Navigating Updates from Washington: A View from Capitol Hill

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Curated for ICAHN

NRHA

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Our mission is to provide leadership on rural health issues.

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Updates from Congress

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Government Shutdown

- **The Federal Government Shutdown continues into 4th week.** What a shutdown means for HHS:
  - HHS has furlough more than 40% of their remaining workforce
    - This now includes a permanent RIF for 30% of SAMHSA or about 140 employees.
  - Half of CMS staff are essential and will continue working on mandatory programs.
  - CMS recalled 3,000 staff last week who were recently furloughed due to the government shutdown to assist with Medicare and ACA Open Enrollment.
  - Also bringing back staff to work on RHTP applications.

Government Shutdown – Cont.

How'd we get here: House and Senate Appropriations Committees already passed FY 2026 Labor-HHS bills out of committee but failed to reconcile differences.

Continuing Resolution (CR): While the House passed a short-term CR to fund the government until November 21, the Senate has not approved it.

Negotiations Stalled: The vast differences between the House and Senate Labor-HHS bills, as well as with other appropriations measures, have prevented the bills from moving toward conference negotiations.

Main Points of Contention:

- Premium Tax Credits in the ACA
- Medicaid payers
- RIF Scale at HHS

What's Ahead? Fall 2025

- **The shutdown has entered week four** mainly due to disagreements on how to approach extending Marketplace enhanced premium tax credits (ePTCs).
- The Senate is holding votes this week on the CR, while the House is in recess until further notice.
  - Several senators have offered piecemeal bills to resolve certain aspects of the shutdown like federal employee pay
- The House is waiting to hold votes or reconvene until the Senate can pass a CR.
  - Speaker Johnson has stated that the House will remain in recess until a document that is agreeable to his caucus is presented.

Hearings Still Being Held – HELP 340B

- Senate HELP Committee (Oct 23) examined the growth, oversight, and patient impact of the 340B Drug Pricing Program.
- Program growth: 340B purchases rose from $6.6 B (2010) to $43.9 B (2021) nearly 19% annual growth, driven largely by rural hospitals.
- Lawmakers questioned whether discounts reach patients, especially in rural and underserved areas.
  - Oversight gaps: HRSA has limited authority to monitor eligibility, contract pharmacies, or ensure savings benefit patients.
  - Proposed ACCESS Act would expand transparency and accountability, requiring clearer reporting on how 340B revenues are used.
- Witnesses raised alarm over HRSA's rebate-based pilot, warning of up to 2,360% higher upfront drug costs for community health centers.
  - Bipartisan group (Sen. Baldwin & Sen. Moran) developing reforms to define "patient," regulate contract pharmacies, and strengthen enforcement.

What's Ahead? Fall 2025

- The following key rural health programs have lapsed, leaving rural patients and providers with uncertainty:
  - Medicare-Dependent Hospital designation
  - Low Volume Hospital payment adjustment
  - Medicare telehealth flexibilities
  - Medicare ground ambulance add-on payments
  - Mandatory funding for safety net programs:
    - Community Health Centers, National Health Service Corps, and Teaching Health Center Graduate Medical Education

- Raise your voice:
  - Extenders advocacy campaign
  - Rural health extenders one pager
  - Rural hospitals 101

ACA ePTC – The Fall Fight

- Marketplace enhanced premium tax credits expire **Dec. 31**
  - 2.8 million rural enrollees are enrolled in the marketplace
  - If ePTCs expire rural enrollees' premiums will increase on average by 107%
  - Rural residents save more with ePTCs - $890 per year or 28% more than urban counterparts
- White House signaled interest in negotiations on extension
- Senators haven't moved on this in a bipartisan basis
  - Senator Mike Rounds commented yesterday that "haven't been any bipartisan discussions about extending the enhanced ACA premium tax credits that expire at the end of the year."
- Raise your voice:
  - Renew Marketplace ePTCs advocacy campaign
  - NRHA ePTC one pager

FY 2026 Appropriations Requests

	NRHA FY 26 Request	President's FY 26 Budget	HAC FY 2026 Bill	SAC FY 2026 Bill	FY 2025 Enacted
Rural Hospital Flexibility Grants	$75 million	$0	$74.277 million	$66.27 million	$64 million
Rural Hospital Stabilization Pilot Program	$15 million	$0	$20 million	$6 million	$4 million
Rural Residency Planning & Development	$14 million	$12.7 million	$14 million	$14 million	$13 million
State Offices of Rural Health	$15 million	$0	$13 million	$13.5 million	$12.5 million
CDC Office of Rural Health	$10 million	TBD	$6 million	$5 million	$5 million
Outreach Programs	$109 million	$101 million	$111million	$104 million	$101 million
RCORP Program	$155 million	$145 million	$145 million	$145 million	$145 million

Key Bill Introductions

- RHC modernization bills:
  - H.R. 5198: RHC Location Modernization Act
  - H.R. 5199: Modernizing NP and PA Utilization Act
  - H.R. 5217: Rural Behavioral Health Improvement Act
  - Joint letter of support with NARHC
- S. 2879/H.R. 5454: Medicare Advantage Prompt Pay Act
- S. 2709/H.R. 5081: Telehealth Modernization Act
- H.R. 5217: Bipartisan Tax Credit Extension Act
- S.1261/H.R. 4206: CONNECT for Health Act
  - NRHA created a template letter for hospitals or other organizations to use to send to their members of Congress and urge them to cosponsor

Rural Health Care Outreach Program

- **H.R. 2943/S. 2301:** Improving Care in Rural America Reauthorization Act
- Reauthorizes Outreach grant programs through 2030
  - Includes Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs
- Passed out of Senate HELP Committee on 7/30
- Passed out of House Energy & Commerce Committee on 9/17
- Authority expires at end of 2025 and bill is set up for passage before end of year

Updates from the Administration

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Rural Health Transformation Program

- $50 billion over 5 years for all states with approved applications
  - Distributed starting FY 2026 to FY 2030
- Eligibility for funds:
  - 50% goes to all 50 states equally
  - 50% distributed to states based on CMS discretion
  - New construction is not allowed
  - Capital expenditures cannot exceed 20%
  - Provider payments cannot exceed 15% Replacing an EMR cannot exceed 5%

Distribution of funding:

- Baseline funding: applications meet minimum requirements.
- Workload funding:
  - Rural population & technical scores (data-driven metrics making state comparisons).
  - Initiative-based quality of programs.
  - State policy actions (licensure compacts, scope of practice, SNAP waivers, data infrastructure). These are optional to include in an application.

Rural Health Transformation Program Strategic Goals

- Making Rural America Healthy Again
  - Population health, prevention/chronic disease, behavioral health
- Fostering sustainable access
  - Viable economic model, appropriate care delivery, provider payments
- Workforce Development
  - Strengthening recruitment and retention, scope of practice
- Innovative Care
  - Value base payment, clinically integrated networks
- Supporting technology innovation
  - Technology-based solutions, training and technical assistance, IT investments

Rural Health Transformation Program Timeline

July 4

HR 1 Establishes the RHTP

September 15

- Application (NOFO) Released
- Formal Guidance Given to States

September 24

The Illinois Department of Healthcare and Family Services (HFS) welcomed feedback on how to use RHTP funds to support rural health communities under P.L. 119-21

September 30

Optional Letters of Intent Due to CMS

•27 States formally give notice of intent.

October

States Begin Application formation

November 5

Application deadline

December 31

Award date

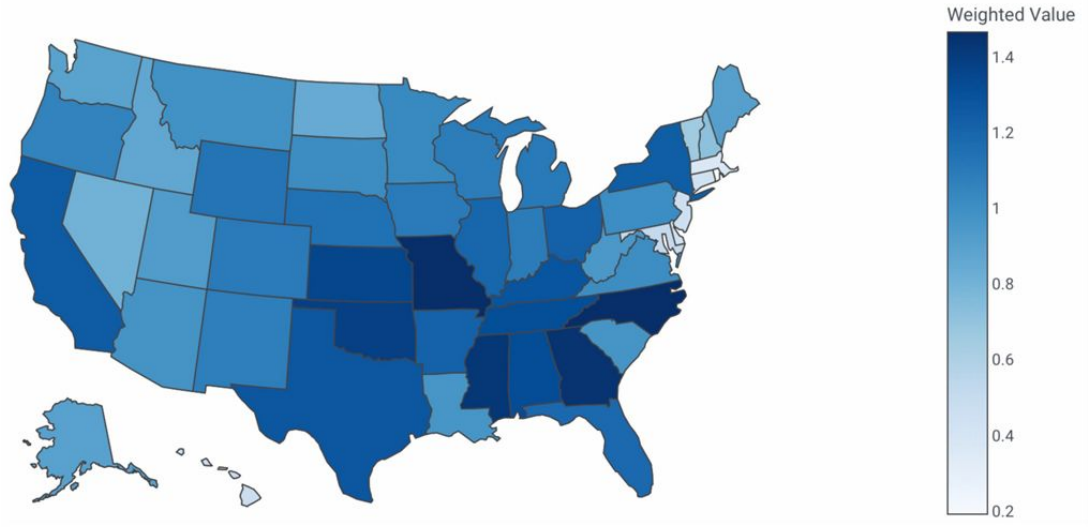
2026

Q1 2026: Continuous monitoring and CMS support begins.

Q2 2026 and Beyond: Round two of funding allocated due to scoring in Nov of following year.

Rural Health Transformation Program

- **How states may perform in "Rural Facility and Population Scores"**
  - Illinois expected to fall middle of the pack in scoring.
  - North Carolina, Missouri, Georgia, Mississippi, Oklahoma, Alabama, Tennessee, Kentucky, Texas among projected top scorers.



Rural Health Transformation Program

New CMS resources:

Updated FAQs (10/28). New information of note:

- CMS will work with states who receive more/less than $200 million to make budget adjustments
- Using RHTP funds to add to an existing program *may* be allowable
- Tribally-operated IHS facilities may be subawardees, but federally operated IHS facilities may not
- States should apply for any relevant SPAs or waivers needed to implement innovative care delivery services
- More details on budgeting in application

Rural Health Transformation Program

New CMS resources:

Scoring calculation fact sheet

- Includes examples of data-driven factor scoring and initiative-based factor scoring
- Example of how workload funding will be calculated across states using each state's score

CMS Scoring of RHTP

- **Data-Driven Score Factors**
  - Points are based on the value of a State's metric in comparison to other States.
- **Initiative-Based Score Factors**
  - Points are based on projects and activities that a State has chosen to pursue.
- **State Policy Action Score Factors**
  - Points are based on **currently implemented State policy** and **State policy actions that States commit to implement**.
  - For the latter, policy must be implemented by the end of 20272 and States will receive partial credit until full implementation.
  - Failure to meet the deadline will result in CMS removing these points and recovering past funds proportional to the amount that the commitment contributed.

Rural Health Transformation Program Scoring

Step Description	Example Calculation
Calculate Points Score for each factor (based on Table 4 of the NOFO)	
1 Determine Each State's Base Score The method will vary for each score factor based on the description in the "Points Scoring Methodology" column of Table 4 and will ultimately result in a *Point Score* from 0–100.	For example, for Technical score factor C. 3, suppose State A received a CON score of 36 on the Cicero Institute Certificate of Need (CON) law ranking. This results in a base score of **75** Points based on the scoring criteria for C. 3 in Table 4 of the NOFO.
2 Sum Scores Across States The sum of all individual State base scores for a given factor is the denominator for the next step of the scoring process.	In this example, each State is assigned a Base Score and the sum of those base scores is **2,500**: **State A score + State B score + State C score + … = 2,500**
3 Re-Index State Scores Divide each State's base score by the sum of all States' scores and multiply by **100** to determine each State's *Points Score*. Re-indexing ensures all score factors are weighted properly in the next step of the scoring process.	State A's *Points Score* for factor C. 3 is re-indexed to: **100 * 75 / 2,500 = 3**

Rural Health Transformation Program Scoring

4 Calculate Weighted Factor Scores

For each State and factor, multiply the re-indexed Points Score by the appropriate factor weight in Table 3 of the NOFO.

For score factor C. 3, the listed factor weight is **1.75%**. State A's re-indexed score of 3 for C. 3 is multiplied by **1.75%** to give **0.0525** points towards State A's *Total Points Score*:

3 * 1.75% = 0.0525

5 Sum Weighted Factor Scores

For each State, sum the weighted factor scores to determine the *Total Points Score*, which is a weighted sum of the re-indexed *Points Scores*.

0.0525 points earned from C. 3 are added to weighted factor scores for the other 22 score factors to calculate State A's *Total Points Score*:

0.0525 + [Weighted Score for A.1] + [Weighted Score for Factor A.2] +... = Total Points Score for State A

6 Determine State Workload Funding

Divide each State's *Total Points Score* by the sum of all States' *Total Points Scores,* then multiply by the total available Workload Funding during that budget period.

Assume State A's *Total Points Score* is **2.1875**, the sum of all States' total points scores is **100** and there is **$5 billion** workload funding available in the budget period. State A would receive **$109,375,000** for this budget period:

(2.1875 / 100) * $5 billion = $109,375,000

RHTP Resources

From the Administration

- RHTP website – sign up for email updates
- RHTP FAQ page

From NRHA

- Rural Health Transformation Fund Program Summary
- Rural Health Transformation Fund Program State Guide
- Rural Health Transformation Program Webpage
- State Index and Submitted RFI examples.
  - For each state, includes information on:
    - State agency office point of contact
    - Information on public requests for information if available
    - Additional information on RFIs, any listening sessions, and information made public from the states

HHS RIFs

- OMB moved forward with reductions in force (RIFs) at HHS earlier this month
- At HRSA, the Division of Nursing and Public Health, Oral Health Workforce Division, and Healthy Start offices lost all staff
- NRHA letter to HHS/OMB

Organization	Employee Count
ACF	47
ASA	18
ASPA	1
ASPR	41
CDC	596
HRSA	99
OASH	55
SAMHSA	125
TOTAL	982

Recent Activities

CY 2026 Medicare Physician Fee Schedule Proposed Rule

- Comment submitted

CY 2026 Outpatient Prospective Payment System (OPPS) Proposed Rule

- Comment submitted

340B Rebate Model Pilot Program Notice

- Comment submitted
- No indication from HRSA that further notices or responses to comments will be released
- Manufacturer plans were due to HRSA by Sept. 15th
- HRSA will approve plans by Oct. 15

Upcoming Activities

At OMB for review

- CY 2026 Outpatient Prospective Payment System (OPPS) final rule
- CY 2026 Home Health PPS final rule
- CY 2026 ESRD PPS final rule

Not yet at OMB review:

- CY 2026 Medicare Physician Fee Schedule final rule

Current Activities

- **State-directed payment guidance from CMS**
  - H.R. 1 phases down SDPs to 100% of Medicare rate (expansion states) or 110% of Medicare rate (non-expansion states) beginning in 2028 and limits any new SDPs to these rates
    - If the completed preprint was filed after July 4, the SDP is immediately subject to the lower rates
  - Certain SDPs will have temporary grandfathering period in which SDP can remain above applicable Medicare rate until 2028
    - SDPs submitted for rating periods within 180 days before or after the July 4 enactment date can be grandfathered AND
    - For any SDPs other than for rural hospitals: Received prior written approval before May 1, 2025/made a good faith effort to receive approval before May 1, 2025, OR
    - Received prior written approval for SDPs for rural hospitals/made good faith effort before July 4, 2025.

State Policy Impacts and Changes

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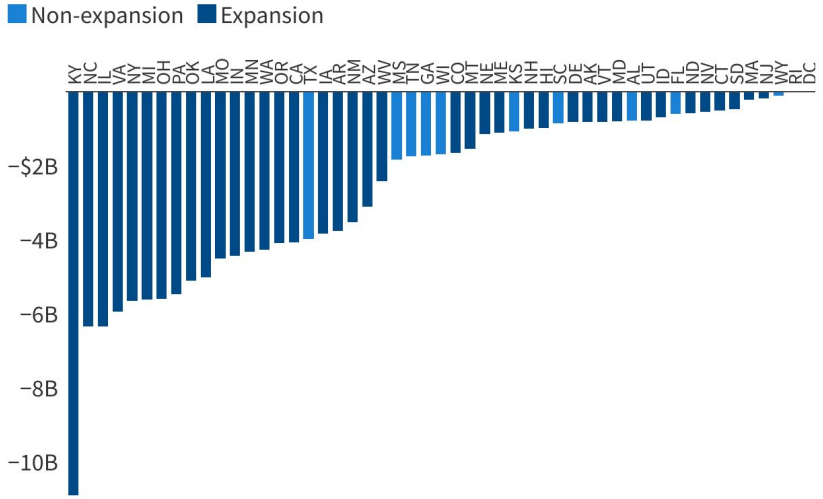
States Face Impending Medicaid Budget Hits

- Over half of rural Medicaid spending reductions are concentrated in 12 states with large rural populations that expanded Medicaid under the ACA.
  - 10 of these states could see federal rural Medicaid spending decline by $5 billion or more over 10 years.
  - These 10 states include: Illinois, Kentucky, Louisiana, Michigan, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Virginia
- **Illinois expected to see the third highest reduction based on raw dollars at -6.36 Billion over the 10-year period.**
- Kentucky would face the largest reduction, with an estimated $11 billion decline in rural Medicaid spending over 10 years.

Figure 2

Largest Declines in Federal Medicaid Spending in Rural Areas Would Occur in States That Expanded Medicaid and Have Higher Shares of Rural Residents

Federal Medicaid spending in rural areas is estimated to decrease by $137 billion over a 10-year period under the enacted reconciliation package



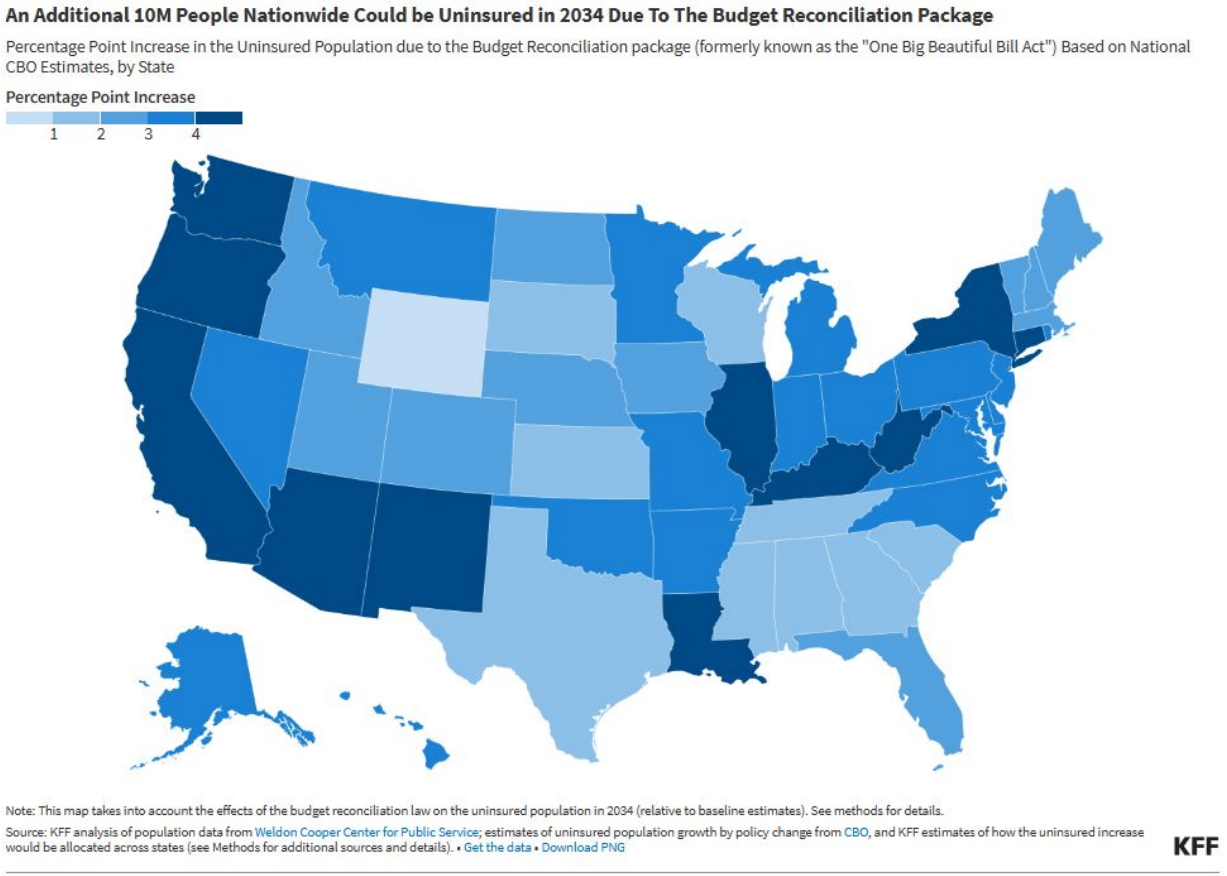
Note: The analysis uses T-MSIS data to estimate the percentage of Medicaid spending that paid for services used by rural enrollees within each state. Those percentages are then applied to state-level estimated reductions in federal Medicaid spending from KFF's broader analysis of federal Medicaid spending reductions. Spending data in 2021 for Mississippi and West Virginia was unusable according to the DQ Atlas, so 2020 data was used instead.

Source: Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States, and KFF analysis of the T-MSIS Research Identifiable Files, 2021

KFF

Illinois Expected Uninsured Impact

- H.R. 1's impact is projected to **increase the uninsured population by roughly 470K people**. This represents around a 4%-point change.
  - This estimate could vary between 350K and 580K based on a 25% range of uncertainty.
- Where does the change occur:
  - 400K would become uninsured due to changes in Medicaid
  - 52K would become uninsured due to changes in the ACA
  - 18K would become uninsured because of changes to Medicare and policy interactions.



Colorado Changes in Special Session

Context of Immediate Fix:

- Because of TABOR (which constrains state spending growth unless voter-approved), the legislature had to find ways to close a roughly $680–$783 million hole in the current fiscal year.
- Gov. Polis called a special session (Aug 21–26, 2025) to focus narrowly on revenue adjustments, protections for health care.

Cuts to Medicaid / health expenditures:

- After the session, the Governor Polis announced nearly $300 million in cuts, including more than $79 million in Medicaid reductions.
- Among those, Colorado reversed a planned 1.6% increase in Medicaid provider reimbursement rates, saving $38 million, and reinstated prior authorization for outpatient therapy beyond a certain number of sessions.

Revenue / tax changes:

- The legislature passed bills to sell state tax credits (for insurance premium credits, corporate tax credits) as a way to raise immediate funds.
- HB 25B-1006 was passed.
  - Under it, if the federal enhanced premium tax credits (ePTCs) are not extended by Dec 31, 2025, the state can issue up to $100 million in state tax credits to fund health insurance affordability
  - It is split between reinsurance, subsidies, and other programs.
- Majority Dem legislature is also proposed closing or narrowing several business tax to bring in estimated $350 million in revenue.

Advocate With Us!

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It takes a village!

Advocacy leave-behinds

All materials in the NRHA Advocacy Priority Areas

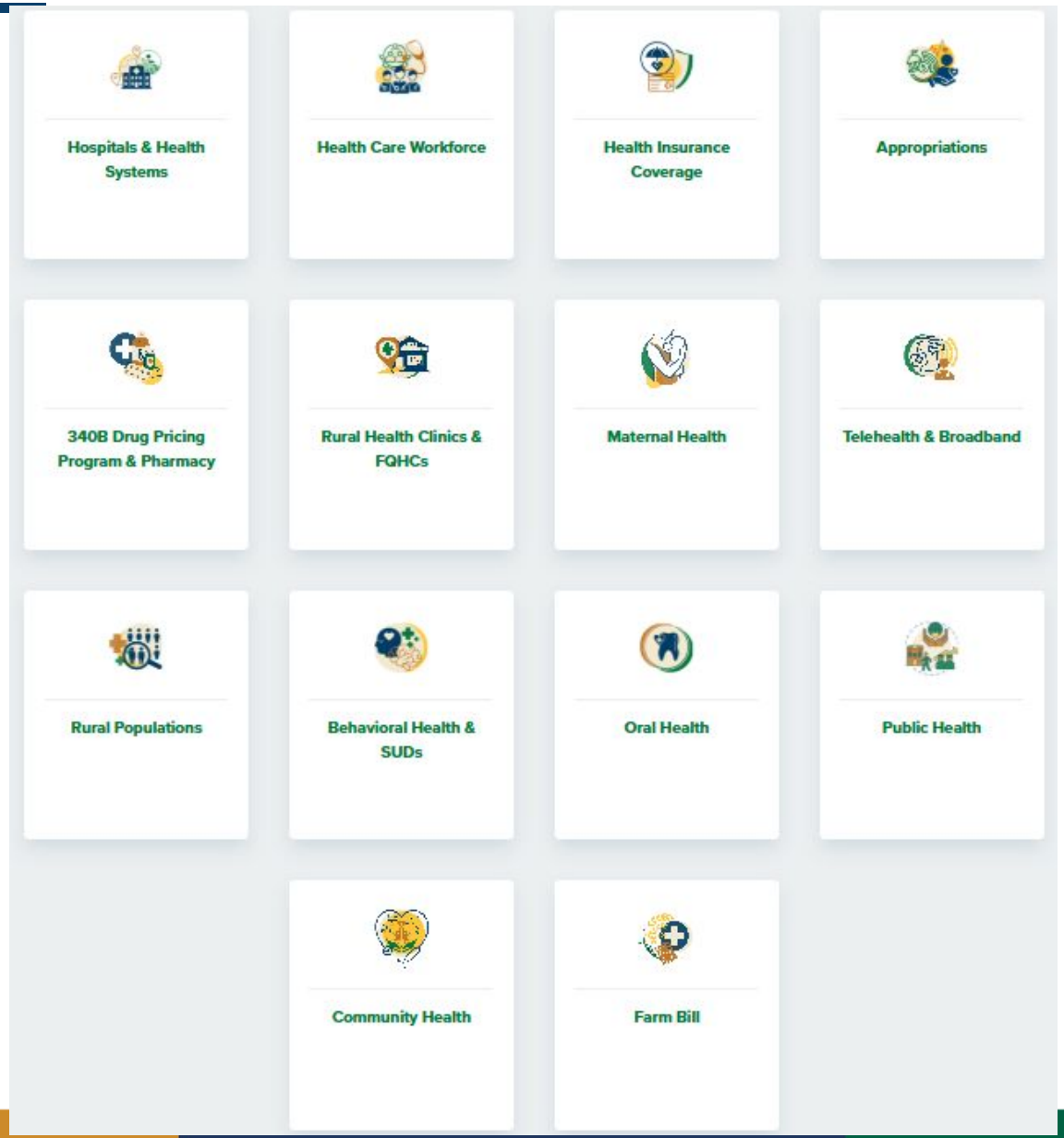
Core materials include:

- NRHA 2025 legislative agenda
- FY26 Appropriations requests
- Rural health 101
- Expiring rural health Medicare extenders
- Rural program reauthorizations

Topic-specific one-pagers include:

- Rural hospitals 101
- 340B
- Rural Health Clinics
- Public health
- And more!

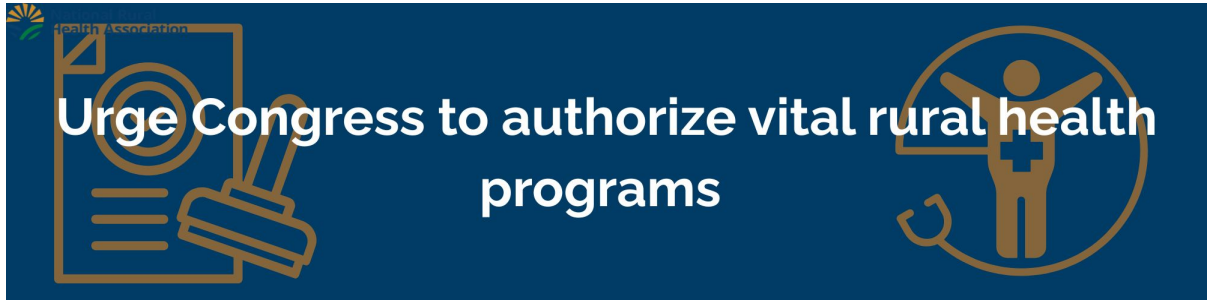
RuralHealth.US/AdvocacyAreas



Advocacy campaigns

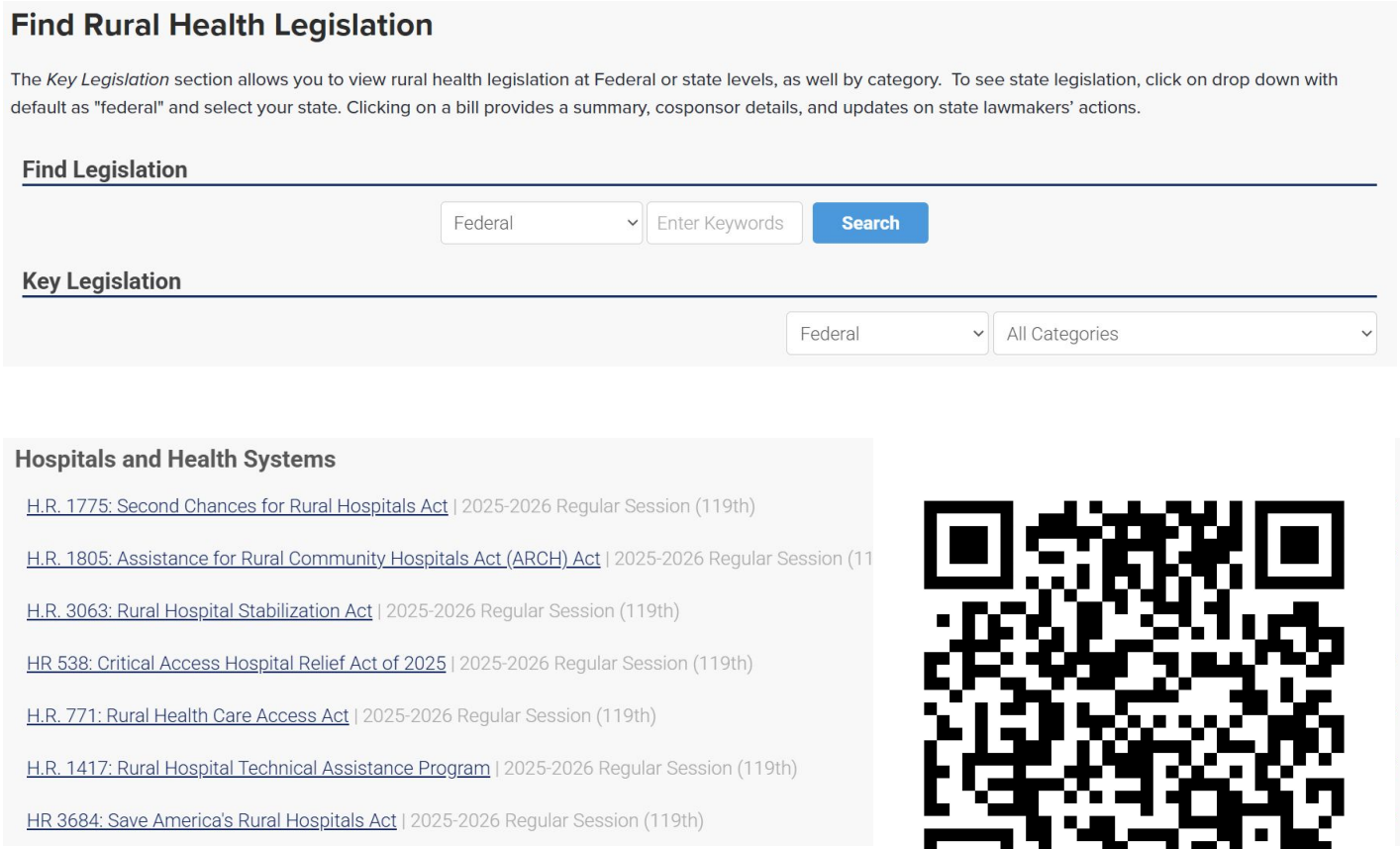
NRHA's advocacy campaigns allow you to send pre-drafted messages to your elected officials on current rural health priorities. Please find all advocacy campaigns on our website under Advocacy Campaigns, along with instructions on how best to use these campaigns.

RuralHealth.US/Campaigns



Legislative tracker

- Tracks Congressional bills supported by NRHA, including state legislation
- Can sort by topic, including **hospitals and health systems** and **rural health clinics**
- Direct access to all bill information
- Reach out to NRHA's Government Affairs team with any questions



RuralHealth.US/Legislation

2025 advocacy Resources

- Coming to D.C.? Let us arrange Hill visits for you!
- Contact your NRHA Government Affairs team:
  - Email: **Carrie Cochran-McClain**, **Alexa McKinley Abel**, **Zil Joyce Dixon Romero**, **Sabrina Ho**, **Marguerite Peterseim**
- Engage with NRHA Advocacy online:

One-stop scan of our advocacy goodies here

National Rural Health Association

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2026 Rural Health Policy Institute

- Join NRHA and hundreds of rural health advocates from across the nation to bring our clout to the Capitol.
- **NRHA's 37th Rural Health Policy Institute is Feb. 10-12 in Washington, D.C.**
- Save the Date!

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