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Linda E. McMahon, Secretary of Education
Department of Education
400 Maryland Avenue SW
5th Floor
Washington, DC 20202

Submitted electronically at <http://www.regulations.gov>

RE: Docket ID ED-2025-OPE-0944

Dear Ms. McMahon:

The National Association of Rehabilitation Providers and Agencies (NARA) represent over 100,000 physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) professionals who provide skilled therapy intervention across the United States to patients from birth to death/end of life through our member organizations. Our trade association represents these rehabilitation providers and their organizations across the continuum of care including outpatient therapy, home health, skilled nursing, inpatient rehabilitation, and other post-acute settings. NARA supports its members through advocacy and regulatory engagement, education and professional development, and practical resources aimed at improving patient access, quality outcomes, and sustainable delivery of therapy services.

On behalf of over 100,000 rehabilitation professionals nationwide, NARA strongly opposes the Department of Education's (DOE) proposed narrowing of "professional degree" programs eligibility for higher federal graduate loan limits. The Office of Postsecondary Education in the DOE is proposing new annual and aggregate borrowing caps that would materially constrain financing for many advanced health professions. As described by the Department, beginning July 1, 2026, new graduate students would be limited to \$20,500 annually and \$100,000 aggregate, while students in designated "professional" programs would be allowed \$50,000 annually and \$200,000 aggregate. These programs are required for licensure and independent clinical practice. Limiting federal loan access will reduce workforce supply, restrict patient access to medically necessary rehabilitation services and disproportionately impact students pursuing essential healthcare careers.

NARA has serious and deep concern that the DOE's interpretation and rationale of "professional degree" excludes core rehabilitation entry-to-practice pathways specifically for Doctor of Physical Therapy (DPT), Masters and Doctor of Occupational Therapy

(MOT/OTD), and Masters of Speech-Language Pathology (MS/MA-SLP) in ways that will predictably:

1. Impede access to medically necessary PT/OT/SLP services which increases risk of harm to patients,
2. Worsen workforce shortages, especially in rural and underserved communities, and
3. Reduce access and enrollment to postsecondary degree programs for PT/OT/SLP

Financing Impact → Predictable Patient-Access Consequences

Even if the Department states it will not consider “financial need” as part of classification, the Department explicitly invites data-driven evidence of impacts to patient-access and programs. For rehabilitation therapy professionals, the impact pathway is straightforward and foreseeable:

- Restricting student access to financing for DPT, MOT/ODT, and MS/MA-SLP programs will shrink the rehabilitation workforce and ultimately impede timely access to medically necessary PT/OT/SLP services. When patients face delays or cannot obtain needed therapy, their risk of functional decline and preventable complications rises, driving worse outcomes, longer lengths of stay, and higher rates of avoidable hospital admissions and readmissions.
- Entry-to-practice clinical programs often require full-time attendance, extensive supervised clinical education, and limited capacity for outside employment, raising reliance on federal loans and reducing substitutability with private credit.
 - Most DPT, MOT/ODT, and MS/MA-SLP graduate programs are cohort-based, with a prescribed, lockstep sequence of didactic and clinical courses that must be completed in a specific order. Unlike many undergraduate programs, students generally cannot mix-and-match course timing or “pause” individual requirements without delaying progression for an entire term or year.
- When federal borrowing is capped, many students are forced toward private loans that often require strong credit, a co-signer, and offer less flexible repayment and fewer protections. These barriers disproportionately affect first-generation and lower-income applicants, in most cases, cannot afford to attend without these loans. Because cohort-based clinical programs frequently limit outside employment, students may have little or no income to qualify independently, making private financing either unattainable or financially risky and ultimately shrinking the pipeline into PT/OT/SLP practice. When federal lending no longer covers the cost of attendance, prospective students particularly first-generation and underrepresented students will defer, choose different fields, or forgo training altogether.
- Workforce/access: Any reduction in program enrollment compounds existing shortages, increasing wait times and reducing availability of PT/OT/SLP services in skilled nursing facilities (SNFs), home health, outpatient, schools, and hospitals especially outside major metro areas.

DOE’s Exclusion Logic Relies on “Historical Practice” Rather Than the Operative Test

NARA’s core interpretive concern is that the DOE appears to treat “we have not historically included this field” as effectively dispositive despite rapid evolution in entry-to-practice standards for regulated clinical professions. A statutory and regulatory framework that uses “include but are not limited to” is inherently designed to accommodate professional standardization over time, particularly when licensure, accreditation, and scope-of-practice requirements evolve. The last time the definition of “professional degree” was amended was November 1, 2007. Healthcare is a dynamic, rapidly evolving sector, and federal policy should be designed to keep pace with modern clinical practice, not freezing today’s workforce pipeline in a definition that is nearly 20 years old. Educational pathways change as licensure standards, scope of practice, accreditation requirements, and patient needs evolve, particularly in regulated clinical professions. The Department should not hinder this progress by relying on outdated historical classifications; instead, it should adopt a forward-looking approach that recognizes current entry-to-practice education and the realities of today’s healthcare delivery system.

For modern rehabilitation practice, DPT, MOT/OTD, and MS/MA-SLP are not aspirational add-ons; they are integrated entry-to-practice pathways that align with licensure and independent clinical practice expectations. The Department’s approach should apply the operative test to current entry-to-practice reality, not freeze the list around legacy degree structures.

DPT, MOT/OTD, and MS/MA-SLP Degrees Meet the Department’s Own Professional-Practice Framing

Physical Therapy (DPT)

Physical Therapy is a regulated clinical profession requiring professional education and clinical training to enter practice. Federal instructional classification recognizes “Physical Therapy/Therapist” as a distinct health profession program (CIP 51.23) within the Health Professions taxonomy.

Across rehabilitation disciplines, state licensure requires education beyond the undergraduate level as a baseline gatekeeper for safe, independent clinical practice. For Physical Therapy, licensure requires completion of a Doctor of Physical Therapy (DPT) from a CAPTE-accredited program (in addition to passing state licensure exams)¹.

The Department’s exclusion of the DPT from the “professional degree” classification seems arbitrary and inconsistent with its own regulatory criteria, which the DPT program clearly meets. The proposed rule, requiring a six- year program, professional licensure, post-baccalaureate academic pathway, applies to the DPT making its omission unjustified.

¹ <https://www.apta.org/your-career/careers-in-physical-therapy/becoming-a-pt>

NARA has concerns over this rationale to deny professional-degree treatment where the profession's entry credential has evolved and is now central to licensure-based practice.

In many states, physical therapists already function as a first point of contact for direct access, and policy is beginning to recognize that reality is more explicitly as healthcare delivery evolves. As of July 1, 2025², all 50 states, the District of Columbia, and the U.S. Virgin Islands allow some form of direct access to physical therapist evaluation and treatment (with varying state-specific parameters), meaning patients can access PT without a physician referral in every U.S. jurisdiction.

The Bureau of Labor Statistics³ (BLS) estimates there are about 267,200 physical therapist jobs (2024) and projects 11% growth from 2024–2034, with about 13,200 openings per year on average due to both growth and retirements. In other words, demand is rising while a steady wave of clinicians are exiting the workforce so any policy that constrains students' ability to finance the required doctoral education will predictably shrink the pipeline, intensify shortages (especially in rural and underserved areas), and delay patient access to medically necessary physical therapy. These workforce projections make it clear that we cannot afford to deter qualified students from DPT programs.

Occupational Therapy (MOT/OTD)

Like Physical Therapy, Occupational Therapy is regulated through state licensure, with clinical profession requiring post-baccalaureate professional education as a condition of entry into practice. Licensure requires graduation from an accredited program, completion of supervised fieldwork, and passage of the National Board for Certification in Occupational Therapy (NBCOT) entry-level exam. NBCOT's eligibility standards distinguish U.S.-educated candidates from internationally educated candidates, reflecting different routes for comparability determinations an important nuance when interpreting any assertion that a specific degree is "not required" to enter the field. The Federal instructional classification recognizes "Occupational Therapy/Therapist" as CIP 51.23.

For Occupational Therapy⁴, state licensure pathways require graduation from an ACOTE-accredited entry-level OT program, completion of required fieldwork, and passing the NBCOT⁵ certification requirements that are inherently post-baccalaureate professional preparation for OT practice.

BLS projections show a strong and growing need for occupational therapists (the MOT/OTD workforce). The Bureau of Labor Statistics⁶ estimates about 160,000 OT jobs (2024) and

² <https://www.apta.org/advocacy/issues/direct-access-advocacy>

³ <https://www.bls.gov/ooh/healthcare/physical-therapists.htm>

⁴ <https://www.aota.org/career/state-licensure/learn-the-steps-to-licensure>

⁵ <https://www.nbcot.org/get-certified/eligibility>

⁶ <https://www.bls.gov/ooh/healthcare/occupational-therapists.htm>

projects 14% growth from 2024–2034, with roughly 10,200 openings per year on average due to growth and workforce churn/retirements. Given that OT is a licensed profession requiring post-baccalaureate education and substantial clinical training, policies that restrict access to federal financing will predictably reduce enrollment and shrink cohort sizes, tightening the pipeline into a field that is already expected to add thousands of clinicians annually. The result is not just fewer graduates; it is longer wait times, reduced service availability (especially in rural and underserved communities), delayed discharges, and higher downstream costs when patients can't access medically necessary OT services in a timely way.

NARA urges the Department not to let edge-case pathways (including international equivalency routes) distort the primary domestic reality: OT entry-to-practice preparation is accredited, clinically intensive, licensure-oriented, and aligned with a regulated clinical scope of practice. The Department's exclusion of the MOT and OTD from the "professional degree" classification is arbitrary and inconsistent with its own regulatory criteria, which the MOT and OTD programs clearly meet. The proposed rule, requiring six-year program, professional licensure, post-baccalaureate academic pathway, applies to both programs making its omission unjustified. NARA has concerns over this rationale to deny professional-degree treatment where the profession's entry credential has evolved and is now central to licensure-based practice.

Speech-Language Pathology (MS/MA-SLP)

Speech-Language Pathology similarly meets all core criteria of a professional clinical degree program tied to licensure and independent practice. Nothing in the Department's framing requires that a "professional degree" must be a doctorate. The Department's own communications recognize that "professional degree" designation is tied to defined professional programs, not exclusively doctoral status.

MS/MA-SLP is a state regulated clinical profession with defined post-baccalaureate professional education and structured supervised clinical experiences prior to independent practice (e.g., clinical fellowship transition and supervision requirements). The Federal instructional classification recognizes "Speech-Language Pathology/Pathologist" as CIP 51.02. The CIP codes are the federal government's standardized way to identify and administer academic programs, which makes them a clean, objective mechanism for determining which programs qualify for the higher "professional degree" loan limits. If Speech-Language Pathology/Pathologist is formally classified as CIP 51.02, DOE can use that existing federal taxonomy to include MS/MA-SLP programs consistently and administrable, thus avoiding arbitrary exclusions, reducing confusion for schools and borrowers, and ensuring students in a clearly defined, licensed clinical profession isn't pushed under lower caps simply due to terminology differences across institutions.

For Speech-Language Pathology⁷, state licensure commonly requires a minimum of a master’s degree, substantial supervised clinical practicum, and postgraduate supervised professional experience prior to full independent practice. Given the MS/MA-SLP’s licensure-tied professional education and supervised practice model, excluding SLP from professional-degree treatment would be inconsistent with the Department’s stated focus on professional-practice characteristics.

BLS⁸ projects that speech-language pathology is one of the faster-growing healthcare professions: employment is projected to grow 15% from 2024 to 2034, with about 13,300 openings per year (on average) over the decade (from both growth and replacement needs). Because MS/MA-SLP is a licensed clinical profession that typically requires a graduate degree plus substantial supervised clinical training, students cannot enter the field through a lower-cost “step-down” pathway and then work their way up later. If financing is restricted, the result is fewer students enrolling and fewer graduates entering the workforce, directly undermining the pipeline needed to meet the projected demand. That translates into longer waitlists, reduced service availability in schools, SNFs, hospitals, and outpatient settings, and delayed care for children and adults with communication and swallowing disorders, the exact opposite of what patients and communities need as demand rises.

The Department’s exclusion of the MS/MA-SLP from the “professional degree” classification is arbitrary and inconsistent with its own regulatory criteria, which the MS/MA-SLP program clearly meets. The proposed rule, requiring a six-year program, professional licensure, post-baccalaureate academic pathway, applies to the SLP making its omission unjustified. NARA has concerns over this rationale to deny professional-degree treatment where the profession’s entry credential has evolved and is now central to licensure-based practice.

Direct Access To Services/Primary Care Providers

At the same time, the U.S. faces a growing physician workforce shortage projected to be as high as 86,000 physicians by 2036 with primary care among the most impacted areas. Reflecting these pressures and the shift toward team-based, accessible care, Utah enacted Senate Bill 196 (Physical Therapist Practice Amendments), expanding the state’s definition of “primary health care” to include services provided by physical therapists and allows health plans to let an insured select a PT as their primary care provider for musculoskeletal conditions⁹.

When therapy is engaged early, especially as a first-line, conservative intervention, total health care spending drops because downstream utilization is avoided (imaging, injections, surgery, ED visits, and opioid exposure). For example, APTA summarized findings showing

⁷ <https://www.asha.org/certification/speech-language-pathology-pathway-to-certification/>

⁸ <https://www.bls.gov/ooh/healthcare/speech-language-pathologists.htm>

⁹ <https://www.apta.org/article/2025/08/06/apta-state-chapters-fuel-legislative-wins-in-2025>

that for low back pain, initiating care with physical therapy lowered average total medical costs by 19% compared with injections-first and by 75% compared with surgery-first¹⁰. APTA's State of Direct Access evidence reviews similarly reports that direct access PT is associated with lower total health care costs and fewer visits, including findings of \$1,828 per patient in total cost savings in studies comparing direct access PT to physician-first pathways¹¹.

AOTA reports parallel value on the OT side: occupational therapy addresses function, safety, discharge readiness, and environmental barriers which are factors tightly linked to preventable utilization of more costly interventions. AOTA's advocacy brief highlights research showing that higher hospital spending on occupational therapy is associated with lower readmission rates, underscoring that investing in OT can reduce costly bounce-backs. AOTA also summarizes broader evidence that OT interventions can be effective in reducing hospital readmissions for certain adult hospitalized populations, supporting the policy argument that front-end rehabilitation involvement reduces avoidable downstream costs while improving outcomes¹².

Occupational therapy access is often broader than many people realize. Using a practice-act lens, MOT-level occupational therapists effectively have direct access in approximately 32 states¹³: Utah explicitly codifies direct access in its OT practice act stating that "*An occupational therapist may evaluate, initiate, and provide occupational therapy treatment for a client without a referral from another health service provider.*" In addition, about 31 states do not address referrals in OT statutes or regulations at all, and the practical position is that this silence functions as direct access because the law does not impose a referral prerequisite. The remaining jurisdictions tend to fall into specific limitation "buckets," such as allowing direct access only for a defined period (e.g., 42 days in Indiana or 10 visits/30 days in New York), permitting direct access for certain services (like evaluation, consultation, or school-based OT) but requiring referrals for other medically oriented services, or applying referral triggers for narrow areas such as low-vision/visual rehabilitation; some also require patient disclosures that coverage may depend on payer rules.

Taken together, the evidence shows that rehabilitation professionals are increasingly positioned as front-door providers in a modern, team-based healthcare system: patients can access PT directly in every U.S. jurisdiction, OT functions as direct access in a

¹⁰ <https://www.apta.org/news/2017/07/26/study-says-cost-savings-of-physical-therapy-for-lbp-are-significant>

¹¹ <https://www.apta.org/contentassets/6f37221cc8cc4087ab79aaf206d8dee8/apta-state-of-direct-access-2025-final-1.pdf>

¹² Rogers AT, Bai G, Lavin RA, Anderson GF. Higher Hospital Spending on Occupational Therapy Is Associated With Lower Readmission Rates. *Med Care Res Rev.* 2017 Dec;74(6):668-686. doi: 10.1177/1077558716666981. Epub 2016 Sep 2. PMID: 27589987.

¹³ <https://www.aota.org/publications/ot-practice/ot-practice-issues/2023/capital-report-recap-advocacy-month>

substantial share of states, and states such as Utah are beginning to elevate PT services within “primary health care” frameworks in response to worsening primary care shortages. These trends reflect the real-world role PT and OT already play in triage, early intervention, and prevention, an approach supported by APTA and AOTA evidence demonstrating lower total costs, fewer downstream interventions, and reduced readmissions when therapy is engaged early. In this context, DPT, MOT/OTD, and MS/MA-SLP programs align with DOE’s professional-degree concept in substance: they prepare clinicians for state-licensed, regulated practice with substantially required clinical education and responsibility for independent patient care. Accordingly, these programs should be eligible for higher federal graduate loan limits, so financing policy does not artificially shrink cohorts, suppress enrollment, and ultimately reduce access to medically necessary PT/OT/SLP services for patients who need timely care.

Illustrative “Real World” Example of Workforce Impact of This Proposed Rule

A student NARA knows will graduate from an allied health undergraduate program in May 2027. He has wanted to become a physical therapist since sixth grade, and he has done everything “the right way” to get there: earning a merit scholarship, piecing together small grants, and working through a work-study program to help cover college costs. But the support that made his undergraduate education possible is not typically available at the same level in doctoral programs, and the DPT path is a cohort-based, lockstep track that leaves little to no room to work, often not even in the summer.

Like many aspiring clinicians, he has spent most of his undergraduate years working only seasonal jobs for low wages while relying on his parents, which means he has not built the kind of credit history or steady income that private lenders require. If federal loan limits are lowered for DPT programs, he won’t simply “find another way to pay.” He will face a painful choice: abandon the career he has prepared for since childhood, step down into a different role solely because it is more affordable, or leave healthcare entirely. That is the human consequence of this proposal: not abstract numbers, but motivated students, future providers, being priced out of the professions our communities are already struggling to access.

Physical therapists, occupational therapists, and speech-language pathologists are unlike many other healthcare careers because they require post-baccalaureate, clinically intensive education as a prerequisite to licensure and practice: a DPT for physical therapy, an MOT/OTD pathway for occupational therapy, and a MS/MA-SLP for speech-language pathology. These professions also require extensive supervised clinical training and competency-based preparation before a clinician can independently treat patients. By contrast, several other essential healthcare roles can enter the workforce with a bachelor’s degree (or less) and then build skills through employer-based training or certification pathways. When federal policy limits financing for fields that *cannot* be accessed at the bachelor’s level, it uniquely penalizes professions where advanced education is not

optional, it is the minimum threshold to protect patient safety and deliver medically necessary care.

Requested Regulatory Remedies

To avoid predictable financing disruptions and access consequences for PT/OT/SLP services, NARA requests the Department amend the professional-degree list to explicitly include:

- Doctor of Physical Therapy (DPT)
- Occupational Therapy entry-to-practice degrees (MOT/OTD)
- Speech-Language Pathology entry degree (MS/MA-SLP)

This approach is objective, auditable, and scalable, and it reduces arbitrary exclusions that are not grounded in licensure/practice realities. NARA encourages the Department to evaluate and respond to evidence on:

1. Patient access indicators (wait times, provider vacancy data, rural service gaps) and how enrollment declines worsen shortages.
2. Accreditation and licensure prerequisites establishing entry-to-practice status, including required supervised clinical education and credentialing (e.g., NBCOT eligibility and state licensure pathways; SLP clinical fellowship supervision requirements).
3. Typical tuition/fees and debt load for DPT, MOT/OTD, and MS/MA-SLP graduates relative to the proposed caps.

Conclusion

The Department's proposed "professional degree" interpretation would materially constrain financing for the very professionals who deliver essential rehabilitation services that keep Americans functional, safe at home, and out of higher-cost settings or procedures. NARA respectfully requests that the Department revise the proposed rule to include DPT, MOT/OTD, and MS/MA-SLP entry-to-practice programs through explicit inclusion.

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Covington, NARA Executive Director at christie.covington@naranet.org.

Respectfully submitted,



Chris Carlin, OTR/L, MBA

President of the Board, National Association of Rehabilitation Providers & Agencies