To: CAFM Members
From: Nina DeJonghe, MPP
Director of Government Relations

Re: Government Relations Report
Date: January 23, 2026

Congressional Activity

Last night, the House of Representatives passed H.R. 7148, the FY 2026 Consolidated Appropriations Act, by a vote of 341–88**.** The bipartisan package reflects months of bicameral negotiations and advances several major appropriations bills as Congress works to complete the FY 2026 funding process.

The legislation now moves to the Senate for consideration ahead of the January 30 funding deadline, marking a key step toward avoiding a lapse in government funding and finalizing federal spending for the year.

The FY 2026 "minibus" includes the final Labor–HHS, Defense, Homeland Security, and Transportation–HUD bills, providing $116.6 billion in funding for the Department of Health and Human Services. The legislation extends several key health care programs, including Medicare-dependent hospital payments, Medicare telehealth flexibilities (extended two years), and the Acute Hospital Care at Home waiver.

Health Professions Funding

The FY 2026 package includes approximately $888 million for HRSA Title VII health professions and Title VIII nursing workforce development programs, representing a modest 0.3% increase over FY 2025 enacted levels. Key program-level changes include:

Increases

- +$1 million for Title VII Oral Health Training and Behavioral Health Workforce Education and Training
- +$5 million for the Medical Student Education program
- +$1 million for Title VIII Nurse Practitioner Optional Fellowship and Nurse Education, Practice, and Retention programs

Reductions

- −$3 million for the Centers of Excellence program

- −$1 million for the Health Careers Opportunity Program
- −$2 million for the Title VIII Nursing Workforce Diversity program

Agency for Healthcare Research and Quality (AHRQ)

Under the FY 2026 Consolidated Appropriations Act, AHRQ is funded at $345.38 million**,** reflecting a $23.6 million decrease from the prior year. While the reduction is not ideal, the funding level sends a clear bipartisan, bicameral signal that Congress intends for the agency to remain intact, independent, and able to carry out its statutory mission, including extramural research.

Importantly, the bill includes directive language requiring HHS to maintain staffing levels necessary to fulfill statutory responsibilities, a response to staffing reductions that have disrupted AHRQ's grantmaking activities.

Budget Activity	FY25 CR	Conference Agreement FY26	Change
Research on Health Costs, Quality and Outcomes	$228,609,000	$214,109,000	-$14,500,000
Center for Primary Care Research	2,000,000	2,000,000	0
Long COVID	10,000,000	10,000,000	0
Menopause Research	5,000,000	5,000,000	0
Patient Safety Data Platforms	1,500,000	4,000,000	+2,500,000
United States Preventative Services Task Force (USPSTF)	11,542,000	11,542,000	0
Medical Expenditures Panel Surveys (MEPS)	$71,791,000	72,791,000	1,000,0000
Program Support	$73,100,000	58,480,000	-$14,620,000
Estimated PCORTF	$125,000,000	133,000,000	+8,000,000

Rural Health Updates

Rural health stakeholders are supportive of the bipartisan, bicameral appropriations and health care extenders package released this week. The FY 2026 legislation would establish a new Rural Hospital Provider Assistance Program within the Office of Rural Health Policy, providing $25 million in direct support to eligible small rural hospitals.

The package also increases funding above FY 2024 and FY 2025 levels for several core rural health programs, including State Offices of Rural Health, Rural Health Outreach Services, the Rural Residency Planning and Development Program (increase of $1 billion), the Rural Hospital Stabilization Program, and the Rural Maternity and Obstetrics Management Program.

Health Center Funding Updates

The bill includes a historic funding increase for the Teaching Health Center Graduate Medical Education (THCGME) program**,** marking the first multi-year authorization at this funding level in the program's 15-year history. After years of flat funding and uncertainty, this phased investment represents a meaningful step forward in strengthening community-based primary care training.

Teaching Health Centers: Phased funding over four years, increasing from $225 million in FY 2026 to $300 million in FY 2029.

Community Health Centers: $4.6 billion for the program in FY 2026.
National Health Service Corps: Two-year extension at $350 million per year.

Support for S. 3038

CAFM is now supporting S. 3038, The Health Care Workforce Real-Time Data Dashboard Act, introduced by Senator Marsha Blackburn (R-TN). The bill would require the Secretary of Health and Human Services to develop and maintain a real-time data dashboard for graduate medical education (GME) residency training position participants with a focus on rural areas. CAFM is meeting with the office soon to further discuss the bill.

Regulatory Activity

Trump Health Plan

On January 15th, President Trump released a health care proposal entitled, "The Great Healthcare Plan." The proposal, which did not include details, contained the following items.

- Post Prices on the wall
- Require any healthcare provider or insurer who accepts either Medicare or Medicaid to publicly post their pricing and fees to avoid surprise medical bills.
- Slash Prescription Drug Prices
- Fund Cost-Sharing Reduction Program
- Publish Costs of Overhead vs. Claim Rates
- Allow More Over-the-Counter Medicines
- Cut Kickback Costs
- Display Claim Denial Rates
- Create the "Plain-English Insurance" Standard

Rural Health Transformation Program (RHTP) Funding

Several important developments have occurred with the new Rural Health Transformation Program (RHTP).

First, CMS is creating an office to oversee implementation of the program. The Center for Medicaid and CHIP Services (CMCS) will oversee the office. The new office will include a Division of State Rural Engagement, which will monitor states' RHTP implementation and provide program guidance. The Division will also work with CMCS to leverage existing systems to develop and implement new applications for state system quality improvement activities and partner with the Center for Program Integrity (CPI) on waste and fraud detection programs.

Second, CMS has allocated RHTP program funding. The 2026 rural health distributions range from $147 million to $281 million and effectively reflect the maximum amount states can expect to receive each year from the program. CMS will reduce future allocations if a state does not meet its goals. Texas received the most rural health funding award at $281.3 million, and Alaska received the second most at $272.2 million. New Jersey will receive the least amount at $147.3 million.

The five-year RHTP is divided into two distributions. The first half of the fund is evenly distributed to each state, meaning all states will receive at least $100 million per year. The other half of the fund is based on "ruralness" as well as subjective metrics. According to CMS, the distributions announced for 2026 essentially reflect the maximum amount a state will receive for future years as the administration will re-score states on their progress toward policy changes each year. Further information about the final grants and state by state allocations are available at this tracker prepared by KFF.

CMS GME Slot Allocation

The Centers for Medicare & Medicaid Services (CMS) has recently allocated 400 Medicare-funded residency slots to 169 teaching hospitals; see the Section 126 tab on the CMS direct GME (DGME) website above. Of those slots, 200 are the fourth allocation from 1,000 new residency positions authorized over five years under Section 126 of the Consolidated Appropriations Act of 2021. CMS published the Section 126 awards in December.

CMS on January 7th opened the application process for the final round of 200 slots for Section 126. Rural hospitals have special priority under the slot allocation process. Hospitals can access the application through the website referenced above.

DEA on Telehealth Flexibilities

The U.S. Drug Enforcement Administration (DEA) has extended current telemedicine flexibilities that allow providers to prescribe controlled substances without an initial in-person visit. These flexibilities, originally implemented during the COVID-19 public health emergency and set to expire on December 31, 2025, will now remain in effect through December 31, 2026. According to the DEA, the extension is intended to avoid a disruption in care while providing the agency additional time to finalize permanent telemedicine prescribing regulations and allow providers to prepare for and comply with any new requirements.

Additional Items

GAO Report on Distribution of GME Slots

On December 22nd, the Government Accountability Office (GAO) released a report entitled, "Information on Initial Distributions of New Medicare-Funded Physician Residency Positions."

The letter to Congress from the GAO said the following. "Rural areas are projected to face a physician shortage of nearly 60 percent compared to a 10 percent shortage in urban areas. Research has shown that physicians in training, commonly referred to as medical residents, often go on to practice in the same area where they completed their GME training. However, medical residents are unevenly distributed across the country, with almost all training occurring in hospitals in urban centers."

GAO interviewed 14 stakeholder organizations, representing hospitals and physicians, about the current allocation process. The report included the following findings of interest.

- "Nearly all (95 percent) of the 186 hospitals that received positions in the first three distributions were in geographically urban areas, while 5 percent were in geographically rural areas."
- Geographically urban hospitals also were more likely to apply for Section 126 residency positions than geographically rural hospitals. Specifically, among hospitals that may have been eligible for Section 126, 27 percent of geographically urban hospitals applied compared to 8 percent of geographically rural hospitals.
- Only ten geographically rural hospitals applied to receive positions in the first three annual distributions, and nine out of 10 received residency positions.
- The reason in part for the disparity was CMS reliance on the health professional shortage area (HPSA) scores determined by HRSA. According to the stakeholders, the reliance on scores disadvantaged hospitals in less-populated areas.
- The grouping of rural reclassified hospitals with geographically rural hospitals in one category may have drawn residency positions away from geographically rural hospitals.

Eight stakeholders told GAO that CMS should create additional criteria for identifying hospitals with the greatest level of need for future funding streams. The stakeholders suggest CMS include hospitals that:

- Provide care to underserved and rural communities.
- Train physicians in medical specialties that align with community needs.
- Use an interdisciplinary approach to care aligning primary care and behavioral health providers.
- Are in states with fewer residency programs, noting that some states without medical schools have more challenges attracting physicians, or are training above their Medicare caps.

AAMC Requests Exception from New H-1B Visa Fee

On December 19, the AAMC sent a letter to the Department of Homeland Security requesting a National Interest Exception (NIE) to the new restriction on entry for some workers which imposed a $100,000 fee on new H-1B visa applications. In requesting the exception, the letter uses the following reasoning, "The AAMC recognizes that the Presidential Proclamation on H-1B visas will worsen the nation's existing physician shortage, put strains on the health care workforce and the occupational shortages of highly skilled workers within academic institutions who are unavailable, and ultimately jeopardize patient access to care. . . Along with American physicians, H-1B visa holders play a critical role in each of these occupations at teaching hospitals, academic health systems, and in rural and medically underserved communities across the United States."

AAIM Recommendations on Fellowship Funding

The Alliance for Academic Internal Medicine (AAIM) sent a letter on December 18 to the National Association of Designated Institutional Officials (NADIO). NADIO has issued recommendations to delay the fellowship start date. AAIM noted in the letter that they support a delayed start date, "contingent on the recommendations outlined in this letter." AAIM agrees that the proposal addresses issues that have plagued the residency-fellowship transition for years: potential violation of federal labor laws and/or CMS funding rules, undue pressure on fellows as they travel and acclimate to a new environment in a compressed timeframe, burdens around scheduling coverages to meet the gaps, etc. "To that end, a set of recommendations will need to be drafted to provide guidance to the internal medicine community for operationalizing this proposal."