and B and Ending the HIV Epidemic.
  - HRSA has historically continued to oversee the National Practitioner Databank and Hansen's Disease Program using existing balances.

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - SAMHSA has historically continued substance abuse and mental health programs, including those that provide critical behavioral health resources in the event of a natural or human-caused disaster, such as disaster behavioral health response teams, the disaster distress helpline that provides crisis counseling to people experiencing emotional distress after a disaster, and the 988 lifeline to connect people in crisis with life-saving resources.
  - SAMHSA has historically continued activities supported with advanced appropriations, including providing resources to individuals seeking help for addiction and behavioral health concerns through the treatment services locator program, the treatment referral line, and the suicide prevention lifeline.
  - SAMHSA has historically had staff ready to receive and properly route any letters indicating suicidal ideation to the appropriate local crisis intervention services.
  - SAMHSA has historically reviewed opioid prescription limit waivers.

- **Centers for Disease Control and Prevention (CDC)**
  - CDC has historically continued to operate programs related to disease outbreaks, laboratory functions, and the 24/7 emergency operations center.
  - CDC has historically continued the World Trade Center Health Program, the Energy Employees Occupational Illness Compensation Program, and the Vaccines for Children Program, which are supported through mandatory funding.
  - CDC's immediate response to urgent disease outbreaks and critical investigation needs in areas such as food, healthcare, vectors (mosquitoes and ticks), and high-consequence pathogens has historically continued.
  - CDC has historically continued to collect data reported by states, hospitals, and others, and to report critical information necessary for state and local health authorities and providers to track, prevent, and treat diseases.

- **National Institutes of Health (NIH)**
  - NIH has historically continued operations at its biomedical research hospital and the NIH Clinical Center, and activities to maintain the safety and continued care of its patients.
  - NIH has historically continued to provide basic care services to protect the health of NIH animals, and retained staff to safeguard ongoing experiments or operations, as well as facilities and infrastructure.

- **US Food and Drug Administration (FDA)**

- FDA activities funded through carryover user fee funding typically continue, including certain activities related to the regulation of human and animal drugs, biosimilar biological products, medical devices, and tobacco products.
- Vital FDA activities related to imminent threats to the safety of human life have historically also continued.
  - FDA has continued to detect and respond to public health emergencies, address existing critical public health challenges, and manage recalls, including drug shortages and outbreaks related to foodborne illness and infectious diseases.
  - Other vital activities that have historically continued include surveillance of adverse event reports for issues that could cause human harm, review of import entries to determine potential risks to human health, certain surveillance inspections of regulated facilities, and criminal enforcement work and certain civil investigations.

- **Advanced Research Projects Agency for Health (ARPA-H)**
  - HHS has historically indicated that ARPA-H activities would continue during a lapse of appropriation.

- **Administration for Strategic Preparedness and Response (ASPR)**
  - ASPR has historically continued support for hurricane and other emergency responses, as needed.

- **Office of the Secretary**
  - Excepted staff in the immediate Office of the Secretary have historically continued to provide leadership and support to ensure HHS operations and national-security-related activities continue.
  - The intergovernmental and external affairs regional directors have historically continued to support working partners in the regions.
  - The assistant secretary for financial resources' budget and grants staff have historically continued to support HHS's funded programs and assisted with orderly phase down of operations.

Healthcare programs set to expire at the end of FY 2025

On March 14, 2025, Congress passed the Full-Year Continuing Appropriations and Extensions Act, 2025, which funded the government through the end of the FY on September 30, 2025. This CR also included a small package of healthcare extenders that continued funding for expiring programs through FY 2025. The chart below details these programs, which require congressional action before midnight on September 30, 2025.

Extenders	Summary	Associated costs	Expiration date	Legislation funding
The Community Health Center Program	The primary form of federal funding for community health centers comes via the Health Center Program using funds authorized through Section 330 of the Public Health Services Act.	$2.4 billion (combined total with NHSC and THCGME)	September 30, 2025	FYCAEA, 2025
National Health Service Corps (NHSC)	The NHSC provides financial and other support to primary care providers in exchange for their service in underserved communities. Although the NHSC has received discretionary appropriations in recent years, the Community Health Center Fund (CHCF) represents 70% of the NHSC's annual funding.	$2.4 billion (combined total with CHCF and THCGME)	September 30, 2025	FYCAEA, 2025
HRSA Teaching Health Center Graduate Medical Education (THCGME) Program	Established and funded under the Affordable Care Act, most of the training programs currently operating in the states are conducted in community health centers.	$2.4 billion (combined total with NHSC and CHCF)	September 30, 2025	FYCAEA, 2025
Personal Responsibility Education Program	This initiative funds projects to reduce teen pregnancy through evidence-based programs.	$38 million	September 30, 2025	FYCAEA, 2025
Special Diabetes Program for Type 1 Diabetes	This program provides funding for Type I diabetes research at the NIH.	$160 million	September 30, 2025	FYCAEA, 2025
Special Diabetes Program for Indians	This grant program funds diabetes prevention and treatment in coordination with the Indian Health Service.	$150 million annually	September 30, 2025	FYCAEA, 2025
Funding for quality	Congress funds CMS to provide quality measurement selections and to contract with a consensus-based	$3 million	September 30, 2025	FYCAEA, 2025

Extenders	Summary	Associated costs	Expiration date	Legislation funding
measure endorsement, input, and selection under the Medicare program	entity to carry out some of the tasks associated with this effort. The Consolidated Appropriations Act, 2024, provided $9 million in continued funding through December 31, 2024, and the American Relief Act, 2025, provided another $2 million through March 31, 2025.			
Funding for outreach and assistance for low-income Medicare programs	This funding is generally provided through state health insurance assistance programs, area agencies on aging, aging and disability resource centers, and the National Center for Benefits and Outreach and Enrollment. Congress has regularly supported these programs.	$24 million	September 30, 2025	FYCAEA, 2025
Low-volume hospital payment adjustment	Medicare applies a payment adjustment for certain hospitals with low inpatient volumes. The program supports hospitals in small and isolated communities whose operating costs often outpace their revenue.	$191 million	September 30, 2025	FYCAEA, 2025
Medicare-Dependent Hospital Program	This program helps rural hospitals with a significant portion of Medicare patients. Congress acknowledged the success of this program and has established special payment provisions to support it.	$63 million	September 30, 2025	FYCAEA, 2025
Medicare telehealth flexibilities	Pandemic-related telehealth capabilities include waivers to the geographic and originating site restrictions, expansions to the list of eligible practitioners, eligibility for federally qualified health centers and rural health clinics, allowing telehealth to be provided through audio-only telecommunications, allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a	$742 million	September 30, 2025	FYCAEA, 2025

Extenders	Summary	Associated costs	Expiration date	Legislation funding
	patient's eligibility for hospice care, and delaying the in-person visit requirement before a patient receives tele-mental health services.			
Hospital at Home, Acute Care at Home Waiver	CMS implemented the Acute Hospital Care at Home Waiver Program to allow Medicare beneficiaries to receive acute-level care at home.	No cost	September 30, 2025	FYCAEA, 2025
Ground ambulance add-on payments	Congress has previously extended Medicare ground ambulance payment add-ons, including a 3% increase for rural trips, a 2% increase for urban trips, and a 22.6% "super rural" add-on for services in the lowest population density areas.	$36 million	September 30, 2025	FYCAEA, 2025
Medicaid disproportionate share hospitals	These are statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients and support the financial stability of safety-net hospitals.	$1.327 billion	September 30, 2025	FYCAEA, 2025
Work geographic practice cost indices (GPCI) floor	Medicare physician payments are adjusted geographically using GPCIs, with a 1.0 floor on the work component repeatedly extended by Congress to protect rural providers from disproportionately lower reimbursement. There are concerns that without these adjustments, physician services in rural areas would be disproportionately affected by lower Medicare payments.	$263 million	September 30, 2025	FYCAEA, 2025
Conrad 30 Waivers	J-1 foreign medical graduates are allowed to apply for a waiver of the two-year foreign residence requirement upon completion of the J-1 exchange program.	N/A	September 30, 2025	FYCAEA, 2025

Extenders	Summary	Associated costs	Expiration date	Legislation funding
Children's hospital graduate medical education	This program supports training of medical residents and fellows at children's hospitals.	N/A	September 30, 2025	FYCAEA, 2025

What's next

Given the intense partisan dynamic in Congress, a government shutdown cannot be ruled out. It is possible that a potential shutdown could be longer, and therefore more significant, than previous ones. The longest two shutdowns were 35 days in 2018 – 2019 and 21 days in 1995 – 96. A longer shutdown would have more significant impacts on healthcare providers. During previous government shutdowns, most CMS activities and payments continued to function normally. However, if a shutdown lasts longer than one quarter, there could be impacts on Medicaid and DSH payments. Given the Trump administration's focus on government efficiency, it is also unknown if larger numbers of federal employees would be furloughed compared to previous shutdowns. Stakeholders should review the healthcare extenders listed above and plan for potential disruption to these programs if Congress cannot reach an agreement on a CR or other funding legislation.

For more information contact [INSERT CONTACT LINKS]