National Alliance for Care at Home

March 2, 2026

VIA ELECTRONIC SUBMISSION

The Honorable Linda McMahon
Secretary of Education
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202

RE: Docket ID ED–2025–OPE–0944, Reimagining and Improving Student Education

Dear Secretary McMahon:

The National Alliance for Care at Home (the Alliance) appreciates the opportunity to comment on the Department of Education's (DOE's) Notice of Proposed Rulemaking, 'Reimagining and Improving Student Education' (RISE).[1]

The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. The Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

The Alliance appreciates the DOE's goal of promoting fiscally responsible federal spending and its efforts to ensure that higher education delivers on its promise to the American people. At the same time, we are concerned that the proposed rule's narrow definition of professional degree, and the resulting exclusion of nursing, physical therapy, physician assistant, occupational therapy, and social work advanced degree programs, would have unintended consequences for the healthcare workforce and for the millions of Americans who depend on care delivered in the home.

[1] 91 Fed. Reg. 4254

We respectfully urge the DOE to adopt a broader definition of professional degree that reflects the full scope of the definition referenced in statute, including post-baccalaureate healthcare degree programs in nursing, physical therapy, occupational therapy, social work, and physician assistant studies.

BACKGROUND

Home-based care is an essential part of our healthcare continuum, serving millions of patients at every stage of life in the setting. Each year, millions of Americans, including both children and older adults, individuals with disabilities, those with chronic and serious illnesses, and people at the end of life, receive care in their own homes – the place they prefer the most.[2] The Alliance's members deliver care across the full continuum of services, including home health, hospice, palliative care, home care, pediatric care, and home and community-based services (HCBS).

Care in the home requires healthcare professionals to exercise a heightened degree of autonomy, independent judgment, and specialized skillsets that are cultivated through both advanced education and training. In a hospital, a nurse or therapist often works alongside a team of colleagues with immediate access to physicians, specialists, and emergency resources. In the home, these professionals are often the sole clinician present, making real-time clinical judgments, managing complex medication regimens, responding to emergencies, and coordinating care across multiple settings. These are precisely the skills that advanced healthcare education programs are designed to develop, and restricting access to federal student loans for these degree programs could restrict the pipeline of professionals delivering safe, effective care in the home.

Home Health

The Medicare Home Health Benefit provides coverage for specific healthcare services provided in a patient's home. It is intended for individuals who are homebound and require intermittent skilled nursing care, physical therapy, speech-language pathology, occupational therapy, home health aide services, or medical social work services.[3] To qualify, a beneficiary must be enrolled in Medicare Parts A or B, be under a physician's or allowed practitioner's care, receive services under a plan of care that a physician or allowed practitioner established and periodically reviews, and be confined to the home, meaning the beneficiary requires the aid of supportive devices or another person to leave the home, or has a condition such that leaving the home is medically contraindicated.[4]

---

[2] Geng F, McGarry BE, Rosenthal MB, Zubizarreta JR, Resch SC, Grabowski DC. Preferences for Postacute Care at Home vs Facilities. *JAMA Health Forum*. 2024;5(4):e240678

[3] CMS, Medicare Benefit Policy Manual, Ch. 7; *see also* 42 C.F.R. § 409.40 *et seq.*

[4] *Id.*; *see also* 42 C.F.R. § 409.42

Hospice

The Medicare Hospice Benefit was implemented in 1983 to provide terminally ill Medicare beneficiaries and their families with holistic, comprehensive, and high-quality care at the end of life.[5] Hospice marks a shift from curative care to palliative care and support services aimed at alleviating symptom burden and maximizing quality of life for individuals with a terminal condition. An interdisciplinary team (IDT) collaborates with the patient and their family to understand their unique needs and preferences and to create a plan of care that respects the individual's wishes. Like home health, hospice care requires clinicians to exercise significant independent judgment in the patient's home.

Palliative Care

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.[6] This involves addressing physical, intellectual, emotional, social, and spiritual needs to facilitate patient autonomy, access to information, and choice. Most palliative services are provided by a physician, nurse practitioner, or nurse with consultative support from social work and chaplaincy services. There is no established Medicare benefit category for palliative care; however, individual services may be covered by Medicare and other payers when medically reasonable and necessary. This means there is wide variation in how palliative care services are organized and delivered, which makes the clinical judgment and advanced training of the professionals who provide these services all the more important.

Home and Community-Based Services

HCBS include a wide range of supports and services delivered to older adults and individuals with disabilities, allowing them to live in their homes and communities instead of a long-term care facility.[7] HCBS can include personal care, help with daily activities, support for community integration, private duty nursing, home health aide services, remote monitoring, supported employment, and certain technology.[8] Most HCBS programs require individuals to demonstrate clinical or functional limitations that would otherwise qualify them for services in an institutional setting. While much of the public discourse around HCBS focuses on direct care workers, the delivery of HCBS also leverages skilled clinical workers, including registered nurses, social workers, and therapists, among others, who perform assessments, develop care plans, provide oversight, and manage complex patient needs.

DISCUSSION

[5] Pub. L. 97-248
[6] *See* 42 C.F.R. § 418.3
[7] *See* 42 U.S.C. § 1396n(c)
[8] https://wms-mmdl.cms.gov/WMS/help/TaxonomyCategoryDefinitions.pdf

Under the One Big Beautiful Bill Act (OBBBA),[9] beginning July 1, 2026, annual and aggregate federal student loan limits for new students will apply differently depending on whether a student is classified as a graduate student or a professional student. Graduate students would be limited to $20,500 per year with a $100,000 aggregate cap, while professional students would be eligible for up to $50,000 per year with a $200,000 aggregate cap.

The OBBBA defined 'professional student' by reference to the existing regulatory definition of 'professional degree', codified at 34 CFR § 668.2, which establishes a three-part operative test:

(1) A degree that signifies both completion of the academic requirements for beginning practice in a given profession,
(2) a level of professional skill beyond that normally required for a bachelor's degree, and
(3) Professional licensure is generally required.[10]

In the NPRM, the DOE applies that definition to recognize the following only as professional degree programs: Pharmacy (Pharm.D.), Dentistry (D.D.S. or D.M.D.), Veterinary Medicine (D.V.M.), Chiropractic (D.C. or D.C.M.), Law (L.L.B. or J.D.), Medicine (M.D.), Optometry (O.D.), Osteopathic Medicine (D.O.), Podiatry (D.P.M., D.P., or Pod.D.), Theology (M.Div. or M.H.L.), and Clinical Psychology (Psy.D. or Ph.D.).[11] The Alliance supports the DOE's inclusion of these professions in the professional degree definition, including the addition of clinical psychology, but we have concerns about the exclusion of many other essential professions.

Specifically, the DOE proposes not to classify Master of Science in Nursing (MSN), Doctor of Nursing Practice (DNP), Doctor of Physical Therapy (DPT), Master of Science in Occupational Therapy (MSOT), Doctor of Occupational Therapy (ODT), Master of Social Work (MSW), Doctor of Social Work (DSW), and Master of Science in Physician Assistant Studies (MSPAS) (collectively, Excluded Professions) as professional degrees for the purpose of federal student loan funding. The Alliance believes these professions meet the operative statutory criteria because they require rigorous post-baccalaureate education, require professional skill beyond that normally required for a bachelor's degree, and implicate licensed clinical practice.

A. The Statute Supports a Broader Professional Degree Definition

We respectfully submit that the statute supports a broader reading that encompasses essential healthcare professional degrees that are proposed to be excluded, a belief that is

[9] Pub. L. 119-21
[10] *See* 34 C.F.R. § 668.2(b)
[11] 91 Fed. Reg. 4254, 4261

shared by more than 140 bipartisan members of Congress urging the DOE to reassess its narrow professional degree definition.[12]

1. The Illustrative List of Professions Is Non-Exhaustive

The OBBBA defines 'professional student' as "a student enrolled in a program of study that awards a professional degree, as defined under section 668.2 of title 34, Code of Federal Regulations (*as in effect on the date of enactment of this paragraph*), upon completion of the program."[13] The phrase *as in effect on the date of enactment* is a static incorporation by reference, which freezes the regulatory text of 34 C.F.R. § 668.2 as it existed on July 4, 2025, and adopts that text as the operative statutory definition.

34 C.F.R. § 668.2 provides in relevant part:

> *Professional degree:* A degree that signifies both completion of the academic requirements for beginning practice in a given profession and a level of professional skill beyond that normally required for a bachelor's degree. Professional licensure is also generally required. Examples of a professional degree include but are not limited to Pharmacy (Pharm.D.), Dentistry (D.D.S. or D.M.D.), Veterinary Medicine (D.V.M.), Chiropractic (D.C. or D.C.M.), Law (L.L.B. or J.D.), Medicine (M.D.), Optometry (O.D.), Osteopathic Medicine (D.O.), Podiatry (D.P.M., D.P., or Pod.D.), and Theology (M.Div., or M.H.L.).

First, by incorporating the regulation 'as in effect on the date of enactment,' Congress froze the entire regulatory definition, including its operative three-part test, as well as the statement that the list of degrees "include[s] but [is] not limited to" the enumerated programs.[14] In other words, Congress did not narrowly adopt only the illustrative list; it adopted the full text, including the open-ended language with the three-part test. Indeed, when Congress borrows established regulatory language, it incorporates the settled meaning of that language.[15] If Congress had intended to limit professional degrees exclusively to the programs enumerated in the illustrative list, it could have done so directly by enacting the list itself. By adopting the three-part test at 34 C.F.R. § 668.2, Congress instructed the DOE to apply this text explicitly to other degree programs vis-à-vis the open-ended language – a test that the Excluded Professions would satisfy.

Second, as the regulatory text makes clear, these programs are merely *examples* of programs that qualify as a professional degree. Indeed, the DOE recognizes this by proposing to add Clinical Psychology (Psy.D. or Ph.D.) to the list of recognized professional degrees—a degree that was not on the original illustrative list.

---

[12] https://www.collins.senate.gov/newsroom/senator-collins-joins-call-for-correcting-exclusion-of-graduate-nursing-degrees-in-professional-degree-definition

[13] One Big Beautiful Bill Act, Pub. L. No. 119-21, § 81001, 139 Stat. 335 (2025) (emphasis added).

[14] *Id. See also* 34 C.F.R. § 668.2

[15] *See Bragdon v. Abbott*, 524 U.S. 624, 645 (1998) ("When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well.")

Third, prior to the OBBBA, the definition of 'professional degree' in 34 CFR § 668.2 served a narrow administrative purpose with no significant consequences. As the DOE itself acknowledges, "the rule existed in a paradigm where there were no significant legal consequences for a degree being counted, or not, as a professional degree."[16] The fact that the regulation was never expanded to include the above excluded degrees does not reflect a judgment that these degrees do not meet the operative test. Rather, it reflects the reality that no such judgment was ever required.

2. The Statutory Definition Does Not Require Unsupervised Practice

In the NPRM, the DOE indicates its belief "that the statute permits the classification of degrees as 'professional' when the degree leads to employment where the employee must be supervised by another professional who has, as required by their license and degree, more education, training, and qualifications than the person being supervised."[17] In addition, the DOE also proposes adding criteria beyond the three-part test at 34 C.F.R. § 668.2 to require "at least six academic years of postsecondary education coursework for completion."[18] It is important to note that these requirements are not included in the OBBBA, nor codified at 34 CFR § 668.2 at the time of the OBBBA's enactment. As the Supreme Court has instructed, statutes are to be interpreted "based on the traditional tools of statutory construction, not individual policy preferences."[19]

Here, the DOE reasons that none of the degrees in the illustrative list require supervision from another profession in their practice.[20] In the case of nursing, the DOE posits that because a substantial portion of states require some form of physician collaboration or supervision for nurse practitioners, nursing does not represent a distinct profession within the meaning of the professional student.

First, while there is variation in state laws governing scope of practice, Congress addressed this variability through its adoption of the regulatory definition at 34 C.F.R. § 668.2. Here, the language "[p]rofessional licensure is also *generally* required" already accommodates state variation rather than treating it as disqualifying.[21] Moreover, 27 states and two territories already grant full practice authority to nurse practitioners, and that number continues to grow.[22] This is a trend the current Administration is actively encouraging through the Rural Health Transformation Program (RHTP).[23] Indeed, the OBBBA itself authorized the $50 billion RHTP, which aims to attract and retain skilled

[16] 91 Fed. Reg. 4254, 4263
[17] 91 Fed. Reg. at 4265
[18] 91 Fed. Reg. at 4260
[19] *See Loper Bright Enters. v. Raimondo*, 144 S.Ct. 2244, 2268 (2024).
[20] 91 Fed. Reg. at 4265
[21] 34 C.F.R. § 668.2 (emphasis added).
[22] https://www.aanp.org/advocacy/state/state-practice-environment
[23] https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

healthcare professionals in rural communities. The Centers for Medicare & Medicaid Services' scoring methodology for RHTP incentivizes states that have enacted full practice authority for nurse practitioners and other healthcare professions, recognizing the essential role these professionals play in expanding access to care in rural areas. [24]

Second, the degree of supervisory requirements varies among professions already on the illustrative list. Medical residents practice under physician supervision for years after obtaining their M.D. or D.O. Newly licensed attorneys in several jurisdictions practice under supervision before handling certain matters independently. The existence of structured transitions to independent practice does not negate a degree's professional character. The operative test asks whether the degree signifies completion of the academic requirements for beginning practice, not whether practice is unsupervised from day one.

Moreover, the DOE's rationale for excluding the nursing profession is not just a supervision issue, but that nurse practitioners "are already licensed nurses when they begin the degree program."[25] Here, the DOE treats the nurse practitioner role as merely an extension of the same nursing profession, not a distinct one, a characterization that may not fully reflect the distinct scope of practice, education, and licensure requirements these advanced degrees entail. The same can also be said for other professionals, such as physical therapy, occupational therapy, and social work.

Further, the DOE's decision to exclude these degree programs from the definition of professional degree is difficult to reconcile with the role these professions occupy under federal law. Illustratively, the Medicare Conditions of Participation (CoPs) for home health agencies (42 C.F.R. Part 484) and hospice (42 C.F.R. Part 418) establish that these professionals are not ancillary to clinical practice; rather, they are integral in the delivery, coordination, and management of patient care. Under the Medicare home health benefit, allowed practitioners, including physicians, nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives, are authorized to certify a patient's eligibility for home health services.[26,27]

The Medicare hospice CoPs are also instructive. Under 42 C.F.R. § 418.56(a)(1), every Medicare-certified hospice must designate an IDT that includes, at a minimum, a physician, a registered nurse, a social worker (or marriage and family therapist or mental health counselor), and a pastoral or other counselor. The hospice medical director and hospice physicians, "*in conjunction with the patient's attending physician*, are responsible for the palliation and management of the terminal illness and conditions related to the

[24] Centers for Medicare & Medicaid Services, U.S. Dep't of Health & Human Services, Rural Health Transformation Program: Notice of Funding Opportunity, CMS-RHT-26-001 (2025)
[25] 91 Fed. Reg. at 4265
[26] 42 C.F.R. § 424.22(a)(1)
[27] 42 C.F.R. § 424.22(a)(1)(v)(A)

terminal illness."[28] A nurse practitioner and physician assistant can serve as the patient's hospice 'attending physician' in consideration of their "most significant role in the determination and delivery of the individual's medical care."[29] The hospice personnel qualification requirements at 42 C.F.R. § 418.114 reinforce this point. All professionals furnishing hospice services must be legally authorized, licensed, certified, or registered, in accordance with applicable federal, state, and local laws, and must act within their scope of practice. For social workers specifically, 42 C.F.R. § 418.114(b)(3) establishes qualification requirements that expressly recognize the MSW as the higher-level credential. Conversely, individuals with a baccalaureate degree in a related field may only practice as a hospice social worker if they are supervised by an MSW. Under federal regulations, it has thus been determined that the MSW represents a qualitatively distinct level of professional competence, with MSW-credentialed social workers serving as supervisors of baccalaureate-level staff.

In other words, these professionals are operating at a level of professional skill beyond that normally required for a bachelor's degree. These post-baccalaureate degrees are not discretionary credentials; rather, they are often a mandatory gateway to licensure, clinical practice, and participation in federal healthcare programs.

B. Our Healthcare Workforce Depends on a Robust Student Pipeline

The DOE indicated its belief that Congress did not instruct it to consider workforce needs in determining which programs qualify for the higher loan limits.[30] While we understand this position, we respectfully submit that the potential impact on the healthcare workforce and patient access to care is relevant context for the DOE's consideration as it finalizes this rule. Advanced degree programs have long served as a critical pipeline for our nation's workforce, and the connection between access to federal student loan funding and the supply of trained professionals in high-need fields is well established. A reduced healthcare workforce can mean longer wait times for patients, increased emergency department visits, and higher costs, particularly in rural and underserved areas.

1. The Healthcare Workforce is Already Constrained

The Bureau of Labor Statistics projects that demand for nurse practitioners, nurse anesthetists, and nurse midwives will grow by 35 percent between 2024 and 2034—much faster than the average for all occupations—and requiring approximately 32,700 new APRNs each year.[31] Similar shortages are projected for physical therapists (11 percent growth), occupational therapists (14 percent growth), and social work (6 percent

[28] 42 C.F.R. § 418.64(a) (emphasis added)
[29] 42 C.F.R. § 418.3
[30] *91 Fed. Reg. at* 4265
[31] https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

growth).[32,33,34] Importantly, approximately 92 million Americans already live in regions designated by HRSA as primary care Health Professional Shortage Areas.[35]

Home health has been undergoing an access crisis, which has been driven in part by reduced capacity arising from Medicare rate cuts and a constrained workforce environment where competition is fierce. An analysis of 2024 Medicare claims data found that over one-third of Medicare beneficiaries referred for home health after hospitalization did not receive this care, and for those who did not, mortality rates were over 40 percent higher, hospital readmission rates were 34.2 percent higher, and total 90-day Medicare spending was 6 percent higher.[36] The same analysis estimated that if all referred beneficiaries had actually received home health services, approximately 5,900 fewer deaths and over 19,000 fewer hospital readmissions would have occurred in the first half of 2024 alone, underscoring that access gaps have real consequences for vulnerable Americans. Further, an analysis by KNG Health Consulting found that the average time from referral to start of care for home health increased from 2.2 days in 2019 to 3.2 days in 2024, and that approximately 10 percent of referrals now wait five days or more for an initial visit, with even longer wait times in rural areas.[37] In the home health context, where nurses and therapists often operate as the sole clinician with eyes on complex patients in the home, workforce shortages translate directly into patients not receiving care they have been referred for with serious consequences.

In the hospice and palliative care space, the workforce challenges are particularly significant, with approximately 19,920 clinicians holding specialty certification in hospice and palliative medicine nationwide, with a national average of only 2.1 physician prescribers per 100,000 population and only an estimated 6,600 physicians actively practicing.[38] This is a ratio far below most other medical specialties. At least 13 million Americans are living with a serious illness, many of whom suffer from attendant pain, symptoms, and distress.[39] The number of individuals aged 85 and older who need palliative care is projected to more than double, from approximately 142,716 in 2014 to 300,910 in 2040.[40] This demographic shift underscores the importance of ensuring a robust pipeline of clinicians trained to deliver this specialized care. In hospice, where over 20 percent of Medicare decedents who use the benefit receive care for four or fewer days,[41] any delay in

---

[32] https://www.bls.gov/ooh/healthcare/physical-therapists.htm
[33] https://www.bls.gov/ooh/healthcare/occupational-therapists.htm
[34] https://www.bls.gov/ooh/community-and-social-service/social-workers.htm
[35] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf
[36] https://carejourney.com/wp-content/uploads/2025/06/Home-Health-Access_2024-Q3-_2025.02.pdf
[37] https://allianceforcareathome.org/wp-content/uploads/Trends-timeliness-home-healthcare.pdf
[38] https://scorecard.capc.org/wp-content/uploads/2025/09/CAPC-Serious-Illness-Scorecard-Report-2025-08.pdf
[39] https://scorecard.capc.org/wp-content/uploads/2025/09/CAPC-Serious-Illness-Scorecard-Report-2025-08.pdf
[40] Etkind SN, Bone AE, Gomes B, Lovell N, Evans CJ, Higginson IJ, Murtagh FEM. How many people will need palliative care in 2040? Past trends, future projections and implications for services. BMC Med. 2017 May 18;15(1):102. doi: 10.1186/s12916-017-0860-2
[41] https://www.cms.gov/files/document/hospice-monitoring-report-2025.pdf

workforce availability directly shortens the already limited window during which meaningful comfort care can be provided.

HCBS also faces significant and interrelated challenges. Over half of the states currently have waiting lists for HCBS programs, with waits ranging from several months to many years, and nationally, it is estimated that nearly 700,000 individuals are on waiting lists for HCBS.[42] Once an individual becomes eligible and enrolls, many struggle to find a provider with the capacity to deliver services due to reimbursement challenges coupled with broader workforce shortages. In fact, all states reported workforce shortages in 2025, with the most common shortages among direct support professionals.[43] Workforce shortages mean these individuals often cannot access the services they need to live in their homes, which may force them into more costly institutional settings.

2. Educational Costs Can Decrease Our Student Pipeline

According to an analysis, approximately 39 percent of students in master's-level health programs currently borrow more than the proposed $20,500 annual cap would allow.[44] The average cost of attendance for nurses pursuing graduate degrees exceeds $30,000 per year, well above the proposed $20,500 annual cap for graduate students.[45] The American Physical Therapy Association reports that the average cost of attendance for DPT programs ranges from $108,212 to $126,034, before living expenses, fees, and other costs.[46] MSW programs at public institutions average $12,596 in annual tuition before living expenses and other costs, rising to nearly $30,000 at private nonprofit institutions, which does not include DSW tuition costs.[47] For many social work students, the proposed $20,500 annual cap would fall short of covering even tuition alone. Students unable to access sufficient federal loan funding may be forced to rely on private loans at significantly higher interest rates or forgo advanced education entirely. For students from rural or underserved backgrounds, these financial barriers can be significant.

National accreditation standards generally require nursing program directors to hold doctoral degrees and faculty to possess graduate-level nursing education. By reducing financial support for students seeking doctoral and graduate degrees, the unintended consequences of this proposal would not only reduce the supply of clinicians entering the workforce, they could reduce the capacity of nursing schools to educate future generations of healthcare professionals.

---

[42] https://www.kff.org/medicaid/waiting-for-care-three-fourths-of-states-have-waiting-lists-for-some-medicaid-home-care-programs/
[43] https://www.kff.org/medicaid/payment-rates-for-medicaid-home-care-ahead-of-the-2025-reconciliation-law
[44] https://www.philadelphiafed.org/-/media/FRBP/Assets/Consumer-Finance/Reports/student-loans-for-graduate-school.pdf
[45] https://www.nursingworld.org/news/news-releases/2025/department-of-educations-loan-proposal-puts-nursing-workforce-and-patient-care-at-risk/
[46] https://ptcasdirectory.apta.org/8529/Total-Cost-of-Education-Comparison
[47] https://nces.ed.gov/programs/digest/d22/tables/dt22_330.50.asp

CONCLUSION

We appreciate your consideration of our comments. The Alliance stands ready to partner with the DOE to ensure a sustainable pipeline for an educated healthcare workforce. If you have any questions, your staff should feel free to contact the Alliance's Chief Government Affairs Officer, Scott Levy, at: slevy@allianceforcareathome.org.

Sincerely,

Jennifer Sheets, RN, MSN, MBA
Chief Executive Officer
National Alliance for Care at Home