

MEMORANDUM

Emerging Medicare Reimbursement Threats to Provider-Based Nursing and Allied Health Education Programs — Revised for August 4, 2026 CMS Final Rule

TO: Hospital-Based Nursing School and Allied Health Education Coalition Members
FROM Strategic Health Care
DATE: September 9, 2026

Overview

Hospital-based nursing and allied health education (NAHE) programs are facing increasingly detailed Medicare contractor scrutiny over costs claimed through host hospitals' annual Medicare cost reports. Reviews are focusing on square footage, kitchens and common areas, hospital overhead, shared administrative services, faculty time, and—most significantly—whether payroll and other expenses were legally and economically incurred by the Medicare-certified host hospital or by a health-system parent or other related organization.

These reviews can produce more than isolated cost disallowances. Under longstanding 42 C.F.R. § 413.85(f), a hospital claiming provider-operated status must directly incur training costs, control the curriculum and administration, employ the teaching staff, and provide and control classroom and clinical training. A MAC could therefore attempt to use payroll, employment or cost-incurrence findings not only to remove individual expenses, but also to challenge whether the hospital itself is the operator of the program.

The August 4, 2026 Amendment Changes the Cost-Reporting Landscape

The regulation currently displays a cross-reference to an amendment published at 91 Fed. Reg. 50,344 on August 4, 2026. That amendment is part of the FY 2027 IPPS/LTCH PPS final rule, CMS-1849-F/CMS-0062-F, published at 91 Fed. Reg. 49,570 and effective October 1, 2026. For NAHE, the amendment changes the net-cost formula in § 413.85(d)(2), clarifies the treatment of indirect costs, and adds a cross-reference to new § 413.84. Importantly, it does not amend the provider-operated criteria in § 413.85(f). For cost-reporting periods beginning on or after October 1, 2026, CMS requires the hospital first to determine allowable direct NAHE costs, including trainee stipends and compensation of faculty employed by the provider; subtract tuition and other student-related program revenue from those direct costs; and then allocate allowable indirect costs under Medicare cost-finding principles. The hospital may use the Worksheet B-1 reconciliation column so the tuition offset does not artificially reduce the accumulated-cost statistic used to allocate overhead.

The final rule also makes the indirect-cost standard more explicit. Allowable NAHE overhead must be incurred by the provider and must be directly attributable to and proportionately benefit the approved educational activity. CMS did not, however, finalize its proposal to require every hospital to componentize or subscript general-service cost centers solely for NAHE purposes. This creates an important defense against a MAC imposing a blanket, NAHE-specific componentization requirement that CMS itself declined to adopt.

The Most Significant Threat: Hospital Versus Related-Entity Cost Incurrence

The central vulnerability remains the distinction between costs incurred by the hospital and costs incurred by a related organization. The pre-amendment regulation already excludes from allowable educational costs amounts incurred by a related organization. The October 1 amendment preserves and sharpens that concept by specifying that indirect costs allocated to NAHE are limited to costs the provider itself incurs in connection with operating the approved educational activity.

This issue should be separated into three different factual situations. They are not equivalent for reimbursement purposes:

- **Hospital employer; system payroll processor.** The hospital is the legal employer, bears the salary obligation, records the expense on its books, funds the cost and controls faculty, while a parent or shared-services organization merely processes payroll or performs administrative functions. This presents the strongest hospital defense because § 413.85(f)(1)(iii) expressly permits administrative functions to be contracted out if the provider maintains control.
- **System parent as employer.** Faculty W-2s are issued by the parent, the parent is the legal employer and initially incurs and funds salaries, and the amounts are subsequently allocated to the hospital. This creates materially greater risk because § 413.85(f) requires the provider to directly incur training costs and employ the teaching staff, while § 413.85(d)(2) excludes related-organization costs from NAHE pass-through reimbursement.
- **System-level overhead.** HR, finance, IT, legal, benefits or other administrative expenses are incurred at a corporate home office and allocated to the hospital and then to the school. The amended rule gives MACs a stronger textual basis to challenge these amounts as NAHE pass-through costs if they were not actually incurred by the provider, even where the service unquestionably benefits the school.

Accordingly, the coalition should avoid framing every payroll dispute as a simple accounting-allocation issue. Hospitals must be able to establish who is the employer, who is legally obligated to pay, where the expense is initially recorded, who funds the obligation, and who controls the employee. A W-2 or payroll system is relevant evidence, but the regulation's administrative-outsourcing language supports a distinction between processing a payroll and actually employing and incurring the cost of the faculty.

Indirect Costs, Square Footage and Shared Space

The August amendment strengthens MAC scrutiny of overhead, but it does not create a categorical prohibition on legitimate hospital overhead or shared space. The operative question is whether the hospital itself incurred the cost and whether the service or resource proportionately benefited the NAHE program. Hospitals should therefore resist categorical positions such as 'legal costs are never allowable,' 'IT never benefits a nursing school,' or 'shared space must be excluded.' The amended rule calls for a benefit-based and proportional allocation, not a label-based exclusion.

Square-footage disputes should similarly be treated as cost-finding disputes. Section 413.85 does not impose an exclusive-use rule for every square foot associated with a nursing school. Classrooms, simulation laboratories, faculty offices, conference rooms, student areas, hallways, restrooms and other common space may all require a reasonable allocation where the educational program receives a demonstrable benefit. The hospital should document the methodology rather than assume either 100-percent inclusion or 100-percent exclusion.

Kitchen and food-service areas deserve the same disciplined approach. A MAC should identify the particular general-service cost being allocated, the statistical basis used on the cost report, and the regulatory or cost-report authority for the adjustment. The question should be whether the allocation statistic reasonably measures the resource consumed by the NAHE program—not simply whether a reviewer regards the area as 'educational.'

Other Recoupment Risks and a New Timing Defense

Personnel who divide time between teaching and patient care remain vulnerable to adjustment. Hospitals should use credible contemporaneous time studies or other records to separate educational activities from patient-care duties. The longstanding prohibition on redistribution of costs also remains important following reorganizations, transfers of employees, changes in ownership or changes in how school costs are booked.

The October 1, 2026 effective date also creates an important audit issue. For cost-reporting periods beginning before October 1, a MAC should not simply apply newly effective regulatory text retroactively. Contractors may argue that portions of the final rule merely clarify longstanding policy, but hospitals should require the MAC to identify the preexisting authority supporting any adjustment to an earlier cost year. A new regulatory requirement and an interpretation of an old requirement are not the same thing for appeal purposes.

National Coalition Strategy

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

- **1. Conduct an immediate provider-operated status review.** Document the legal employer of faculty; W-2 issuer; entity legally obligated for salary and benefits; source of payroll funding; initial general-ledger treatment; hiring and termination authority; control of curriculum, tuition, payroll records and day-to-day operations; degree-granting entity; and control of classroom and clinical training.
- **2. Separate payroll processing from employment and cost incurrence.** Review shared-services agreements and, where supported by the facts, document that the parent is acting as an administrative agent while the hospital remains the employer, economic obligor and program operator. Where the parent truly employs faculty or incurs program costs, consider prospective restructuring before future cost-reporting periods.
- **3. Build a standardized October 1 compliance and audit-defense file.** Maintain floor plans, shared-space methodologies, faculty time studies, intercompany agreements, general-ledger support, benefit analyses for HR/IT/legal/finance functions, and historical cost reports demonstrating consistent treatment of school costs.
- **4. Force MACs to identify the legal theory for every disallowance.** The hospital should require the contractor to state whether the adjustment is based on direct-cost incurrence, the related-organization exclusion, failure of provider-operated status, lack of benefit, an allocation statistic, redistribution of costs, or another specific authority. These theories have different factual and legal defenses.
- **5. Preserve retroactivity and appeal arguments.** For pre-October 1 cost years, hospitals should object where contractors rely on the new text rather than the regulation and instructions applicable to the year under audit. Material adjustments should be preserved through the NPR and Provider Reimbursement Review Board process.
- **6. Seek national CMS clarification and continue the statutory strategy.** CMS should be asked to distinguish centralized administrative processing from actual employment and cost incurrence, and to confirm that shared-service arrangements do not by themselves defeat provider-operated status. Congressional legislation remains important because the underlying regulation still does not fit many integrated health-system structures.

Principal References

- 42 C.F.R. § 413.85, Cost of approved nursing and allied health education activities (current text and amendment cross-reference).
- Medicare Program; FY 2027 IPPS/LTCH PPS Final Rule, CMS-1849-F and CMS-0062-F, 91 Fed. Reg. 49,570, 50,344 (Aug. 4, 2026), effective Oct. 1, 2026.