

June 5, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

File Code CMS-0062-P
Submitted via: <http://www.regulations.gov>.

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Proposed Rule CMS-1833-P; File Code CMS-0062-P

Dear Administrator Oz:

On behalf of the National Coalition of Hospital-based Schools of Nursing and Allied Health, we appreciate the opportunity to submit comments on the FY 2027 Inpatient Prospective Payment System proposed rule. We write specifically regarding the proposed changes affecting Medicare payment, approval standards, and cost-reporting treatment for hospital-based nursing and allied health education programs.

For more than 15 years, the Coalition has represented provider-based nursing and allied health education programs that are central to our clinical workforce strategies and to the availability of trained nurses, allied health professionals, technicians, therapists, and other essential caregivers in the communities we serve. These programs are not ancillary activities. They are core clinical workforce infrastructure. At a time when hospitals are facing persistent shortages across nursing and allied health disciplines, Medicare policy should strengthen — not destabilize — provider-based education programs that directly support the health care workforce.

We are seriously concerned that several proposals in the FY 2027 IPPS proposed rule would make it more difficult, more costly, and more uncertain for hospitals to operate approved provider-based nursing and allied health education programs. While we support appropriate transparency, program integrity, and reasonable cost-reporting rules, CMS should avoid adopting policies that would reduce reimbursable NAH costs, create unnecessary compliance risk, or impose operationally burdensome cost-reporting methodologies without clear evidence of abuse or improper payment.

For the reasons described below, we urge CMS to withdraw, substantially revise, or delay implementation of the proposed NAH-related changes and to engage directly with hospital-based NAH program operators before finalizing policies that could affect program viability.

I. CMS Should Not Finalize Changes That Would Undermine Provider-Based NAH Programs During a Workforce Crisis

Hospital-based nursing and allied health education programs are an essential part of the nation's clinical workforce pipeline. These programs require sustained investment in faculty, preceptors, classroom and simulation resources, student support, accreditation compliance, clinical supervision, administrative infrastructure, and coordination across hospital departments.

The proposed rule would impose several new requirements that, taken together, could materially affect program operations and reimbursement. These include new approval-related compliance standards, revised treatment of tuition and student-fee revenue, additional limitations on indirect cost recovery, componentization of administrative and general cost centers, and new treatment of related-party costs. Each of these proposals may appear technical in isolation. In combination, however, they would significantly increase the financial and administrative burden of operating a provider-based NAH program.

CMS should evaluate these proposals against the real-world operating environment facing hospitals. Many provider-based NAH programs are already financially fragile. They are often maintained not because they are profitable, but because they are necessary to meet workforce needs, support community access to care, and train students in clinical settings where shortages are most acute. Policies that reduce Medicare's recognition of reasonable education costs may discourage hospitals from sustaining or expanding these programs.

Requested action: CMS should not finalize the NAH-related cost-reporting proposals unless it first conducts a more complete operational and financial impact analysis specific to provider-based NAH programs.

II. CMS Should Preserve Reasonable-Cost Treatment for Approved NAH Programs and Avoid Policies That Reduce Reimbursable Net Cost Artificially

CMS proposes to revise 42 C.F.R. § 413.85(d)(2) to clarify the sequence for calculating the net cost of approved NAH education activities. Under the proposal, hospitals would identify allowable direct costs, subtract student-related revenues such as tuition, fees, and textbooks purchased for resale, and only then allocate allowable indirect costs incurred by the provider.

We are concerned that this sequencing would understate the actual cost of operating provider-based NAH programs. Tuition and student fees do not necessarily offset all categories of program cost in the way CMS assumes. These revenues often support a broader educational infrastructure, may be restricted or program-specific, and may not correspond neatly to the Medicare cost-reporting categories CMS proposes to use. Offsetting tuition and fees before indirect cost allocation could reduce direct program costs to zero or below, thereby limiting recognition of legitimate overhead and support costs that the hospital must incur to operate the program.

This approach risks treating provider-based NAH programs as though they are ordinary revenue-generating educational enterprises, rather than hospital-operated workforce programs with substantial clinical, administrative, accreditation, compliance, and supervision costs. It also risks penalizing programs that charge tuition or fees to sustain access, support faculty, or maintain accreditation.

Requested action: CMS should withdraw the proposed sequencing rule or, at minimum, allow hospitals to offset tuition and student-fee revenue after allocation of allowable indirect costs, so Medicare recognizes the full reasonable cost of operating the approved education activity before applying revenue offsets.

III. The Proposed Worksheet B-1 Reconciliation Adjustment Is Too Complex and Should Not Be a Substitute for Sound Cost Recognition

CMS acknowledges that offsetting tuition and student-related revenue before overhead allocation could distort the accumulated-cost statistics used to allocate administrative and general expenses. CMS proposes a Worksheet B-1 reconciliation-column adjustment that would add back the revenue offset for overhead-allocation purposes only.

While this proposed adjustment appears designed to mitigate one distortion, it also illustrates the problem with the underlying sequencing proposal. CMS is creating an administratively complex corrective mechanism because the proposed revenue-offset methodology could distort cost-finding results. Hospitals would be required to track, offset, add back, reconcile, and document student-related revenues in multiple places on the cost report. This would increase audit risk and administrative burden without improving the accuracy of Medicare's recognition of reasonable NAH program costs.

For many NAH programs, the operational challenge will not be theoretical. Program finance teams, reimbursement staff, and NAH administrators would need to develop new workpapers linking direct NAH costs, tuition and student-fee revenue, Worksheet A-8 adjustments, and Worksheet B-1 reconciliation entries. These requirements will be especially difficult for hospitals with multiple NAH programs, shared faculty, shared simulation resources, student rotations across departments, or integrated academic partnerships.

Requested action: CMS should not finalize the proposed Worksheet B-1 reconciliation methodology as a required approach. If CMS proceeds, it should make the approach optional, provide detailed cost-reporting instructions, allow a transition period of at least two cost-reporting years, and protect hospitals from adverse audit findings where they make good-faith implementation efforts.

IV. CMS Should Not Require Overly Granular Componentization of Administrative and General Cost Centers Without Clear Standards

CMS proposes a more granular approach to allocating indirect costs to NAH programs, including requiring hospitals to analyze general service cost centers, particularly Administrative and General costs, to determine which functions benefit NAH programs and which do not. Where a broad general service cost center includes both benefiting and non-benefiting functions, hospitals would need to create subscripted or fragmented cost centers.

We strongly caution CMS against finalizing this proposal without substantial revision. Provider-based NAH programs rely on the same hospital infrastructure that supports clinical care, workforce operations, compliance, finance, human resources, information technology,

accreditation readiness, legal review, purchasing, facilities, security, student onboarding, employee health, and other administrative functions. These services are often integrated across the hospital and are not designed to be separated into discrete NAH-benefiting and non-NAH-benefiting components.

The proposed approach could require hospitals to create artificial distinctions that are difficult to support operationally and administratively. It would also invite inconsistent audit treatment across Medicare Administrative Contractors. One contractor may accept a hospital's judgment that a particular overhead function supports NAH; another may disagree. The result would be uncertainty, appeals, and inconsistent reimbursement for similarly situated hospitals.

In addition, CMS should recognize that NAH programs benefit from many hospital functions even when those functions are not exclusively or primarily educational. For example, legal, compliance, admissions, human resources, information technology, purchasing, safety, and facilities functions may all support student onboarding, clinical placement, faculty employment, affiliation agreements, accreditation compliance, and program operations. A narrow view of "benefit" would fail to capture how provider-based education programs actually operate within hospitals.

Requested action: CMS should withdraw the proposed mandatory componentization requirement for NAH-related overhead. If CMS finalizes any change, it should adopt a flexible reasonableness standard, allow hospitals to use existing cost-finding methodologies where they are consistently applied, and provide examples of acceptable allocation bases.

V. CMS Should Clarify That Indirect Costs Are Legitimate and Necessary Costs of Provider-Based NAH Programs

We appreciate CMS's recognition that indirect costs are not categorically excluded from NAH reimbursement. That principle is essential. Provider-based NAH programs cannot operate without administrative, faculty-support, compliance, facilities, information technology, and institutional infrastructure. These costs are real, necessary, and directly related to the hospital's ability to train students safely in a clinical environment.

However, the proposed rule's discussion of indirect costs may be read by auditors as an invitation to narrow allowable overhead aggressively. CMS should avoid finalizing language that suggests indirect costs are suspect merely because they are allocated or shared. Provider-based NAH programs are inherently integrated into the hospital. Their cost structure will necessarily include shared resources.

CMS should also be careful when distinguishing educational costs from patient-care costs. In a hospital-based training environment, education and patient care are closely connected. Nurses, therapists, technicians, and other clinicians may supervise students while also supporting patient care. Time studies and salary apportionment may be appropriate in some cases, but CMS should not impose unrealistic documentation expectations that assume clinical education can be separated minute-by-minute from patient-care operations.

Requested action: CMS should state clearly in the final rule that reasonable, consistently allocated indirect costs remain allowable when they support the operation of an approved provider-based NAH program. CMS should also provide practical documentation standards for mixed clinical and educational roles.

VI. CMS Should Avoid Policies That Penalize Hospitals for Related Educational and Clinical Training Arrangements

CMS's discussion of nonprovider-operated NAH clinical training programs and related-party costs raises additional concerns. Many hospitals operate or support NAH training through complex structures involving hospital-affiliated schools, parent organizations, universities, health-system entities, joint ventures, or other related arrangements. These relationships often exist for legitimate academic, operational, accreditation, workforce, and community-access reasons.

CMS proposes that providers claiming certain clinical training costs must distinguish overhead costs incurred directly by the provider from overhead incurred by a related party and remove related-party overhead through a post-stepdown adjustment. This proposal may be difficult to operationalize and may fail to recognize the integrated nature of modern health-system education arrangements.

Hospitals should not be penalized simply because a workforce training function is housed in a related entity or supported through an affiliated structure. The relevant question should be whether the cost is reasonable, necessary, properly documented, and related to an approved NAH education activity — not whether the cost flows through a particular corporate entity.

Requested action: CMS should not finalize a categorical exclusion of related-party overhead without further stakeholder input. CMS should instead allow reimbursement where the hospital can demonstrate that the cost is reasonable, necessary, not duplicative, and directly connected to approved NAH clinical training.

VII. CMS Should Reconsider the Proposed New Approval-Related Nondiscrimination Standard

CMS proposes to create a new nondiscrimination requirement at 42 C.F.R. § 413.84 and cross-reference it in the NAH payment regulation at 42 C.F.R. § 413.85. We support compliance with applicable federal nondiscrimination law. Hospitals and NAH programs already operate under extensive federal and state civil rights, employment, accreditation, and education-related requirements.

Our concern is not with nondiscrimination as a principle. Our concern is that CMS proposes to make compliance with a newly articulated standard part of maintaining Medicare-approved program status for pass-through payment purposes. That raises significant operational and payment risk. A dispute over admissions criteria, employment practices, resource allocation, accreditation standards, or program participation could potentially become a Medicare payment

approval issue, even where the hospital is otherwise operating in good faith and complying with applicable law.

CMS should not create an open-ended standard that could allow program approval or reimbursement to be challenged based on ambiguous allegations, unsettled legal interpretations, or accreditation-related disputes. Provider-based NAH programs need clear, objective, and administrable standards.

Requested action: CMS should not finalize the proposed nondiscrimination requirement as a condition of Medicare-approved NAH program status unless it narrows the standard, aligns it expressly with existing federal law, provides due-process protections, and clarifies that payment will not be denied absent a final, binding determination by the appropriate enforcement authority.

VIII. CMS Should Not Introduce Accreditation-Related Payment Uncertainty for NAH Programs

The proposed new 42 C.F.R. § 413.84 also includes accreditation-related language concerning standards requiring the performance of, training in, referral for, or arrangements for training in induced abortion. For NAH programs, this provision may create uncertainty regarding how CMS will evaluate accreditation status, program approval, clinical placement obligations, and affiliation agreements.

Hospital-based NAH programs depend on stable accreditation pathways. They should not be placed in the position of navigating conflicting interpretations among CMS, accrediting bodies, state regulators, educational partners, and clinical placement sites. Any Medicare payment rule that affects accreditation recognition must be clear, limited, and operationally workable.

Requested action: CMS should clarify that NAH programs will not lose Medicare-approved status or pass-through payment eligibility due to good-faith reliance on existing accreditation requirements, state law, or established clinical training standards. CMS should also delay implementation of any accreditation-related change until it has issued subregulatory guidance and allowed programs sufficient time to assess their accreditation and affiliation agreements.

IX. CMS Should Retain Flexibility in Recognizing NAH Accrediting Organizations

CMS proposes to remove older regulatory examples of specific NAH accrediting organizations. We understand CMS's rationale that the field has evolved and that a fixed list of legacy accrediting bodies may be outdated. However, CMS should ensure that removal of examples does not create uncertainty for hospitals, auditors, or Medicare contractors.

Many NAH programs rely on accreditation by specialized national professional organizations. If CMS removes named examples, it should provide a clear standard for determining whether an accrediting body is the recognized national professional organization for the activity. Without

such clarity, hospitals could face inconsistent contractor determinations regarding whether a program is properly approved.

Requested action: CMS should finalize this proposal only if it also provides clear guidance confirming that programs accredited by nationally recognized professional accrediting organizations remain eligible for approved NAH program status.

X. CMS Should Provide a Meaningful Transition Period and Prospective-Only Implementation

The proposed effective date of October 1, 2026, does not provide sufficient time for hospitals to evaluate, redesign, document, and operationalize the proposed NAH changes. Hospitals would need to review program policies, accreditation standards, tuition and fee accounting, cost-center structures, Worksheet A-8 and B-1 reporting, overhead allocation methodologies, related-party arrangements, affiliation agreements, and documentation systems.

These changes cannot be implemented responsibly in a compressed timeframe. In particular, cost-reporting changes require coordination among NAH program leaders, hospital finance departments, reimbursement teams, outside advisors, and Medicare Administrative Contractors. Hospitals may also need to modify accounting systems or create new cost centers and workpapers.

Requested action: If CMS finalizes any of these proposals, it should make them prospective only and delay implementation for at least two full cost-reporting periods. CMS should also prohibit retroactive audit application of any new interpretation.

XI. CMS Should Engage Directly With Provider-Based NAH Program Operators Before Finalizing These Policies

Provider-based NAH programs are operationally distinct from other educational arrangements. Their costs, staffing, accreditation requirements, clinical training obligations, and hospital integration are complex. Before finalizing major changes to NAH reimbursement and approval standards, CMS should seek direct input from hospitals that operate these programs.

CMS should also consider whether these proposals are consistent with broader federal priorities to strengthen the health care workforce, expand clinical training capacity, and support access to care in underserved communities. Reducing reimbursement predictability for NAH programs would work against those goals.

Requested action: CMS should convene a technical expert panel or stakeholder listening session with hospital-based NAH program operators, Medicare reimbursement experts, accrediting organizations, and workforce leaders before finalizing the proposed NAH provisions.

XII. Conclusion

Provider-based nursing and allied health education programs are a critical component of the nation's health care workforce infrastructure. CMS should not finalize proposals that would increase administrative burden, reduce recognition of reasonable education costs, or create new uncertainty around approved program status.

We respectfully urge CMS to:

1. Withdraw or substantially revise the proposed NAH net-cost calculation methodology;
2. Avoid mandatory componentization of A&G and other overhead cost centers;
3. Preserve recognition of reasonable, properly documented indirect costs;
4. Reconsider the treatment of related-party educational and clinical training costs;
5. Narrow and clarify any new approval-related nondiscrimination or accreditation requirements;
6. Provide clear contractor guidance and practical documentation standards; and
7. Delay implementation and apply any final changes prospectively only.

We appreciate CMS's consideration of these comments and would welcome the opportunity to discuss the operational impact of these proposals on provider-based nursing and allied health education programs. Our contact is:

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