

PUBLIC LAW 119–21—JULY 4, 2025

139 STAT. 327

**CHAPTER 4—PROTECTING RURAL HOSPITALS AND PROVIDERS**

**SEC. 71401. RURAL HEALTH TRANSFORMATION PROGRAM.**

Time periods.

(a) IN GENERAL.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsection:

“(h) RURAL HEALTH TRANSFORMATION PROGRAM.—

“(1) APPROPRIATION.—

“(A) IN GENERAL.—There are appropriated, out of any money in the Treasury not otherwise appropriated, to the Administrator of the Centers for Medicare & Medicaid Services (in this subsection referred to as the ‘Administrator’), to provide allotments to States for purposes of carrying out the activities described in paragraph (6)—

“(i) \$10,000,000,000 for fiscal year 2026;

“(ii) \$10,000,000,000 for fiscal year 2027;

“(iii) \$10,000,000,000 for fiscal year 2028;

“(iv) \$10,000,000,000 for fiscal year 2029; and

“(v) \$10,000,000,000 for fiscal year 2030.

“(B) UNEXPENDED OR UNOBLIGATED FUNDS.—

“(i) IN GENERAL.—Any amounts appropriated under subparagraph (A) that are unexpended or unobligated as of October 1, 2032, shall be returned to the Treasury of the United States.

Effective date.

“(ii) REDISTRIBUTION OF UNEXPENDED OR UNOBLIGATED FUNDS.—In carrying out subparagraph (A), the Administrator shall, not later than March 31, 2028, and annually thereafter through March 31, 2032, determine the amount of funds, if any, that are available under such subparagraph for a previous fiscal year, are unexpended or unobligated with respect to such fiscal year, and will not be available to a State in the current fiscal year, pursuant to clause (iii).

Deadline.  
Determination.

“(iii) AVAILABILITY OF FUNDS.—

“(I) IN GENERAL.—Amounts allotted to a State under this subsection for a year shall be available for expenditure by the State through the end of the fiscal year following the fiscal year in which such amounts are allotted.

“(II) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under clause (ii) with respect to a fiscal year shall be available for expenditure by the State through the end of the fiscal year following the fiscal year in which such amounts are redistributed (except in the case of amounts redistributed in fiscal year 2032 which shall only be available for expenditure through September 30, 2032).

“(iv) MISUSE OF FUNDS.—If the Administrator determines that a State is not using amounts allotted or redistributed to the State under this subsection in a manner consistent with the description provided by the State in its application approved under paragraph (2), the Administrator may withhold payments to, or reduce payments to, or recover previous payments from, the State under this subsection as the

Determination.

Administrator deems appropriate, and any amounts so withheld, or that remain after any such reduction, or so recovered, shall be returned to the Treasury of the United States.

“(2) APPLICATION.—

Deadline.

“(A) IN GENERAL.—To be eligible for an allotment under this subsection, a State shall submit to the Administrator during an application submission period to be specified by the Administrator (but that ends not later than December 31, 2025) an application in such form and manner as the Administrator may specify, that includes—

Transformation plan.

“(i) a detailed rural health transformation plan—

“(I) to improve access to hospitals, other health care providers, and health care items and services furnished to rural residents of the State;

“(II) to improve health care outcomes of rural residents of the State;

“(III) to prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management;

“(IV) to initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other health care providers in order to promote measurable quality improvement, increase financial stability, maximize economies of scale, and share best practices in care delivery;

“(V) to enhance economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training;

“(VI) to prioritize data and technology driven solutions that help rural hospitals and other rural health care providers furnish high-quality health care services as close to a patient’s home as is possible;

“(VII) that outlines strategies to manage long-term financial solvency and operating models of rural hospitals in the State; and

“(VIII) that identifies specific causes driving the accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reduction;

Certification.

“(ii) a certification that none of the amounts provided under this subsection shall be used by the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law, including under the State plan established under this title, the State plan established under title XIX, or under a waiver of such plans; and

“(iii) such other information as the Administrator may require.

“(B) DEADLINE FOR APPROVAL.—Not later than December 31, 2025, the Administrator shall approve or deny all applications submitted for an allotment under this subsection.

“(C) ONE-TIME APPLICATION.—If an application of a State for an allotment under this subsection is approved by the Administrator, the State shall be eligible for an allotment under this subsection for each of fiscal years 2026 through 2030, except as provided in paragraph (1)(B)(iv).

“(D) ELIGIBILITY.—Only the 50 States shall be eligible for an allotment under this subsection and all references in this subsection to a State shall be treated as only referring to the 50 States.

“(3) ALLOTMENTS.—

“(A) IN GENERAL.—For each of fiscal years 2026 through 2030, the Administrator shall determine under subparagraph (B) the amount of the allotment for such fiscal year for each State with an approved application under this subsection.

Determination.

“(B) AMOUNT DETERMINED.—Subject to subparagraph (C), from the amounts appropriated under paragraph (1)(A) for each of fiscal years 2026 through 2030, the Administrator shall allot—

“(i) 50 percent of the amounts appropriated for each such fiscal year equally among all States with an approved application under this subsection; and

“(ii) 50 percent of the amounts appropriated for each such fiscal year among all such States in an amount to be determined by the Administrator in accordance with subparagraph (C).

“(C) REQUIREMENTS.—In determining the amount to be allotted to a State under clause (ii) of subparagraph (B) for a fiscal year, the Administrator shall—

Determination.

“(i) ensure that not less than  $\frac{1}{4}$  of the States with an approved application under this subsection for a fiscal year are allotted funds from amounts that are to be allotted under clause (ii) of such subparagraph; and

“(ii) consider—

“(I) the percentage of the State population that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

“(II) the proportion of rural health facilities (as defined in subparagraph (D)) in the State relative to the number of rural health facilities nationwide;

“(III) the situation of hospitals in the State, as described in section 1902(a)(13)(A)(iv); and

“(IV) any other factors that the Administrator determines appropriate.

“(D) RURAL HEALTH FACILITY DEFINED.—For the purposes of subparagraph (C)(ii), the term ‘rural health facility’ means the following:

“(i) A subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d)) that—

“(I) is located in a rural area (as defined in paragraph (2)(D) of such section);

“(II) is treated as being located in a rural area pursuant to paragraph (8)(E) of such section; or

“(III) is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

“(ii) A critical access hospital (as defined in section 1861(mm)(1)).

“(iii) A sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

“(iv) A Medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv)).

“(v) A low-volume hospital (as defined in section 1886(d)(12)(C)).

“(vi) A rural emergency hospital (as defined in section 1861(kkk)(2)).

“(vii) A rural health clinic (as defined in section 1861(aa)(2)).

“(viii) A Federally qualified health center (as defined in section 1861(aa)(4)).

“(ix) A community mental health center (as defined in section 1861(ff)(3)(B)).

“(x) A health center that is receiving a grant under section 330 of the Public Health Service Act.

“(xi) An opioid treatment program (as defined in section 1861(jjj)(2)) that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

“(xii) A certified community behavioral health clinic (as defined in section 1905(jj)(2)) that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

“(4) NO MATCHING PAYMENT.—A State approved for an allotment under this subsection for a fiscal year shall not be required to provide any matching funds as a condition for receiving payments from the allotment.

“(5) TERMS AND CONDITIONS.—The Administrator shall specify such terms and conditions for allotments to States provided under this subsection as the Administrator deems appropriate, including the following:

“(A) Each State shall submit to the Administrator (at a time, and in a form and manner, specified by the Administrator)—

Plan.

“(i) a plan for the State to use its allotment to carry out 3 or more of the activities described in paragraph (6); and

Reports.

“(ii) annual reports on the use of allotments, including such additional information as the Administrator determines appropriate.

“(B) Not more than 10 percent of the amount allotted to a State for a fiscal year may be used by the State for administrative expenses.

“(6) USE OF FUNDS.—Amounts allotted to a State under this subsection shall be used for 3 or more of the following health-related activities:

“(A) Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

“(B) Providing payments to health care providers for the provision of health care items or services, as specified by the Administrator.

“(C) Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.

“(D) Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.

“(E) Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.

“(F) Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.

“(G) Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.

“(H) Supporting access to opioid use disorder treatment services (as defined in section 1861(jjj)(1)), other substance use disorder treatment services, and mental health services.

“(I) Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

“(J) Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the Administrator.

Determination.

“(7) EXEMPTIONS.—Paragraphs (2), (3), (5), (6), (8), (10), (11), and (12) of subsection (c) do not apply to payments under this subsection.

“(8) REVIEW.—There shall be no administrative or judicial review under section 1116 or otherwise of amounts allotted or redistributed to States under this subsection, payments to States withheld or reduced under this subsection, or previous payments recovered from States under this subsection.

“(9) HEALTH CARE PROVIDER DEFINED.—For purposes of this subsection, the term ‘health care provider’ means a provider of services or supplier who is enrolled under this title, title XVIII, or title XIX.”

(b) CONFORMING AMENDMENTS.—Title XXI of the Social Security Act (42 U.S.C. 1397aa) is amended—

(1) in section 2101—

(A) in subsection (a), in the matter preceding paragraph (1), by striking “The purpose” and inserting “Except with respect to the rural health transformation program established in section 2105(h), the purpose”; and

(B) in subsection (b), in the matter preceding paragraph (1), by inserting “subsection (a) or (g) of” before “section 2105”;

42 USC 1397ee.

(2) in section 2105(c)(1), by striking “and may not include” and inserting “or to carry out the rural health transformation program established in subsection (h) and, except in the case of amounts made available under subsection (h), may not include”; and

42 USC 1397ff.

(3) in section 2106(a)(1), by inserting “subsection (a) or (g) of” before “section 2105”.

42 USC 1397aa  
note.

(c) IMPLEMENTATION.—The Administrator of the Centers for Medicare & Medicaid Services shall implement this section, including the amendments made by this section, by program instruction or other forms of program guidance.

(d) IMPLEMENTATION FUNDING.—For the purposes of carrying out the provisions of, and the amendments made by, this section, there are appropriated, out of any monies in the Treasury not otherwise appropriated, to the Administrator of the Centers for Medicare & Medicaid Services, \$200,000,000 for fiscal year 2025, to remain available until expended.

## Subtitle C—Increase in Debt Limit

31 USC 3101  
note.

### SEC. 72001. MODIFICATION OF LIMITATION ON THE PUBLIC DEBT.

The limitation under section 3101(b) of title 31, United States Code, as most recently increased by section 401(b) of Public Law 118-5 (31 U.S.C. 3101 note), is increased by \$5,000,000,000,000.

## Subtitle D—Unemployment

26 USC 3304  
note.

### SEC. 73001. ENDING UNEMPLOYMENT PAYMENTS TO JOBLESS MILLIONAIRES.

#### (a) PROHIBITION ON USE OF FEDERAL FUNDS.—

(1) IN GENERAL.—No Federal funds may be used—

(A) to make payments of unemployment compensation benefits under an unemployment compensation program of the United States in a year to an individual whose wages during the individual’s base period are equal to or exceed \$1,000,000; or

(B) for any administrative costs associated with making payments described in subparagraph (A).

(2) COMPLIANCE.—

Procedure.

(A) SELF-CERTIFICATION.—Any application for unemployment compensation under an unemployment compensation program of the United States shall include a form or procedure for an individual applicant to certify that such individual’s wages during the individual’s base period do not equal or exceed \$1,000,000.

(B) VERIFICATION.—Each State agency that is responsible for administering any unemployment compensation program of the United States shall utilize available systems



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February 11, 2026

Good afternoon Madam Chair and Honorable Members of the Senate Health and Welfare Committee.

Thank you for the opportunity to provide testimony today. My name is Lisa Raye Anderson, Advocacy Director for AARP Idaho. AARP is a nonpartisan, nonprofit organization with over 188,000 Idaho members, many of whom live in rural and frontier communities. We come before you today to respectfully request that you support **Senate Bill 1253**.

We appreciate the work reflected in Idaho's Rural Health Transformation Program (RHTP) plan and rise in support of the elements that directly strengthen care access for older Idahoans living outside our urban centers.

Rural older adults face unique and compounding barriers: provider shortages, hospital closures or service reductions, transportation challenges, limited specialty care, and higher rates of chronic disease. Idaho's plan addresses several of these realities in meaningful ways.

**First, the plan's focus on strengthening rural primary care and value-based care models is critical.** Expanding team-based care and incentivizing participation in alternative payment models helps stabilize rural clinics that serve Medicare-eligible and dual-eligible older adults. For many older Idahoans, their rural primary care provider is their only consistent point of care.

**Second, investment in behavioral health integration is especially important.** Rural older adults experience high rates of depression, isolation, and suicide risk, yet behavioral health services are often hours away. Embedding behavioral health into primary care settings improves early intervention and reduces stigma — particularly for older men in rural communities.

**Third, the plan's emphasis on care coordination and community health workers directly benefits older adults managing multiple chronic conditions.** Many rural seniors are juggling diabetes, heart disease, COPD, and medication management without nearby specialty care. Care coordination reduces preventable hospitalizations and helps older adults remain safely at home.

**Fourth, telehealth infrastructure expansion is a lifeline.** Broadband-supported telehealth allows rural older adults to connect with specialists without traveling long distances — especially in winter months.

However, implementation must ensure digital literacy support and maintain audio-only options for those without reliable internet access.

**Fifth, workforce development strategies included in the plan — particularly recruitment and retention incentives for rural providers — are foundational.** Without addressing workforce shortages, transformation cannot succeed. Older Idahoans disproportionately rely on consistent, long-term provider relationships, and turnover in rural settings disrupts care continuity.

**Finally, efforts within the plan that reduce avoidable emergency room utilization and strengthen transitional care are essential for older adults following hospital discharge.** Poor discharge coordination is a major driver of readmissions among Medicare beneficiaries in rural communities. For rural older Idahoans, this plan is not abstract policy — it is the difference between aging in place and leaving their community for care. It is the difference between preventive care and crisis care.

AARP Idaho supports continued implementation and oversight of the Rural Health Transformation Program with particular attention to measurable outcomes for adults age 50 and older in rural and frontier counties.

We urge continued collaboration to ensure:

- Rural access remains geographically equitable
- Telehealth remains accessible and affordable
- Care coordination is adequately funded
- Workforce investments prioritize sustainability

Thank you for your commitment to strengthening rural health systems and protecting the independence and health of older Idahoans. We urge you to move this legislation forward and I stand ready for any questions.

**SB 1264**

**Comments from the IAFP**

**Liz Woodruff, Executive Director**

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Madame Chair, members of the Committee, my name is Liz Woodruff, and I'm the director of the Idaho Academy of Family Physicians. We represent over 800 family doctors across Idaho, including those in rural areas. Strengthening the physician workforce is a strategic focus for the IAFP. Our Workforce and Rural Support Committee is led by family doctors from all corners of rural Idaho, from Montpelier to Orofino, and Hailey to Emmett.

The opportunity for rural health investment through the Rural Health Transformation Program (RHTP) funds is a once-in-a-generation chance to impact healthcare in Idaho. The IAFP has actively contributed to the input and review process led by IDHW during its application, and we appreciate their efforts.

As you consider SB 1264, we want to emphasize the importance of guiding the RHTP with clear principles and priorities to ensure projects are effective, sustainable, and responsive to community needs.

First, Idaho should prioritize regional coordination, collaborating across the state to identify the most impactful investments in the key areas outlined in Idaho's application.

Idaho's application aims to add 40 new physicians to rural areas over the next four years. Achieving this requires targeted training for Idaho medical students and strengthening our Graduate Medical Education programs. The committee established by this legislation can reference the "Train Here, Stay Here, Grow Here" plan from the SBOE's UME Workgroup as a guiding framework.

We should adopt a balanced approach to technology, avoiding overemphasis on high-tech solutions while still supporting innovation. Grant dollars should enhance access to well-trained providers and equipped health systems.

We support investments in Critical Access Hospitals, as these are vital for rural Idahoans' health needs. Investments in the Idaho Perinatal Quality Collaborative will improve maternal health outcomes for rural families. Enhanced Emergency Medical Services initiatives should focus on recruiting and retaining EMS personnel to improve access to care.

Fostering care coordination within Patient-Centered Medical Homes is critical for achieving better health outcomes.



We look forward to collaborating with the committee established by SB 1264 to support meaningful investments with RHTP funds that will lead to lasting improvements in our rural healthcare system. Thank you for your time and consideration. I'm happy to answer any questions.

**Five Areas of Focus in Idaho's Application**

(Improving rural access through technology, Ensuring accessible quality care through Innovative models, Sustaining the rural workforce through training and retention, Implementing evidence-based projects, and investing in rural health infrastructure)



## **Principles and Priorities for Implementing Rural Health Transformation Program Funds in Idaho**

It is crucial for the success of the Rural Health Transformation Program (RHTP) to be guided by clear principles and priorities. Idaho faces unique challenges in rural healthcare access and service delivery, and it's important to work together to ensure that investments are effective, sustainable, and responsive to the needs of rural Idaho. By focusing on coordination, input from rural health professionals, balanced technological approaches, and access to quality care, we can make meaningful improvements in health outcomes for Idahoans.

### **Principles**

#### **Regional Coordination**

Collaborate across Idaho's regions to identify the most cost-effective and impactful investments in the five focus areas outlined in Idaho's application.  
Input from Rural Health Professionals

#### **Consult Experts**

Actively seek insights and recommendations from experienced rural health professionals to ensure programs are relevant and effective.

#### **Balanced Approach to Technology**

Avoid overemphasizing high-tech solutions; prioritize practical, actionable investments that meet the immediate needs of rural communities.

#### **Focus on Quality**

Ensure grant dollars facilitate access to highly-trained providers and well-equipped health systems, thereby enhancing the quality of care available in rural areas.

### **Priorities**

#### **Investment in Critical Access Hospital Infrastructure**

Critical Access Hospitals (CAHs) are vital for addressing the health needs of rural Idahoans. RHTP funds should be used to strategically improve CAH infrastructure and services through coordinated efforts targeting areas of high need for investment in equipment and facilities.

### **Growing Idaho's Physician Workforce**

Idaho's application to CMS identified a goal of adding 40 new physicians to rural areas in the next four years. This will require targeted and deliberate training for Idaho medical students, and strengthening and growing Graduate Medical Education programs in Idaho. The recent "Train Here, Stay Here, Grow Here" plan released by the interim workgroup on medical education should be used as a reference for these targeted investments.

### **Enhancing EMS Services for Rural Idaho**

Support specific initiatives for recruiting and retaining Emergency Medical Services (EMS) personnel in rural areas to improve emergency care access and response times.

### **Invest in the Idaho Perinatal Quality Collaborative to Support Maternal Health in Rural Idaho**

Enhancing maternal care is vital for the health of mothers and their babies, and the Idaho PQC will play a crucial role in improving practices and addressing barriers to maternal health in rural areas.

### **Fostering Care Coordination in Patient-Centered Medical Homes**

Health care value and improved health outcomes require regular access to primary care providers within a coordinated patient-centered medical home. Access to care in a healthcare setting is the most effective way to achieve lower costs and better health outcomes.

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# BECKER'S --- **HOSPITAL REVIEW** ---

January 27, 2026

## **Idaho system lays off 10% of workforce, plans to close infusion clinic**

Driggs, Idaho-based Teton Valley Health Care laid off 26 employees, or around 10% of its 276-person workforce, on Jan. 22 and 23 and plans to close its infusion clinic amid financial pressures.

The layoffs affected staff across multiple departments, including management, Nancy Osmundson, chief public relations officer and foundation executive director at the system, confirmed with *Becker's*.

Ms. Osmundson cited multiple factors for the system's financial challenges, including a 75% drop in patient days from what they budgeted, delayed reimbursement and extreme weather that has reduced typical winter patient volumes. The system also saw a \$1.2 million Medicare-Medicaid takeback in November and around \$2 million in employee retention credits frozen by the IRS.

"It was a couple of factors that hit us very quickly," she said. "Downsizing our workforce is always our last resort, but we are at that point."

A closure date was not set for the hospital's infusion clinic, which will close once its existing medication supplies have been depleted. Ms. Osmundson said there is hope it will eventually reopen. She also said a donor has provided bridge funding to cover the system's shortfalls for up to 12 months.

Teton Valley Health Care comprises Driggs-based Teton Valley Health Hospital, Driggs Health Clinic and the Victor (Idaho) Health Clinic, according to its [website](#).

