Medicare Reimbursement Policy for Provider-Based Nursing and Allied Health Education Programs

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TO: **HHS/CMS**
FROM: **The National Coalition of Hospital-based Schools of Nursing and Allied Health**
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Purpose

Hospital-operated nursing and allied health education programs are an important source of nurses and other health professionals for hospitals, health systems, rural communities, and underserved areas. The hospitals participating in this effort are not asking CMS to reimburse unrelated expenses, duplicate costs, or costs borne by independent educational institutions. They are asking HHS and CMS to distinguish clearly between requirements that appear in statute or regulation and additional restrictions that have developed through Medicare Administrative Contractor (MAC) audit practice, cost-report conventions, or older interpretive guidance.

The central concern is that several current interpretations can deny otherwise legitimate educational costs based on corporate structure, payroll mechanics, physical location, or allocation methodology even when the hospital operates the approved program, controls the curriculum, employs or directs the faculty, incurs the economic burden of training, and receives the workforce benefit.

The discussion below presents concrete scenarios and asks HHS/CMS to identify the statutory or regulatory basis for each result and, where the governing text is ambiguous or silent, to consider national clarification.

Governing Framework

Section 1861(v)(1)(A) of the Social Security Act defines reasonable cost as the cost actually incurred and directs the Secretary to take account of both direct and indirect provider costs. 42 C.F.R. § 413.85 implements that authority for approved nursing and allied health education (NAHE) programs.

Effective for cost-reporting periods beginning on or after October 1, 2026, CMS revised § 413.85(d)(2). The current rule expressly limits allowable direct costs to trainee stipends and compensation of faculty employed by the provider; requires student-related revenues to be offset; limits indirect costs to costs the provider itself incurs and that are directly attributable to operating the approved educational activity; and excludes patient-care costs, related-organization costs, redistributed costs, and certain community-supported costs.

At the same time, the longstanding provider-operated criteria in § 413.85(f) remain unchanged. A provider must directly incur training costs, control the curriculum and administration, employ the teaching staff, and provide and control classroom instruction and clinical training. Importantly, § 413.85(f)(1)(iii) expressly permits the provider to contract with another entity to perform some administrative functions if the provider retains control.

Scenario 1 — Centralized Health-System Payroll and Shared Administrative Services

Example

A hospital operates an accredited school of nursing. The hospital controls admissions, curriculum, faculty assignments, student evaluation, clinical rotations, and day-to-day operations. For efficiency, however, the health system uses one centralized payroll platform, benefits office, HR department, accounting function, and IT system. Faculty may receive a paycheck or W-2 processed through the system parent even though they work exclusively for the hospital school.

Policy concern

A MAC may treat the centralized payroll arrangement as evidence that the hospital did not directly incur the cost or employ the faculty, or may characterize the salary and benefit expense as a related-organization cost. That can lead not only to disallowance of particular expenses but potentially to a broader challenge to provider-operated status.

Questions for HHS/CMS

- Where does the statute or § 413.85 say that use of a system-wide payroll, benefits, HR, accounting, or IT platform—standing alone—means the hospital is no longer the operator of the school?
- How should hospitals distinguish a parent entity that merely processes payroll from a parent entity that is the actual employer and economic obligor?
- How does CMS reconcile an expansive MAC view of centralized administration with § 413.85(f)(1)(iii), which expressly permits contracted administrative functions so long as the hospital retains control?
- Would CMS consider national guidance identifying objective indicators of provider control and cost incurrence, rather than allowing the outcome to turn principally on the name appearing on a payroll system or W-2?

Requested clarification

CMS should distinguish centralized processing from substantive transfer of employment or program operation. A shared-service platform should not, by itself, determine provider-operated status when the hospital remains responsible for the program and can document the economic and operational substance of that responsibility.

Scenario 2 — Indirect Costs and Related-Organization Overhead

Example

A hospital school uses hospital or health-system HR, legal, finance, cybersecurity, telecommunications, facilities, payroll, purchasing, and compliance services. Those functions demonstrably support the school, but some are housed at a system home office or related entity.

Policy concern

The current regulation expressly excludes costs incurred by a related organization, so this issue cannot fairly be characterized as wholly extra-regulatory. The unresolved question is how CMS determines who actually 'incurs' a cost in a modern integrated system and whether costs economically borne by the hospital can be treated as home-office costs merely because the service is administratively centralized.

Questions for HHS/CMS

- What objective test should determine whether the hospital itself incurred an indirect cost versus receiving a cost incurred by a related organization?
- If the hospital is contractually liable for, funds, and is charged for a service used to operate its nursing school, when does that become a hospital-incurred cost rather than a prohibited related-organization cost?

- Can CMS provide examples of permissible shared-service arrangements that satisfy § 413.85(d)(2)(C) and § 413.85(f)?
- Can CMS confirm that indirect-cost allowability should turn on documented attribution and benefit to the approved program, rather than the label of the cost center?

Requested clarification

CMS should publish a national framework distinguishing prohibited related-organization costs from legitimate hospital-incurred costs administered through an integrated system. This would reduce inconsistent MAC treatment without weakening the prohibition on duplicate or nonprovider costs.

Scenario 3 — Shared Space, Common Areas, Kitchens, Simulation Areas, and Square Footage

Example

A hospital school occupies classrooms, faculty offices, simulation laboratories, hallways, conference rooms, student areas, restrooms, and food or common areas. Some areas are used exclusively by the school; others are shared with hospital functions or used by students only part of the time.

Policy concern

MACs may disallow shared areas entirely, challenge kitchen or common-space square footage, or require increasingly detailed support. Yet § 413.85 does not contain a general 'exclusive use' requirement for provider-operated educational space. Medicare cost finding ordinarily depends on reasonable allocation statistics reflecting resources consumed.

Questions for HHS/CMS

- Where does § 413.85 require every reimbursable square foot to be used exclusively by the nursing or allied health program?
- Why should a shared conference room, simulation area, hallway, or other common resource receive a zero allocation if the provider can document a reasonable percentage of educational use?
- For each disputed category, what cost center and allocation statistic does CMS believe governs—square footage, meals served, accumulated cost, salaries, time, or another measure?
- Can CMS establish a safe-harbor methodology for reasonable proportional allocation of shared educational space?

Requested clarification

CMS should confirm that shared resources may be allocated proportionately when the hospital maintains credible contemporaneous documentation. The 2024 Beaumont PRRB decision underscores the importance of reliable records, but it does not create a universal exclusive-use rule.

Scenario 4 — Faculty Who Divide Time Between Teaching and Patient Care

Example

A nurse educator or clinical instructor spends part of the week teaching, evaluating students, conducting simulation, and supervising formal clinical education, and another part providing or supervising ordinary patient care.

Policy concern

Patient-care costs are expressly excluded, so allocation is appropriate. The concern is whether MACs impose documentation standards not found in the regulation—for example, requiring one specific type of contemporaneous time study or rejecting another reasonable methodology.

Questions for HHS/CMS

- Where does § 413.85 prescribe one mandatory form of time study or one exclusive documentation methodology for allocating mixed educational and patient-care duties?
- Would CMS recognize periodic time studies, scheduled teaching assignments, payroll coding, faculty workload records, or other auditable methods when they reasonably establish educational time?
- Can CMS define which faculty activities count as education—for example, student evaluation, clinical conferences, simulation preparation, curriculum work, and direct supervision of students?

Requested clarification

CMS should establish nationally consistent documentation standards that protect Medicare from patient-care cost shifting while allowing providers more than one reasonable method to document genuine education activity.

Scenario 5 — Corporate Reorganization and 'Redistribution of Costs'

Example

A health system reorganizes. Faculty move between payroll entities, school assets move to or from a subsidiary, or accounting responsibility is centralized. The same hospital-based school continues to operate with substantially the same students, faculty, curriculum, and economic support.

Policy concern

Section 413.85 prohibits redistribution of costs that historically belonged to an educational institution. The concern is that a bona fide corporate reorganization may be treated as an impermissible redistribution even when there is no newly manufactured cost and no attempt to shift an independent school's expense to Medicare.

Questions for HHS/CMS

- What factual changes distinguish a prohibited 'redistribution of costs' from a legitimate corporate reorganization of an existing hospital-operated program?
- If the same health system continues to bear the same economic burden, what additional evidence should a provider maintain to demonstrate continuity?
- Can CMS create a process for advance or prospective confirmation when health systems restructure provider-based educational programs?

Requested clarification

CMS should clarify that the redistribution rule targets newly shifted nonprovider educational costs, not every change in legal entity, accounting structure, or shared-services arrangement.

Scenario 6 — Clinical Training at a Rural Clinic or Other Off-Campus Site

Example

A hospital operates its own nursing school and wants students to rotate through a rural clinic ten miles from the hospital. The hospital controls the curriculum and rotation, provides the faculty, and incurs the training expense. The rotation is intended to prepare graduates to work in the rural communities the health system serves.

Policy concern

Students may receive the training, but hospitals have been told that the off-campus portion is not reportable as a NAHE pass-through cost. Yet the explicit 250-yard location requirement in § 413.85(g)(2)(i) applies to certain nonprovider-operated programs. Section 413.85(f), which governs provider-operated programs, contains no comparable 250-yard limitation.

Questions for HHS/CMS

- Where does § 413.85(f) impose a 250-yard, hospital-campus, or 'four walls' limitation on clinical training furnished as part of a provider-operated program?
- If the rural clinic is an off-campus department of the same Medicare-certified hospital, what regulatory provision converts an otherwise allowable training cost into a nonallowable cost solely because the student travels ten miles?
- How should CMS apply the definition of 'clinical training,' which describes training in the actual environment in which the student will use those skills upon graduation, to rural and community rotations?
- Would CMS permit reimbursement where the hospital continues to control the program and incurs the faculty and training costs even though the clinical experience occurs off campus?

Requested clarification

CMS should confirm that the 250-yard rule in § 413.85(g)(2)(i) is not automatically imported into § 413.85(f). For provider-operated programs, CMS should consider allowing hospital-incurred clinical training costs at rural, outpatient, and community sites when the hospital maintains program control and adequate documentation.

Scenario 7 — The 250-Yard Rule and the Distinction Between Provider-Operated and Nonprovider-Operated Programs

Example

A MAC cites the 250-yard rule as a general reason that off-campus nursing education costs are unallowable, without first determining whether the school is provider-operated under § 413.85(f) or nonprovider-operated under § 413.85(g).

Policy concern

The regulation places the 250-yard requirement specifically within the criteria for certain nonprovider-operated programs. Applying it as a universal geographic condition may collapse two distinct regulatory categories.

Questions for HHS/CMS

- Does CMS agree that § 413.85(g)(2)(i) is textually limited to the nonprovider-operated programs described in § 413.85(g)?
- If CMS believes the same geographic limitation applies to provider-operated programs, what statutory or regulatory text supplies that requirement?
- Would CMS issue national instructions to MACs distinguishing the location rules applicable under § 413.85(f) from those applicable under § 413.85(g)?

Requested clarification

A national clarification could eliminate significant inconsistency without changing the statute: first determine the program category, then apply the requirements written for that category.

Scenario 8 — Applying the October 1, 2026 Rule to Earlier Cost-Reporting Periods

Example

A MAC audits a 2023, 2024, or 2025 cost report and applies the wording and concepts adopted in the FY 2027 IPPS final rule—such as the newly stated sequence for direct costs, revenue offsets, and indirect costs—as though those exact requirements were already contained in the regulation.

Policy concern

CMS expressly revised § 413.85(d)(2) for cost-reporting periods beginning on or after October 1, 2026. Applying a newly promulgated substantive formulation to earlier years raises fairness and administrative-law concerns, particularly if the earlier regulation did not clearly impose the same requirement.

Questions for HHS/CMS

- Which portions of the 2026 rule does CMS regard as genuinely new requirements, and which does CMS regard as mere clarification of preexisting law?
- For pre-October 1, 2026 cost years, what authority permits a MAC to apply a requirement that appears only in the amended regulatory text?
- Can CMS instruct MACs not to use the 2026 amendment as an independent basis for retroactive disallowances?
- Where a MAC relies on subregulatory guidance to establish a payment condition for an earlier year, how does CMS ensure compliance with the Medicare Act's notice-and-comment requirements recognized in Azar v. Allina Health Services?

Requested clarification

CMS should expressly identify the prospective effective date of the amended requirements and distinguish prior-year interpretations from the post-October 1, 2026 regulatory standard.

Scenario 9 — Cost Disallowance Versus Loss of Provider-Operated Status

Example

A MAC identifies a discrete issue—such as a payroll-processing arrangement, a portion of shared space, or an indirect-cost allocation—and then uses that issue to question whether the hospital operates the entire school.

Policy concern

A disputed cost and program-operator status are not necessarily the same question. A hospital could misallocate one category of overhead and still satisfy the separate § 413.85(f) criteria for operating the program.

Questions for HHS/CMS

- When does an individual cost disallowance justify a conclusion that the hospital fails the entire provider-operated test?
- Must a MAC separately analyze each of the § 413.85(f) operator criteria before denying provider-operated status?
- Can CMS require MACs to identify explicitly whether an adjustment concerns cost allowability, allocation methodology, documentation, or operator status?

Requested clarification

CMS should require these issues to be analyzed separately. Program-wide loss of provider-operated status should require evidence that the hospital fails the operator criteria, not merely that one claimed cost is unallowable.

Recommended HHS/CMS Actions

- Issue national guidance distinguishing provider-operated status from individual cost-allowability and allocation disputes.
- Clarify when centralized health-system services constitute mere administrative processing versus prohibited related-organization cost incurrence.

- Confirm that the 250-yard rule in § 413.85(g)(2)(i) is specific to the nonprovider-operated category unless CMS identifies separate authority applying it to § 413.85(f).
- Create reasonable documentation safe harbors for shared space, mixed faculty duties, and indirect-cost allocation.
- Clarify the prospective application of the October 1, 2026 amendments and instruct MACs regarding pre-2026 cost years.
- Consider a targeted regulatory update allowing provider-operated schools to receive reasonable-cost reimbursement for hospital-incurred clinical training at rural, outpatient, and community sites when the hospital retains control of the program.
- Convene a technical session with hospital-based nursing and allied health programs, MAC representatives, and CMS cost-report policy staff to identify areas of inconsistent interpretation before additional recoupments occur.

Conclusion

The hospitals raising these issues support program integrity and appropriate Medicare cost allocation. The concern is not whether CMS may exclude patient-care costs, duplicate costs, or costs actually incurred by an independent educational institution; the statute and regulation provide authority to do so. The concern is whether additional operational, geographic, documentation, or corporate-structure tests are being imposed without a clear statutory or regulatory basis—or whether a rule written for one category of program is being applied to another.

For each scenario above, the requested approach is straightforward: identify the governing statutory or regulatory text; distinguish explicit requirements from interpretive practice; and, where the text does not clearly address modern integrated health-system structures or off-campus workforce training, establish a nationally consistent policy through transparent CMS guidance or rulemaking.

Key Authorities

- Social Security Act § 1861(v)(1)(A), 42 U.S.C. § 1395x(v)(1)(A) (reasonable cost; direct and indirect costs).
- 42 C.F.R. § 413.85 (Cost of approved nursing and allied health education activities), current effective text.
- FY 2027 IPPS/LTCH PPS Final Rule, 91 Fed. Reg. 49,570 (Aug. 4, 2026), including amendments to 42 C.F.R. § 413.85 effective for cost-reporting periods beginning on or after Oct. 1, 2026; technical correction published Sept. 29, 2026.
- Medicare Program; Payment for Nursing and Allied Health Education, 66 Fed. Reg. 3,358 (Jan. 12, 2001).
- William Beaumont Hospital–Royal Oak v. WPS Government Health Administrators, PRRB Dec. No. 2024-D07.
- Azar v. Allina Health Services, 587 U.S. 566 (2019).