

Comments of the Commission on Accreditation of Allied Health Education Programs (CAAHEP) on updated guidance regarding requirements and responsibilities for Third-Party Servicers and Institutions (GEN-23-03 Requirements and Responsibilities for Third-Party Servicers and Institutions (Updated Feb. 28, 2023)).

About CAAHEP

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) is a programmatic accrediting organization recognized by the Council on Higher Education Accreditation (CHEA). CAAHEP accredits more than 2200 programs in thirty-one allied health professions, including surgical technology, emergency medical services, and medical assisting. At present, 45,000 students are enrolled in CAAHEP-accredited programs. We write to express our serious concern about guidance issued by the Department of Education in GEN-23-03 Requirements and Responsibilities for Third-Party Servicers and Institutions (Updated Feb. 28, 2023). Under this guidance, the Department has enumerated activities, functions, services, or roles that are subject to third-party servicer (TPS) requirements if performed on behalf of an eligible Title IV institution through a written contract.

Clinical Experiential Learning Sites Should Not Be Considered Third-Party Servicers under the Department's Regulations

Experiential education is a critical component of allied health education programs at Title IV-eligible institutions to equip students with the workforce skills and qualifications needed to be successful practitioners. It is typically arranged through affiliation agreements with accredited healthcare facilities, such as hospitals, community-based medical centers (including health centers that are federally qualified under the Affordable Care Act), and outpatient treatment and diagnostic facilities. With few exceptions, clinical experiential learning is present in every allied health discipline and close to 100% of CAAHEP-accredited programs. Although the required amount of clinical experiential learning varies among disciplines, it can comprise up to 50% of a student's program. The Department's guidance seems to indicate that to the extent such a facility delivers instruction, assesses student learning, or develops curricula or course materials, it would be considered a TPS and, therefore, subject to the Department's TPS requirements.

CAAHEP's concern is that if the TPS requirements apply to clinical experiential learning facilities, the resulting regulatory burden, and risk of liability would cause many such facilities to stop serving as experiential learning sites for students. This will have a devastating effect on the capacity of health education programs to enroll new students and ultimately exacerbate already critical shortages in the number of qualified front-line healthcare workers needed to care for the nation's citizens. This may be unintended, but it is the probable consequence of the policy position articulated in the Department's guidance, and leaves us asking what is to be gained by upending what has been a highly successful model for educating the nation's healthcare workforce for more than a century.

CAAHEP is gratified by the Department's decision to extend the public comment period and the effective date of this guidance. We expect that many of the allied health disciplines will contribute comments individually, and we have encouraged CAAHEP Committees to share their views on the impact of the Department's guidance on their programs and students. The Department should be aware that accreditation standards, CAAHEP's among them, already require programs to demonstrate direct oversight of curriculum, instruction, assessment, and resources in classroom, lab, and clinical settings to

assure they are of adequate quality to achieve program goals and expected educational outcomes. This longstanding practice of accreditors seems to fulfill the stated purpose of the Department's guidance and may very well obviate the need to extend the TPS requirements to experiential learning facilities.

For the foregoing reasons, CAAHEP urges the Department to reconsider the applicability of the TPS regulations to clinical experiential learning sites. We are eager to serve as a resource to the Department as it gives further consideration to this guidance and implications for healthcare education.

Please feel free to contact [CAAHEP](#) at your convenience.

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Addendum: Concerns from CAAHEP Allied Health Committees on Accreditation

Medical Assisting

With the Department's proposed language in defining a TPS, a concern is that healthcare educational learning sites would start their own training programs, minimizing the formal academic education, as a means of bypassing the regulatory restrictions of partnering with Title IV educational institutions. While obviously more of a concern for unlicensed professions, this phenomenon would be reinforced by the proposed regulation and would create a less-qualified workforce and affect patient care. Basically, in-house training could become the norm, and there would be deleterious effects on the development of the healthcare workforce.

In addition, designating hospitals and clinical sites as third-party services is an inaccurate classification of the relationship. The experiential education students received at clinical rotations, practicums, and field internships requires a partnership between the site and the academic program. The academic program oversees the students' experience through a Memorandum of Understanding, staff/faculty oversight, and program policy. The clinical partner participates in the educational program through representation on the advisory committee and communication with the program. This partnership is vital to the program's relevance in ensuring that the students receive the academic education to prepare them for the profession. Reducing that relationship to a mere provider agreement diminishes the vitality of the academic program and affects the development of the profession.

Emergency Medical Services

The cornerstone of medical education is active exposure and practice in the clinical setting. The clinical experiential learning for Emergency Medical Services (EMS) includes the capstone field internship as well as field experience that can only be accomplished onboard Advanced Life Support (ALS) or Mobile Intensive Care (MICU) ambulances staffed by highly qualified Paramedics who serve as preceptors charged with oversight of students enrolled in Paramedic educational programs. The qualified preceptors and clinical experiential education sites help students meet exit-level requirements to demonstrate they can care for critically ill and injured patients. Completing that capstone requirement helps qualify the graduate to take a national board examination that allows reciprocity throughout the county.

EMS agencies and clinical experiential learning sites (hospitals) are already stretched and overburdened. The COVID-19 pandemic exacerbated the stress all of these critical medical education sites experienced, and many of their personnel have or are on the verge of leaving their respective professions. During that period, CAAHEP, its Committees on Accreditation, and allied health educators worked together to keep the "educational pipeline" open. All of medicine and healthcare were at war with a pathogen that was killing millions. To further push more educational oversight on these key medical education facilities, creating the extra burden of audit requirements and oversight may be too much for many to continue.