FY 2027 IPPS Proposed Rule

Impact on Hospital-based Nursing and Allied Health Education

Medicare Payment and Compliance Proposals

Executive Takeaway

This proposed (April 10, 2026) CMS Inpatient Prospective Patient System (IPPS) rule would continue the existing capped Medicare Advantage nursing and allied health education payment pool, while adding NAH-relevant compliance and cost-reporting proposals that could materially affect approved program status, tuition and fee offsets, indirect cost recovery, related-party arrangements, and the documentation hospitals need to defend pass-through reimbursement.

1. Overview

This overview covers the proposed Medicare Advantage NAH payment update, the new nondiscrimination and accreditation-related proposals, and additional cost-reporting provisions that directly affect NAH programs. Click here for the proposed rule.

The proposals are not final. **The public comment period ends June 9, 2026**. The final rule will take effect October 1, 2026.

Source in proposed rule: Public Inspection PDF pp. 1, 5, 524-546, 1147-1154, and 1231-1234. Page references are to the PDF pagination.

2. Medicare Advantage NAH Payment Pool: What the Proposed Update Means

Medicare pays hospitals for approved provider-operated nursing and allied health education programs on a reasonable-cost basis. Under that methodology, Medicare reimburses its share of the hospital's reasonable costs for approved education activities. Congress later required CMS to account for Medicare Advantage utilization when determining Medicare's share of those nursing and allied health education costs.

The MA-related nursing and allied health education payment is capped at $60 million nationally each year. CMS allocates that capped amount among eligible hospitals based on each hospital's relative share of national nursing and allied health education payments and Medicare Advantage utilization. The payment is funded through an offset to analogous Medicare Advantage direct graduate medical education payments made to teaching hospitals.

For calendar year 2025, CMS proposes to distribute the full $60 million pool for MA nursing and allied health education payments. CMS also proposes an offset of 2.33 percent to Medicare Advantage DGME payments to fund the pool. CMS would use the third-quarter 2025 update of 2023 HCRIS cost-report data, projected forward two years, to estimate the 2025 payments.

Source in proposed rule: Public Inspection PDF pp. 524-528.

3. New Nondiscrimination Condition for Approved NAH Programs and Accreditors

CMS proposes to create a new nondiscrimination requirement at 42 CFR § 413.84 and cross-reference it in the NAH payment regulation at 42 CFR § 413.85. The proposal would apply to approved medical residency programs and approved nursing and allied health education programs. For hospital-based NAH programs, compliance with the nondiscrimination standard would become part of maintaining Medicare-approved program status for pass-through payment purposes.

The proposed prohibition would bar unlawful discrimination, or promotion or encouragement of discrimination, based on race, color, national origin, sex, age, disability, or religion. CMS also indicates that prohibited criteria would include use of those characteristics, or intentional proxies for them, in employment, program participation, selection, resource allocation, or similar benefits.

The proposed effective date is October 1, 2026. Senior NAH leaders should treat this as a program-approval issue, not merely a general institutional compliance requirement.

Source in proposed rule: Public Inspection PDF pp. 528-530 and 1231-1233.

4. Accreditation-Related Protection Involving Abortion-Training Standards

The proposed new 42 CFR § 413.84 also includes accreditation-related protection that is broader than the nondiscrimination discussion. CMS proposes that approved medical residency programs and approved NAH education programs would include programs that otherwise would be accredited except for an accrediting agency's reliance on a standard requiring an entity to perform an induced abortion, require, provide, or refer for training in induced abortion, or make arrangements for such training. CMS states this would apply regardless of whether the accrediting standard includes exceptions or exemptions.

For NAH programs in fields where accreditation standards may touch reproductive-health training or referral expectations, this provision could become relevant to institutional policy, accreditation strategy, and Medicare approval status. Senior leaders should assess whether any program standards, affiliation agreements, or clinical placement requirements implicate this proposal.

Source in proposed rule: Public Inspection PDF pp. 1231-1232.

5. Removal of Named NAH Accreditor Examples

CMS proposes to remove older regulatory examples of specific NAH accrediting organizations, such as the Commission on Accreditation of Allied Health Education Programs, the National League of Nursing Accrediting Commission, the Association for Clinical Pastoral Education, and the American Dietetic Association. CMS indicates that the field has evolved and that listing only a limited set of accrediting bodies is no longer useful.

It makes the regulation less tied to a fixed list of legacy organizations. Programs would still need to show that they are licensed by state law or, where state licensing is not required, accredited by the recognized national professional organization for the activity.

Source in proposed rule: Public Inspection PDF pp. 530 and 1233.

6. Revised Calculation of Reimbursable NAH Net Cost

CMS proposes to revise 42 CFR § 413.85(d)(2) to clarify and codify how hospitals calculate the net cost of approved NAH education activities. The proposed sequence is important: first identify allowable direct costs; then subtract student-related revenues such as tuition, student fees, and textbooks purchased for resale; then allocate allowable indirect costs that the provider itself incurs because of operating the approved educational activity.

This sequencing matters because tuition and fee revenue would be offset against direct NAH program costs before indirect overhead is allocated. Some hospitals have favored an approach in which tuition and fees are offset after overhead allocation. CMS proposes the opposite. For NAH programs with significant tuition or fee revenue, this could materially reduce reimbursable pass-through cost.

Financial implications

- Programs with substantial tuition or fee revenue may see lower reported net cost and lower Medicare reimbursement.
- Tuition and fees could reduce direct NAH program costs to zero or below before overhead allocation.
- Hospitals will need stronger documentation of what revenues are received from students or on behalf of students and how those revenues relate to the approved NAH program.
- Budget models for hospital-based NAH programs should be retested using the proposed sequencing to estimate potential reimbursement impact.

Source in proposed rule: Public Inspection PDF pp. 536-539 and 1233.

7. Worksheet B-1 Reconciliation Adjustment for Overhead Allocation

CMS recognizes that offsetting tuition and other student revenue before overhead allocation could artificially reduce the accumulated-cost statistic used to allocate administrative and general expenses. To address that concern, CMS proposes a Worksheet B-1 reconciliation-column adjustment.

Under this approach, the hospital would still offset tuition and similar NAH revenue on Worksheet A-8 for net-cost purposes. But for overhead-allocation purposes only, the hospital would add back the revenue offset in the Worksheet B-1 reconciliation column. This prevents the overhead allocation statistic from being understated merely because tuition revenue reduced the NAH cost center on Worksheet A.

CMS gives an example in which a hospital has $1 million of direct allied health education costs and $1.2 million of tuition and fee revenue. Worksheet A would show negative $200,000 for the program after the revenue offset. For purposes of allocating administrative and general overhead, the hospital would add back the $1.2 million revenue offset in the Worksheet B-1 reconciliation column so the overhead statistic is not distorted.

Administrative meaning

- CMS is not allowing tuition revenue to increase reimbursable net NAH cost, but it is trying to prevent tuition revenue from distorting the overhead-allocation base.
- Cost-report staff will need to coordinate closely with NAH program finance leaders so tuition and fee revenue is identified, offset, and then properly treated for Worksheet B-1 reconciliation purposes.
- Hospitals should preserve detailed workpapers showing the link between direct NAH costs, student-related revenues, Worksheet A-8 adjustments, and Worksheet B-1 reconciliation entries.

Source in proposed rule: Public Inspection PDF pp. 537-539.

8. Required Componentization of General Service Cost Centers

CMS proposes a more granular approach to allocating indirect costs to NAH programs. Hospitals would have to analyze general service cost centers, especially Administrative and General, to determine which functions actually benefit the NAH program and which do not. Where a broad general service cost center includes both benefiting and non-benefiting functions, the hospital would need to create subscripted or fragmented cost centers.

Only the portion of overhead that actually benefits the NAH program would be allowed to flow to the NAH cost center for Medicare pass-through reimbursement. CMS gives an example of a hospital with $100 million in A&G costs, of which $75 million benefits both the hospital and the NAH program, while $25 million, such as legal services or inpatient admissions, does not benefit the NAH program.

The hospital would separate those functions and zero out the NAH allocation statistic for the portion that does not benefit NAH.

Operational implications

- Hospitals should not assume that broad A&G allocations will continue to be accepted without function-level support.
- NAH administrators should work with reimbursement and finance teams to identify which overhead functions actually support the education program.
- Hospitals may need new cost-center subscripts, revised cost-finding workpapers, and clearer documentation of benefit to the NAH program.
- The proposal increases audit risk for hospitals that lack documentation connecting indirect costs to actual NAH program benefit.

Source in proposed rule: Public Inspection PDF pp. 540-546.

9. Broader Cost-Allocation Proposal at 42 CFR § 413.24

CMS also includes a broader proposal to codify cost allocation principles at 42 CFR § 413.24. This is not labeled as an NAH-only proposal, but CMS cross-references it in the NAH discussion. For hospital-based NAH programs, the provision matters because NAH overhead allocations must use statistical bases that reasonably relate to the general service costs and reflect the proportion attributable to downstream cost centers, including NAH.

CMS proposes to require providers to use a Negative Adjustment Method, a Fragmenting/Componentizing A&G Method, or both, to prevent improper allocation of overhead on the Medicare cost report. If a provider componentizes A&G costs, it must track and allocate overhead expenses based on actual resource consumption.

Why this matters for NAH leaders

- NAH programs should expect more scrutiny of A&G, home-office, purchased-service, and other overhead allocation methodologies.
- Hospitals may need to revise cost-report workpapers and statistical bases used to allocate general service costs to NAH cost centers.
- Changes to cost-finding methods may require coordination with reimbursement advisors and, where applicable, MAC approval or discussion.
- NAH leaders should not treat this as a remote finance-only provision; it may determine how much of the program's support infrastructure is reimbursable.

Source in proposed rule: Public Inspection PDF pp. 544 and 1147-1154.

10. Nonprovider-Operated NAH Clinical Training Programs and Related-Party Costs

CMS's NAH overhead discussion also addresses nonprovider-operated programs paid for clinical training costs under 42 CFR § 413.85(g)(1) and (2). CMS says providers may receive reasonable-cost payment for clinical training costs in certain nonprovider-operated programs, including some related-organization clinical training costs. However, overhead costs incurred by a related organization generally are not allowable for NAH pass-through payment.

CMS proposes that providers claiming these costs must distinguish between overhead costs incurred directly by the provider and overhead incurred by a related party. CMS says this would be done by creating an additional subscript of the relevant general service cost center containing only the related-party costs. Those related-party overhead costs would then be removed as a post-stepdown adjustment on Worksheet B-2.

Operational meaning

- Hospitals supporting clinical training programs not fully operated by the provider should review whether claimed overhead is provider-incurred or related-party overhead.
- Hospital-affiliated schools, health-system entities, parent organizations, universities, and joint arrangements should be assessed for related-party cost-reporting exposure.
- Affiliation agreements and intercompany allocations may need to be reviewed to determine which costs can be claimed and which must be removed.
- NAH leaders should ensure that programmatic arrangements align with reimbursement documentation, not merely academic or operational convenience.

Source in proposed rule: Public Inspection PDF pp. 544-545.

11. Clarification of Allowable and Non-Allowable Costs

CMS emphasizes that indirect costs are not categorically excluded from NAH reimbursement. A hospital may allocate overhead to NAH cost centers when the NAH program benefits from the overhead function and the provider itself incurs the cost. However, the allocation must be proportional and must reflect the extent to which the NAH program actually benefits.

CMS also distinguishes educational costs from ordinary patient-care costs. For example, a nursing supervisor who spends part of her time supervising patient care and part of her time instructing students would need to have her salary apportioned. The student-instruction portion may be treated as an education cost; the ordinary patient-care portion may not.

The proposed regulatory text would also clarify that NAH costs do not include patient-care costs, costs incurred by a related organization, redistributed costs from an educational institution to a provider, or costs already supported by community support. The combined effect is a narrower, better-documented view of allowable NAH pass-through cost.

Source in proposed rule: Public Inspection PDF pp. 536, 540-543, and 1233.

12. Bottom Line for Senior NAH Administrators

For senior administrators, the immediate task is to determine whether the hospital's current program policies, accreditation structure, cost-report methodology, overhead-allocation workpapers, and related-party arrangements would withstand review under the proposed standards. Programs with significant tuition revenue, broad A&G allocations, related-party training structures, or limited documentation of overhead benefit are the most likely to face reimbursement pressure or audit exposure.

Source in proposed rule: Public Inspection PDF pp. 528-546, 1147-1154, and 1231-1234.

Source Note

This briefing summarizes NAH-related provisions discussed in the FY 2027 IPPS proposed rule, Public Inspection PDF 2026-07203. Section-level source notes identify the Public Inspection PDF pages that support each section. These page references use the PDF page number shown by the PDF viewer, not Federal Register print-page citations. This document is intended for internal leadership review, planning, and comment-development purposes. It should be reviewed against the final rule and applicable CMS instructions before operational implementation.