

incurred in connection with providing CPE that is undertaken to meet the requirements of an academic degree. In addition, since generally a minimum of approximately 1,600 hours of CPE is required to become a board-certified chaplain, any costs incurred for an individual participating in CPE training that exceeds the minimum number of hours required to obtain board certification would not be eligible to be paid on a reasonable cost basis.

However, we note that we do not completely defer to the information provided by industry representatives in order to determine the "industry norm." Rather, if at any time we obtain information that calls our view of industry norms into question, we may make our own determination based on a random sample of hospitals. Therefore, assuming all other requirements under § 413.85 are met, a hospital may receive reasonable cost pass-through payment for the hours of CPE for which academic credit is *not* granted (since *those* CPE hours are not generally provider-operated), and for the hours of CPE that may be used to satisfy training requirements for board certification. We will continue to allow reasonable cost payment for CPE that leads to board certification as long as we do *not* have evidence indicating that, based on a statistically valid, random sample, the "industry norm" is *not* to require board certification for chaplains that are employed by hospitals.

We also recognize that industry norms are susceptible to change over time. Therefore, although it may not currently be the "industry norm" to require completion of a particular nursing or allied health education program in order to practice and begin employment in a particular specialty, it may become the "industry norm" in the future. If we find that it has become the "industry norm," we may allow the hospitals operating those programs (and meeting the requirements at § 413.85) to be paid for the costs of those programs on a reasonable cost basis.

In relation to the commenters' recommendation that reasonable cost reimbursement should be provided for CPE supervisory training, we understand that, essentially, the purpose of the supervisory training is to prepare a chaplain to develop CPE programs and to teach interns and residents. We believe that CPE supervisors are practicing in the teaching profession, not within a nursing or allied health discipline. Furthermore, we do not believe that Congress intended to provide for reasonable cost pass-through payments for programs that are intended to

produce instructors or teachers. While we recognize that CPE supervisors are necessary to train and prepare individuals for hospital chaplaincy, we believe that it is appropriate for the costs of supervisory programs in general to be treated as normal operating costs and paid accordingly.

Comment: One commenter stated that our proposed definition of provider-operated programs intended to exclude programs "that do not lead to certification required to practice or begin employment in a nursing or allied health specialty * * *" is not appropriate in light of the growing number of skills that require intensive clinical experiences. Another commenter stated that this proposal will seriously hinder reversal of the nursing shortage across the nation and, as a result, will have an adverse impact on the quality and safety of care provided in hospitals. The commenters used the example of nurse residencies, which a number of hospitals across the country are hosting for registered nurses. The commenters explained that these residencies, which are postgraduate and typically last 1 year, are designed to equip the newly licensed nurse with the skills to care for patients who require the most complex and sophisticated diagnostic and therapeutic services, and to prepare the nurses for leadership roles earlier in their careers and give them the tools to improve the quality of care and reduce medical errors. The commenters claimed that the Federal Government has thus far provided minimal funding to help ameliorate the nursing shortage and, therefore, the proposed rule is particularly distressing. They urged CMS to include criteria in the final rule for pass-through payment of nurse residencies.

Response: First, we do not believe that nurse residencies, which are intended to help integrate newly licensed nurses into complex acute care environments by enhancing their competencies and skills, are programs that qualify these nurses to be employed in a new specialty. Accordingly, it is more appropriate to treat such activities as normal operating costs. As we stated above, Medicare reasonable cost pass-through payment will only be provided for programs that, according to industry norms, qualify an individual to be employed in a specialty in which the individual could not have been employed prior to completing a particular education program. Second, we note that nurse residencies do not qualify for reasonable cost payment because they also do not meet the requirement for accreditation by a national approving body under

§ 413.85(d)(1)(i)(A). Therefore, while we are sympathetic to the commenters' concerns, we do not believe that it is appropriate at the present time to allow for pass-through payment to be made under the Medicare program for nurse residencies.

Comment: Some commenters stated that CMS was "entirely correct" in identifying CPE as continuing education and concurred with our proposal to discontinue pass-through payments for CPE. One commenter contended that ACPE-accredited training is not primarily used to prepare students to be health care chaplains. Rather, CPE is primarily ministry training, and there are various ways that one can choose to use CPE. One commenter added that very few individuals who train in CPE, including those individuals in 1-year residencies, become employed as health care chaplains. The commenter further stated that CPE is "properly a funding responsibility of the church rather than the government". The commenters argued that Medicare should not be supporting continuing education for religious care providers whose primary base and certifying group is their denomination or faith group.

Another commenter presented a similar argument concerning pharmacy residencies and questioned why Medicare (that is, taxpayers) should subsidize these residency programs. The commenter claimed that hospitals "use government monies in order to hire these 'residents,' utilize them in 'clinical' positions under the guise of postgraduate training, thereby bypassing having to use FTEs in the hospital pharmacy budget." The commentator believed that if hospitals and pharmacists were truly concerned with improving patient care, hospital pharmacy departments would train their own staff pharmacists to perform the clinical aspects themselves, rather than having taxpayers provide the funding.

Response: We are sympathetic to the commenters' concerns. However, we understand that many CPE programs do occur in hospitals, and that, while there may be various kinds of CPE training, generally, completion of approximately 1,600 hours of CPE training is required for board certification and employment by a hospital. Therefore, we believe that CPE residencies that lead to board certification generally would not be considered continuing education.

In response to the commenters' concerns about the taxpayers, through the Medicare program, providing support for CPE and pharmacy residencies, we note Medicare payment for these and other similar programs are made in accordance with the Medicare