

MEMORANDUM

TO: Hospital-Based Nursing School and Allied Health Education Coalition Members
FROM: Strategic Health Care
DATE: September 9, 2026
RE: Emerging Medicare Reimbursement Threats to Provider-Based Nursing and Allied Health Education Programs

Overview

Hospital-based nursing and allied health education programs are facing increasingly detailed Medicare contractor scrutiny over costs claimed through their host hospitals' annual Medicare cost reports. Recent reviews have focused on square footage, kitchens and common areas, allocation of hospital overhead, shared administrative services, faculty activities, and—most significantly—whether expenses such as payroll are technically incurred by the Medicare-certified host hospital or by another entity within the health system.

The concern extends beyond individual cost disallowances. A Medicare Administrative Contractor (MAC) could use findings involving payroll, employment, or related-organization costs to challenge whether the hospital itself is the operator of the nursing or allied health program. Loss of provider-operated status could jeopardize Medicare reasonable-cost reimbursement for the program as a whole. 42 C.F.R. § 413.85 establishes reasonable-cost reimbursement for approved nursing and allied health education activities. The rule, however, reflects a more traditional hospital structure than the integrated health-system model now common, in which payroll, human resources, information technology, finance, legal services and other functions are frequently centralized.

The Most Significant Threat: Who “Incurs” the Cost?

[Section 413.85](#) allows reimbursement for educational costs incurred by the provider, including trainee stipends, faculty compensation and other allowable costs determined under Medicare cost-finding principles. It expressly excludes patient-care costs, costs incurred by a related organization, redistributed educational-institution costs and certain costs supported by the community. See 42 C.F.R. § 413.85(d)(2).

To qualify as the operator of an approved program, the hospital must directly incur the training costs; directly control the curriculum; control program administration, including payroll records; employ the teaching staff; and provide and control classroom instruction and clinical training. See 42 C.F.R. § 413.85(f)(1).

This creates significant exposure for integrated systems. Faculty may work entirely for a hospital-based school while payroll is processed through a system parent or home office. Human resources, benefits administration and accounting may also be centralized. In some organizations, faculty W-2s identify the parent health system rather than the Medicare-certified hospital.

The critical distinction should be between centralized administrative processing and actual ownership and operation of the educational program. Section 413.85 expressly permits the hospital to contract with another entity to perform administrative functions so long as the hospital maintains control over those functions. A MAC therefore should not automatically conclude that a program is nonprovider-operated merely because payroll or another administrative function is performed through a health-system shared-services organization.

The risk is much greater where the parent organization is genuinely the employer, initially incurs the payroll obligation, funds the expense and later allocates the cost to the hospital. In that circumstance, the issue can move from a discrete payroll disallowance to the threshold question of whether the hospital satisfies the provider-operated requirements at all.

Indirect Costs, Shared Space and Other Emerging Audit Issues

MACs also appear to be intensifying review of hospital overhead allocated to nursing programs. The regulation does not limit reasonable-cost reimbursement to faculty salaries and classroom expenses; it incorporates Medicare cost-finding principles under § 413.24. Hospitals therefore have a strong basis to challenge categorical exclusions of human resources, finance, legal, IT, telecommunications, facilities, employee benefits and administrative costs when the program receives a demonstrable benefit from those services.

The same principle should govern square-footage disputes. Section 413.85 does not establish a general exclusive-use requirement for every portion of nursing-school space. Modern schools routinely include classrooms, simulation laboratories, faculty offices, student lounges, conference rooms, hallways, restrooms and other shared areas. The appropriate question should be whether the hospital uses a reasonable allocation methodology that reflects the resources consumed by the education program—not whether every square foot is exclusively dedicated to students and faculty.

Kitchen and food-service areas should be evaluated in the same manner. Before accepting a disallowance, hospitals should require the MAC to identify the specific general-service cost being allocated, the applicable cost-report statistic, and the regulatory or cost-report authority supporting the adjustment. This moves the dispute from a subjective judgment about what “looks educational” to Medicare's actual cost-finding methodology.

Other areas of exposure include faculty or supervisory personnel who divide time between teaching and patient care, and the regulation's prohibition against “redistribution of costs.” Hospitals should use credible time studies for mixed-duty personnel and preserve historical cost-report treatment following reorganizations, transfers of employees, changes in school ownership, or modifications in cost-accounting practices. The regulation defines redistribution to include attempts to begin claiming educational costs that previously belonged to an educational institution and were not historically claimed by the provider. See 42 C.F.R. § 413.85(c).

Why Provider-Operated Status Matters

The fallback rules for programs that CMS determines are not provider-operated are narrow. Section 413.85(g) permits reasonable-cost reimbursement for certain nonprovider-operated clinical training programs only under restrictive historical and operational conditions, including requirements tied to costs claimed before October 1, 1989. A separate special rule applies to certain programs transferred to wholly owned educational subsidiaries, but it too is narrowly conditioned. For many current hospital schools, losing provider-operated status therefore cannot be cured simply by moving into another reimbursement category.

National Coalition Strategy

The coalition should pursue a coordinated national strategy rather than allowing these issues to develop hospital by hospital and MAC by MAC:

- **1. Conduct an immediate provider-operated status review.** Each hospital should document who legally employs faculty, who issues W-2s, who funds payroll, where the liability initially appears on the books, who hires and terminates faculty, who controls curriculum and tuition, who maintains payroll records, who awards degrees, and who controls day-to-day operations. Particular attention should distinguish a parent that merely processes payroll from a parent that actually employs faculty and incurs their compensation.
- **2. Develop a standardized audit-defense package.** Hospitals should maintain floor plans and shared-space allocation methodologies; documentation of HR, IT, legal, finance and other services provided to the school; faculty time studies where duties are mixed; intercompany agreements; historical cost reports; and documentation demonstrating that the hospital retains control over contracted administrative functions.

- **3. Challenge categorical MAC interpretations and preserve appeal rights.** Contractors should be required to identify the precise regulatory, manual or cost-report authority for each adjustment. Hospitals should distinguish disputes over a particular cost or allocation methodology from the far more consequential question of provider-operated status. Significant adjustments should be preserved for Provider Reimbursement Review Board appeal.
- **4. Seek national CMS clarification.** The coalition should request guidance distinguishing centralized shared services from transfer of program operation to a related organization. A hospital should be able to use a centralized payroll or administrative platform without automatically losing reimbursement when it remains economically responsible for the program and retains the control required by § 413.85.
- **5. Continue pursuing a statutory solution through Congress.** The Rebuild America’s Health Care Schools Act, H.R. 1708 and S. 1087, is intended to address structural weaknesses in current Medicare treatment of hospital-based nursing and allied health education. Emerging MAC disputes strengthen the policy case for legislation that recognizes modern integrated health-system structures, including related-entity payroll and administrative arrangements.

Conclusion

Hospital-based nursing and allied health programs should view the current audit environment as more than a series of isolated cost-report disputes. Shared-space, overhead and indirect-cost reviews can produce meaningful reimbursement reductions. The greater threat is that MACs may use related-organization payroll and administrative arrangements to contend that the host hospital no longer directly incurs program costs or employs and controls the teaching staff.

The coalition response should therefore combine aggressive defense of reasonable and properly documented costs with a prospective review of corporate and payroll structures, a coordinated CMS strategy, preservation of appeal rights, and continued congressional efforts to modernize the statute. Medicare policy should recognize contemporary integrated health systems without allowing administrative form—such as which health-system entity processes a paycheck—to override the substantive reality that a hospital finances, controls and operates an approved nursing education program.

Principal References

- [42 C.F.R. § 413.85, Cost of approved nursing and allied health education activities](#)
- [CMS FY 2027 IPPS Final Rule, CMS-1849-F \(published August 2026\)](#)
- [Rebuild America’s Health Care Schools Act, H.R. 1708](#)
- [Rebuild America’s Health Care Schools Act, S. 1087](#)