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HEALTHCARE EXTENDERS AND EXPIRING PROGRAMS TRACKER: Updated February 11, 2026

Summary
Many healthcare programs are extended for specific time periods, some as short as one or two years, others as long as 10. These "extenders" are usually attached to a larger piece of must-pass legislation. Additionally, while traditional authorizations for some of these programs expire, funding can often continue via the regular appropriations process. On February 3, 2026, Congress finalized, and President Trump signed, the Consolidated Appropriations Act, 2026 (CAA, 2026), a comprehensive fiscal year (FY) 2026 appropriations package that includes appropriations for the Department of Health and Human Services (HHS), addresses expiring healthcare programs, and includes other health policy priorities.

The chart below tracks healthcare programs that require congressional action between now and 2030 and highlights recent congressional action on each.

Listed in Order of Expiration Date			
Extenders	**Summary**	**Expiration Date**	**Legislation Providing Latest Funding/ Reauthorization**
Supplemental Nutrition Assistance Program (SNAP)	The Farm Bill is popularly associated with the provision of agricultural subsidies, conservation programs and new farm policies. For the past several decades, the legislation authorizing SNAP has been included in the Farm Bill. Overall, nutrition spending makes up 80% of the total budget for the Farm Bill. Of the programs covered by nutrition, SNAP accounts for 95% of all spending. The appropriations bill covering the Department of Agriculture was one of the three full FY 2026 bills included in the Continuing Appropriations and Extensions Act, 2026 (CAEA, 2026), that ended the government shutdown in November 2025. Thus, SNAP funding is extended through September 30, 2026.	September 30, 2026	CAEA, 2026

Community Health Centers	The primary form of federal funding for community health centers is the Health Center Program, which is authorized in Section 330 of the Public Health Services Act. More commonly known as the "330 Grant," funding for the Health Center Program comes from a combination of discretionary funding, appropriated by Congress each year, and mandatory funding from the Community Health Center Fund (CHCF). The CAA, 2026 extended funding for this program through December 31, 2026.	December 31, 2026	CAA, 2026
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 CHCF represents more than 70% of the program's annual funding. The CHCF is time-limited. At its outset, it was an appropriation for FY 2011 through FY 2015, but it has been extended several times, most recently through December 31, 2026, in the CAA, 2026.	December 31, 2026	CAA, 2026
Personal Responsibility Education Program	Funds projects to reduce teen pregnancy through the use of evidence-based programs. The CAA, 2026 extended funding for this program through December 31, 2026.	December 31, 2026	CAA, 2026
Special Diabetes Program for Type I Diabetes	Provides funding for Type I diabetes research at the National Institutes of Health. The CAA, 2026 extended funding for this program through December 31, 2026.	December 31, 2026	CAA, 2026
Special Diabetes Program for Indians	Grant program, coordinated by the Indian Health Service (IHS) Division of Diabetes with guidance from the Tribal Leaders Diabetes Committee. Provides funds for diabetes treatment and prevention to IHS, Tribal and Urban Indian health programs across the United States. The CAA, 2026 extended funding for this program through December 31, 2026.	December 31, 2026	CAA, 2026
Low-Volume Hospital Payment Adjustment	The Medicare low-volume hospital program 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. The CAA, 2026 extended the low-volume hospital payment adjustment through December 31, 2026.	December 31, 2026	CAA, 2026
Medicare-Dependent Hospital (MDH) Program	The MDH program, established in 1987, helps support small, rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. Congress acknowledged the importance of Medicare reimbursement to	December 31, 2026	CAA, 2026

	MDHs and established special payment provisions to buttress these hospitals. The CAA, 2026 extended the MDH program through December 31, 2026.		
Work Geographic Practice Cost Indices (GPCI) floor	Medicare payments to physicians are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the GPCIs, that reflect how each geographic area compares to the national average. In 2003, Congress established that for three years there would be a floor of 1.0 on the work component of the formula used to determine physician payments. Congress has repeatedly extended the 1.0 floor. There are concerns that without these adjustments, physician services in rural areas would be disproportionately affected by lower Medicare payments. The CAA, 2026 extended the work GPCI floor through December 31, 2026.	December 31, 2026	CAA, 2026
Clinical Laboratory Fee Schedule Cuts	The Protecting Access to Medicare Act (PAMA) reformed how CMS calculated laboratory service reimbursement rates under the Clinical Laboratory Fee Schedule (CLFS). Specifically, PAMA established a single national fee schedule based on private market data as reported directly from participating laboratories. Stakeholders have challenged the reliability of the underlying data and the resulting rates ever since. Because of this, Congress has acted to delay payment cuts and further data reporting since 2021. The CAA, 2026 delays the cuts through December 31, 2026. The CAA provision also delays the next PAMA reporting deadline from Feb-Apr 2026 to May-July 2026. Further, the CAA, 2026 also shifts the period from which data much be reported from 2019 to 2025.	December 31, 2026	CAA, 2026
Medicare Conversion Factor (CF) (*i.e.*, physician pay)	Physicians and other clinicians experienced a cut to the Medicare PFS CF of 2.83% in CY 2025. \A provision was included in the One Big Beautiful Bill Act (OBBBA) to provide a one-year payment increase of 2.5% to the PFS CFs for CY 2026 (note that there are two CFs starting in CY 2026, one for clinicians participating in Advanced Alternative Payment Models and one for all other clinicians.) Since the 2.5% bump is only a one-year update, it expires at the end of CY 2026, and CMS would, absent further congressional action, be required to take 2.5% out of the CFs for CY 2027.	December 31, 2026	OBBBA, 2025

PAHPA Reauthorization	The Pandemic and All-Hazards Preparedness and Response Act (PAHPA), first passed in 2006, contains key legal authorities to sustain and strengthen the United States' preparedness for public health emergencies involving chemical, biological, radiological and nuclear agents, as well as emerging infectious disease threats. PAHPA has been reauthorized and subsequently expired several times since its creation, but certain programs within PAHPA have still received individual authorizations. These programs received individual authorizations most recently in ARA, 2025 and the FYCAEA, 2025 through September 30, 2025. Certain PAHPA provisions were extended in CAA, 2026 through December 31, 2026.	December 31, 2026	Certain PAHPA provisions were extended in CAA, 2026 through CY 2026. The most recent full reauthorization was in the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019.
Advanced Alternative Payment Model (APM) Bonus Payment	The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) set up a Quality Payment Program (QPP) that incentivizes the transition to alternative payment models (APMs). There are two tracks under the QPP: the Merit-based Incentive Payment System track or the APM track. Clinicians who qualify for the APM track (called Qualifying APM participants or QPs), must have a certain percentage of their payments or patients tied to an Advanced APM (an Advanced APM is an APM that requires providers to take on downside financial risk, among other requirements). The patient and payment threshold (called the QP threshold) increased over time. MACRA included temporary 5% incentive payments for QPs. These incentive payments were paid out two years after the performance period, and the last incentive payments under MACRA were available for performance year 2022/payment year 2024. Starting in CY 2026, MACRA also provides a higher payment update on the Physician Fee Schedule (PFS) for QPs. QPs have their conversion factors updated by 0.75% each year, while other clinicians have their conversion factors updated by 0.25%. Once the 5% incentive payments expired, Congress extended the availability of these incentive payments multiple times. The CAA, 2023 extended the APM incentive payment for one year, providing a 3.5% incentive payment (rather than 5%) for performance year 2023/payment year 2025. It also retained lower QP thresholds. The CAA, 2024 extended the APM incentive payments again for another year (for performance year 2024, affecting payments in 2026), but at an even lower percentage of 1.88%. The bill also continued to freeze the QP	December 31, 2026	CAA, 2026

	thresholds, preventing higher ones from going into place. Further extension of the APM bonus or performance year 2025/payment year 2027 was included in a bipartisan healthcare package announced in December 2024, but the package was ultimately excluded from the government funding package passed that month. Without Congressional action, no incentive payments were available for performance year 2025/payment year 2027. In addition, higher QP thresholds went into effect that year. After a one-year gap, the CAA, 2026 provided a 3.1% incentive payment for performance year 2026/payment year 2028, and temporarily reinstated lower QP thresholds for this year.		
Medicaid Disproportionate Share Hospitals (DSH)	DSH payments are statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals. The Affordable Care Act included a reduction Medicaid DSH payments starting FY 2014 due to the assumption that Medicaid expansion would decrease the uninsurance rate and uncompensated care. However, scheduled DSH cuts have been delayed over the years. In the CAA, 2026, DSH payment cuts were delayed through the remainder of fiscal year 2026 and all of fiscal year 2027, effectively delaying cuts until fiscal year 2028.	September 30, 2027	CAA, 2026
Funding for quality measure endorsement, input and selection under the Medicare program	CMS is tasked with developing reliable and meaningful quality measurement that focuses on outcomes. Congress has supported these efforts with funding for CMS to provide quality measure selections and to contract with a consensus-based entity to carry out some of the tasks associated with this effort. The CAA, 2026 provides funding through FY 2027.	September 30, 2027	CAA, 2026
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program	The federal MIECHV program supports home visiting services for families with young children who reside in communities that have concentrations of poor child health and other indicators of risk. The ACA established the MIECHV program under Section 511 of the Social Security Act in March 2010. The CAA 2023 authorized five years of funding for the MIECHV program (increasing the annual funding level to $800 million by 2027), and described how funding for both federal base grants and federal matching grants would be allocated.	October 1, 2027	CAA, 2023

Puerto Rico Medicaid Funding	Medicaid funding for the US territories needs to be regularly reauthorized. The CAA 2022, which passed in March 2022, temporarily increased the federal share of Medicaid payment from the 55% set in historic statute to 76%. The CAA 2023 extended Puerto Rico's 76% Medicaid match through FY 2027, and permanently set the federal Medicaid match for American Samoa, the Commonwealth of the Northern Mariana Islands, Guam and the US Virgin Islands at 83%.	October 1, 2027	CAA, 2023
FDA User Fee Reauthorization Act	The User Fee Act (UFAs) were initially established in the Prescription Drug User Fee Act (PDUFA), which was enacted in 1992. UFAs include US Food and Drug Administration (FDA) user fee programs for branded/reference drugs and biologics, medical devices, generic drugs and biosimilars (PDUFA, MDUFA, GDUFA and BsUFA). PDUFA authorized FDA to collect various user fees from companies that submit applications for certain human drug products. In the years that followed, PDUFA resources enabled a more modern and efficient approach to FDA's review of new drug applications. The user fees must be reauthorized every five years and often serve as vehicles for other FDA-related policies. The Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023, extended the UFAs through FY 2027.	October 1, 2027	Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023
Money Follows the Person Program	The Money Follows the Person Program was created in 2005. The program provides states with enhanced federal matching funds for services and supports to help seniors and people with disabilities move from institutions to home-based care. Forty-four states participate in the program, which has helped more than 90,000 institutional residents transition back to their communities. The CAA 2023 provided a four-year extension of the Money Follows the Person Program through FY 2027.	October 1, 2027	CAA, 2023
Ground Ambulance Add-On Payments	The ambulance fee schedule incorporates several add-on payments tied to the mode of ambulance transport and/or the geographic location of the point of pickup The ground ambulance add-on payments were established by Congress and have been extended several times. The ground ambulance add-on payments increase the base payment and mileage rate for ground transports by 3% for transports originating in rural ZIP codes and by 2% for transports originating in urban ZIP codes. There is also a "super rural" add-on payment that increases the base payment by 22.6% for all ground ambulance transports	December 31, 2027	CAA, 2026

	where the point-of pickup ZIP code is located in a rural county that is among the lowest quartile of all rural counties by population density. These provisions were extended in the CAA, 2026 through December 31, 2027.		
Medicare Telehealth Flexibilities	Congress and CMS provided many Medicare telehealth flexibilities during the COVID-19 public health emergency (PHE). The FYCAEA, 2025 extended certain pandemic-related telehealth capabilities, including waivers to the geographic and originating site restrictions, expansions to the list of eligible practitioners, eligibilities 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 patient's eligibility for hospice care, and delaying the in-person visit requirement before a patient receives tele-mental health services through September 30, 2025. These flexibilities expired briefly during the government shutdown from October 1, 2025 to November 12, 2025, and were then restored. Most recently, the CAA, 2026 extended Medicare telehealth flexibilities through December 31, 2027.	December 31, 2027	CAA, 2026
Funding for outreach and assistance for low-income Medicare programs	There are several programs that provide Medicare beneficiary outreach, enrollment and education activities for low-income populations. These are generally provided and funded 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 and continued that trend by providing funding through December 31, 2027 (via CAA, 2026).	December 31, 2027	CAA, 2026
Provision of cardiopulmonary rehabilitation services via telehealth	Previously, Medicare only reimbursed cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR), when furnished via telehealth, under the Physician Fee Schedule. This meant that hospital outpatient departments could not be reimbursed for virtual CR, ICR, or PR under the Medicare program. The CAA, 2026 includes a provision to allow these services to be paid when furnished via telehealth under the Medicare Hospital Outpatient Prospective Payment System, through CY 2028.	December 31, 2028	CAA, 2026
Teaching Health Centers	The Health Resources and Services Administration operates Teaching Health Center Graduate Medical Education programs	October 1, 2029	CAA, 2026

	focused on increasing the primary care workforce in medically underserved communities. The program was established and funded for five years under the Affordable Care Act (ACA) and has been reauthorized and funded several times since then. Most of the training programs currently operating in the states are conducted in community health centers. The CAA, 2026 extended funding for this program through FY 2029.		
CHIP	CHIP is a block grant that needs continual reauthorization and extension.	October 1, 2029	CAA, 2023
Hospital at Home, Acute Hospital Care at Home Waiver	CMS implemented the Acute Hospital Care at Home waiver program to allow Medicare beneficiaries to receive acute-level healthcare services in their home environment during the COVID-19 PHE. However, the federal regulatory flexibilities that enabled the model were tied to the duration of the PHE. The Acute Hospital Care at Home waiver initiative was extended multiple times, including earlier this year by the FYCAEA, 2025 through September 30, 2025. This flexibility expired briefly during the government shutdown from October 1, 2025 to November 12, 2025. The CAEA, 2026 restored the waiver through January 30, 2026. Most recently, the CAA, 2026 extended the waiver program through September 30, 2030.	September 30, 2030	CAA, 2026
****Already Expired****			

Marketplace Enhanced Advanced Premium Tax Credits (APTCs)	The ACA included APTCs to help individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) purchase health insurance in the federal exchange marketplace. The American Rescue Plan Act of 2021 (ARPA) temporarily extended these tax credits to individuals with incomes above 400% of the FPL and made the subsidy more generous for those below 400%. For 2021 and 2022, ARPA also expanded the ACA requirement that a health plan premium not be more than 8.5% of an individual's income to those with incomes above 400% of the FPL. The Inflation Reduction Act of 2022 extended the expanded APTCs for three years, through 2025. These tax credits are identical to those included in ARPA. This provision simply pushed the sunset date of the ARPA tax credits to January 1, 2026. (ARPA also provided enhanced marketplace subsidies for people who received or were approved to receive unemployment compensation for any week beginning in 2021. However, the IRA did not include an extension of this provision.) The enhanced APTC expiration was a major component of the 2025 government shutdown, with Democrats urging Republicans to include an extension in the government funding bill, and Republicans declining to do so. While the House passed a three-year enhanced APTC extension as a result of a procedural maneuver that allowed Democrats to bring up the bill, Senate negotiators have been unable to reach an agreement on an APTC compromise. The most recent government funding bill (CAA, 2026) did not include an extension of the enhanced APTCs.	January 1, 2026	Inflation Reduction Act, 2022

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