AACOM
American Association of Colleges of Osteopathic Medicine

June 20, 2023

The Honorable Miguel Cardona, PhD
Secretary of Education
400 Maryland Avenue, SW
Washington, D.C. 20202

Via electronic submission at regulations.gov

Re: Comments on Notice of Proposed Rulemaking, Docket ID ED-2023-OPE-0089

Dear Secretary Cardona:

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), I am pleased to submit written comments on the U.S. Department of Education's recent notice of proposed rulemaking on a variety of regulatory matters pertaining to Title IV, *Higher Education Act* (HEA) programs.

AACOM leads and advocates for the full continuum of osteopathic medical education to improve the health of the public. Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents all 40 accredited colleges of osteopathic medicine (COMs)—educating more than 35,000 future physicians, 25 percent of all U.S. medical students—at 64 teaching locations in 35 U.S. states, as well as osteopathic medical education professionals and trainees at U.S. medical centers, hospitals, clinics and health systems.

AACOM supports the Department's goals to protect students and promote principles of accountability across Title IV programs. We also recognize the importance of appropriate oversight and improving outcomes for all students. Concurrently, as the nation faces a physician workforce shortage, we firmly believe that federal policies must also support the educational pathway of the future healthcare workforce.

<u>Gainful Employment</u>
AACOM urges the Department to ensure formulas for determining debt-to-earnings (D/E) rates (§668.403) and the earnings premium measure (§668.404) reflect the unique medical training model and consider a medical graduate's earnings only after they have completed their residency and fellowship training.

AACOM appreciates the Department's suggestion to use an extended cohort period calculation for programs whose students are required to complete a medical residency, including osteopathic medical programs. However, we are concerned that the extended lookback as described in the regulation is not individualized. Medical residencies vary greatly depending upon the specialty being pursued. For example, training for

neurological surgery is seven years, whereas a psychiatry residency takes four years, and family medicine and general internal medicine training are three years in duration. After residency training, many physicians pursue subspecialty fellowships, which add more years to their post-doctoral training. Therefore, the lookback does not account for these varying lengths of medical residencies. Assessing a medical program's D/E rate and earnings premium measure during the sixth through ninth cohort award years does not adequately account for graduates who match into specialties with longer residencies or who participate in fellowships, both of which can add additional years to a physician's training.

The D/E rate and the earnings premium measure for medical programs should consider a graduate's earnings only after they have completed their residency and fellowship training. Failure to do so may result in medical programs being inadvertently labeled as "high-debt burden" or "low-earnings"—or, even worse, at risk of losing their Title IV funding—without recognizing the medical program's value to our nation's healthcare system resulting from graduating physicians who will complete longer, specialized residencies.

It is imperative for the Department to evaluate the income of our graduates only after they complete their postgraduate training because the salaries of medical residents and fellows are not indicative of their future income. In fact, after graduation from medical school, medical residents often use federal financial aid programs, such as forbearance and income-driven repayment, to postpone or reduce their obligations until they become fully-licensed physicians. This is because residency salaries are a fraction of their future earnings. The Department recognizes this because federal education loan servicers are required to grant a medical resident's forbearance for the duration of their residency upon the resident's request.

Once physicians begin practicing following their residency or subspecialty fellowship, their earnings are usually more than sufficient to meet their student debt obligations. This is reflected in the exceptionally low loan default rates for U.S. osteopathic medical school graduates. According to AACOM data collected in 2018, reported program loan default rates were between 1.10 percent and 1.43 percent.

Additionally, AACOM urges the Department to consider borrowers' use of the various loan repayment programs when calculating a borrower's earnings for D/E rates. Public service programs play a critical role in addressing physician deficits and recruiting healthcare professionals to work in full-time public service positions, especially in medically underserved areas. These programs, such as the National Health Service Corps Loan Repayment Program (LRP), the Indian Health Service LRP, Health Professions LRP and the Veterans Affairs Specialty Education LRP, provide loan forgiveness benefits to participants in exchange for a service commitment. Failure to consider these LRPs may adversely affect the medical schools whose students commit to public service through higher student participation in these programs.

Enclosed are letters from AACOM's member institutions, the Burrell College of Osteopathic Medicine, the Idaho College of Osteopathic Medicine and Rocky Vista University College of Osteopathic Medicine, outlining the impact this rule would have on these medical schools and their students. AACOM endorses the concerns and recommendations in these letters and believes they illustrate the problem these policies could pose for proprietary U.S. medical schools.

Financial Value Transparency

AACOM encourages the Department to modify the financial value transparency reporting requirements (§668.408) for medical programs in consideration of the unique U.S. medical education training process.

All osteopathic medical schools in the United States, regardless of non-profit or for-profit status, are accredited by the Commission on Osteopathic College Accreditation (COCA), which is recognized by the Department. Through its enforcement of rigorous accreditation standards, COCA ensures that COMs achieve sufficiently high educational standards and consequently, provide a return on investment for graduates. COCA certifies that no low-value programs are accredited by providing quality assurance in medical education through standards on curriculum, faculty and staff, mission, administration, finances, facility, learning environment, research and student outcomes (including passing national licensing board examinations and placement of graduates into residency programs) and assessment.

As proposed, the reporting requirements in section 668.408 may create an inaccurate depiction of the proprietary COM's value. For example, a program's or institution's current "value" to students would be measured based on the outcomes of students from over a decade ago, long before a medical program would know what metrics the Department considers good financial value in 2024. The reported information would not account for any changes to the program in the intervening years. The stale data would not be useful for prospective students, and therefore the significantly increased and costly administrative burden for institutions to comply would not be justified.

Failure to account for the medical education training model may result in the Department inadvertently and inaccurately identifying medical programs as low-financial value, damaging their ability to recruit students and address the nation's physician workforce shortage.

Certification Procedures

AACOM strongly urges the Department to abandon and delay the proposed requirements in section 668.14 that require institutions to comply with all state consumer protection laws related to closure, recruitment and misrepresentations until a negotiated rulemaking (Neg-Reg) panel with requisite expertise is convened to address the State Authorization (§600.9). Such a State Authorization Neg-Reg panel would be better positioned to comprehensively craft new regulations that address

the Department's concerns related to both provisions without threatening to destroy the vital and hard work already undertaken by states and institutions with respect to reciprocity arrangements.

The proposed state consumer protection requirements in section 668.14 and the existing State Authorization requirements in section 600.9 are undeniably interconnected because institutions would be required to comply with closure, recruitment and misrepresentation laws in each state where they are located and where their students reside, in addition to already complying with the burdensome State Authorization requirements in those same states. However, the proposed state consumer protection requirements fail to adequately recognize this interconnectedness.

Closure, recruitment and misrepresentation consumer protection laws vary widely state-to-state, as do many states' requirements for an institution to be authorized to operate within those same states. States and institutions have worked together to reduce the significant administrative burden borne by them under the State Authorization regime by implementing a robust system of state authorization reciprocity agreements (SARAs), whereby institutions can satisfy common requirements to be authorized in all states participating in such reciprocity pacts. The new requirements in section 668.14, however, will create additional severe and unnecessary burdens on COMs, particularly those participating in SARAs. Proposed section 668.14 would also threaten to destroy or significantly undermine the efficacy of SARAs, which have saved COMs hundreds of thousands of dollars in compliance costs. In order to reduce costs to monitor and comply with state laws on closure, recruitment and misrepresentation in each state where their students train, COMs may choose to limit out-of-state clinical rotations options for their students, reducing their exposure to diverse practice settings.

It is vital that any Neg-Reg panel addressing State Authorization and new requirements for compliance with state consumer protection laws include representation from the osteopathic medical education community. Our institutions have serious concerns with both provisions, which will cause undue financial and administrative burdens on osteopathic medical schools and students.

We draw the Department's attention to the March 24, 2023 Federal Register notice indicating intent to establish a negotiated rulemaking committee on State Authorization and reiterate our public comments submitted on April 24, 2023. The Department should convene a Neg-Reg committee to evaluate the unintended consequences of the existing State Authorization regulations and the proposed requirements in section 668.14 because they will collectively disparately burden COMs that offer distance education, clinics and residencies in diverse geographic areas and fail to accommodate the unique characteristics of medical education.

Importantly, we note that the 2022 negotiated rulemaking committee that proposed the state consumer protection law requirements did not include State Authorization experts and was embedded within Certification Procedures (§668.14) rather than State

Authorization. It is unlikely that the same group of expert stakeholders would be able to thoroughly and thoughtfully assess and debate these important issues. We encourage the Department to hold an open and collaborative process with the convening of appropriate stakeholders, including the osteopathic medical education community, to closely study the impact of these policies and address any unintended consequences.

If the proposed state consumer protection rules are finalized, AACOM strongly recommends that U.S. medical schools, and the clinical rotations of their students, be exempted as a condition of Title IV eligibility. The existing State Authorization provisions in section 600.9(a) through (c) have already significantly increased the financial and administrative burdens for AACOM's member institutions as they work to offer robust learning experiences for medical students during core clinical rotations in the third and fourth year of medical school. The proposed state consumer protection rules in section 668.14 threaten to exacerbate these challenges because they do not recognize the uniqueness of medical education, which requires clinical rotations that often occur away from campus.

The Department must be mindful of the unique nature of remote medical instruction. With increasing competition for clinical training opportunities, COMs, many of which are located in rural areas, may lack sufficient in-state options and send their students out of state to complete their core clinical rotations. Some schools also participate in multi-state consortium training models to enhance educational experiences and produce physicians capable of practicing in a variety of clinical settings. The disruption of this clinical education model may limit the number of medical school graduates who have experience training in rural and underserved areas and will have profound effects on the physician workforce pipeline and access to healthcare for these areas.

If an exemption from proposed section 668.14 is not provided to U.S. medical schools, AACOM seeks clarifying language to ensure that COMs do not face undue administrative burdens and fees that further complicate distance education requirements. AACOM recommends that revised regulations explicitly confirm that students enrolled in out-of-state core clinical education rotations are considered to be enrolled at the main campus of their medical institution and not deemed enrolled in distance education or correspondence courses.

AACOM encourages the Department to provide clarifying language to the definition of "additional location" in §600.2. The definition should be made consistent with previous Department interpretations, which explain that for state authorization purposes, "in the case of an additional location of an institution where a student cannot complete more than 50 percent of a program, the student is considered to be enrolled at the main campus of the institution, and thus, no additional State authorization would be required."

Medical schools should be excluded from the requirement in proposed section 668.14 that requires institutions to determine, in each state where the institution is located and where its students are enrolled, that each program satisfies the applicable

professional licensure or certification for graduates to obtain employment and practice their chosen profession in those states.

Requiring COMs to provide a list of states in which they are aware that they do and do not meet licensing requirements is unnecessary given COCA's accreditation standards. COCA accreditation indicates that COM graduates are qualified to enter residency training and the program satisfies the licensure requirements in all 50 states. This unnecessary duplication would increase administrative compliance costs on COMs, which could reduce student services or increase tuition as a result.

Administrative Capability

AACOM urges the Department to clarify that §668.16(r) does not apply to medical programs where students are required to complete clinical rotations as part of their coursework and complete a residency for licensure.

As written, it is unclear if or how the proposed changes in §668.16(r) apply to clinical rotations offered by COMs. Osteopathic medical students typically spend the first two years of their medical education at the institution to receive academic instruction in the medical sciences, obtain a core set of clinical examination skills and train in ethics and professional responsibility. The students then spend their third and fourth years on core, elective and audition clinical rotations where they further refine these skills, are exposed to a variety of medical specialties and gain hands-on experience treating patients.

A student's core clinical rotations are scheduled at core clinical sites affiliated with their program. Students schedule their elective and audition rotations independently or with the assistance of their COM at hospitals and other medical facilities throughout the country. These rotations form an integral part of the students' coursework and are vital to students' exposure to different medical specialties and residency programs. Requiring that all rotations be provided by the COM and be geographically accessible undermines the ability of students to pursue training in medical specialties of their choice in diverse geographical locations.

We are also concerned that § 668.16(r) may unintentionally require COMs to provide residency opportunities to students who do not otherwise match into a residency program upon graduation. Many COMs do not have the administrative capacity to build from scratch residency programs, which would be duplicative of already existing, adequate and entrenched national match programs.

To obtain a state license to practice, all medical school graduates are required to complete medical residency training. Medical students are predominantly placed into U.S. medical residency programs through the National Resident Matching Program, a process where graduating medical school seniors compete for acceptance into residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Other match programs include the military match (for those

graduates with military service obligations) and the early matches to Ophthalmology and Plastic Surgery.

Currently, unmatched students participate in the Supplemental Offer and Acceptance Program (SOAP) for placement into residency programs with unfilled positions. Requiring COMs to provide residencies for unmatched students within 45 days of the completion of their coursework would both undermine the match process and place an extreme financial and administrative burden on the medical programs. It is also unnecessary as DO Seniors achieved a residency placement rate of 99.5 percent across all elements of the match process in 2023.

If the Department determines that § 668.16(r) does apply to medical programs, we ask you to clarify the definition of "geographically accessible" or exempt medical programs from the geographic requirement in order to ensure it does not unintentionally restrict the training of medical students, particularly those who train in rural and underserved areas.

According to the Health Resources and Services Administration's Advisory Committee on Interdisciplinary, Community-Based Linkages, there is a growing trend toward providing care in smaller community-based clinics. As the provision of care has shifted to community facilities, so has the training of medical students. However, over three-quarters of all medical schools report concerns about the number of clinical training sites and the quality and supply of preceptors, especially in primary care. When hospitals are geographically accessible, they often have policies that prohibit training students, requiring the institutions training them to look for clinical training opportunities outside of their geographic region out of necessity.

This issue is particularly acute for COMs because they prioritize training future physicians in rural and underserved areas. Approximately 60 percent of COMs are located in Health Professional Shortage Areas and 64 percent require their students to go on clinical rotations in rural and underserved areas. As trainees exposed to underserved populations and receiving medical education in a rural location are more likely to practice in a rural or other underserved area, the use of geographic accessibility as a metric for acceptable clinical experiences may undermine the ability of COMs to supply physicians to rural and underserved areas. Should the geographic accessibility requirement become final, the Department should delay implementation to allow COMs time to establish the appropriate clinical rotations.

Additionally, AACOM urges the Department provide flexibility to medical programs regarding their financial aid counseling and communications with students (§668.16(h)). As part of COCA accreditation requirements, COMs are already required to provide financial aid counseling to all students and to assist them with financial aid applications and debt management. The requirements in section 668.16(h) are too prescriptive and interfere with the COMs ability to effectively communicate with their students.

Conclusion

Thank you for your consideration of our views. AACOM looks forward to working closely with the Department to ensure that medical schools, their students and the communities they serve benefit from Title IV federal financial aid programs. If you have questions or require further information, please contact David Bergman, JD, Vice President of Government Relations, at dbergman@aacom.org.

Sincerely,

Robert A. Cain, DO, FACOI, FAODME
President & Chief Executive Officer
American Association of Colleges of Osteopathic Medicine

3501 Arrowhead Drive
Las Cruces, NM 88001
www.burell.edu

June 20, 2023

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

Re: Comments on Gainful Employment

Dear Secretary Cardona:

On behalf of the Burrell College of Osteopathic Medicine (BCOM), I am pleased to submit written comments on the U.S. Department of Education's recent notice of proposed rulemaking pertaining to Gainful Employment. Unless changes are made as recommended below, there will be significant unintended consequences to our nation's supply of physicians.

BCOM was founded in 2013 in Las Cruces, New Mexico under a mission to increase diversity in the physician workforce and foster a practice of life-long learning, compassion, respect, and excellence in our students. We matriculated our first class in 2016 and have graduated four full classes to date. We rank second in the nation among all osteopathic medical schools in the number of underrepresented minority students (URM) and with 99% of our graduates being placed into post graduate medical education residencies (GME). Approximately 60% of our graduates have chosen to pursue primary care specialties.

BCOM urges the Department to ensure formulas for determining debt-to-earnings (D/E) rates (§668.403) and the earnings premium measure (§668.404) reflect the unique medical training model and consider a medical graduate's earnings only after they have completed their residency and fellowship training.

BCOM appreciates the Department's suggestion to use an extended cohort period calculation for programs whose students are required to complete a medical residency, including osteopathic medical programs. However, we are concerned that the extended lookback as described in the regulation is not individualized. Medical residencies vary greatly depending upon the specialty being pursued. For example, training for neurological surgery is seven years, whereas a psychiatry residency takes four years, and family medicine and general internal medicine training are three years in duration. After residency training, many physicians pursue subspecialty fellowships, which add more years to their post-doctoral training. Therefore, the lookback does not account for these varying lengths of medical residencies. Assessing a medical program's D/E rate and earnings premium measure during the sixth through ninth cohort award years does not adequately account for graduates who match into specialties with longer residencies or who participate in fellowships, both of which can add additional years to a physician's training.

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The D/E rate and the earnings premium measure for medical programs should consider a graduate's earnings only after they have completed their residency and fellowship training. Failure to do so may result in medical programs being inadvertently labeled as "high-debt burden" or "low-earnings"—or, even worse, at risk of losing their Title IV funding—without recognizing the medical program's value to our nation's healthcare system resulting from graduating physicians who will complete longer, specialized residencies.

It is imperative for the Department to evaluate the income of our graduates only after they complete their postgraduate training because the salaries of medical residents and fellows are not indicative of their future income. In fact, after graduation from medical school, medical residents often use federal financial aid programs, such as forbearance and income-driven repayment, to postpone or reduce their obligations until they become fully-licensed physicians. This is because residency salaries are a fraction of their future earnings. The Department recognizes this because federal education loan servicers are required to grant a medical resident's forbearance for the duration of their residency upon the resident's request.

Once physicians begin practicing following their residency or subspecialty fellowship, their earnings are usually more than sufficient to meet their student debt obligations. This is reflected in the exceptionally low loan default rates for U.S. osteopathic medical school graduates. According to AACOM data collected in 2018, reported program loan default rates were between 1.10 percent and 1.43 percent.

Additionally, BCOM urges the Department to consider borrowers' use of the various loan repayment programs when calculating a borrower's earnings for D/E rates. Public service programs play a critical role in addressing physician deficits and recruiting healthcare professionals to work in full-time public service positions, especially in medically underserved areas. These programs, such as the National Health Service Corps Loan Repayment Program (LRP), the Indian Health Service LRP, Health Professions LRP and the Veterans Affairs Specialty Education LRP, provide loan forgiveness benefits to participants in exchange for a service commitment. Failure to consider these LRPs may adversely affect the medical schools whose students commit to public service through higher student participation in these programs.

Thank you for your consideration of our views. If you have questions or require further information, please contact me at jhummer@burrell.edu.

Respectfully,

John L. Hummer
President

Idaho College of Osteopathic Medicine

June 12, 2023

U.S. Secretary of Education
Dr. Miguel A. Cardona,
400 Maryland Avenue, SW
Washington, DC. 20202

Dear Dr. Miguel Cardona,

The Idaho College of Osteopathic Medicine (ICOM) writes to express serious concerns with the gainful employment (GE) proposed rules under consideration by the U.S. Department of Education (ED) and the impact it will have on our ability to train osteopathic medical students. In short, *we urge ED to adjust its GE calculation timeframe to begin upon completion of a post-graduate student's medical residency.*

ICOM supports ED in its goal to protect student borrowers and promote principles of accountability in the Title IV student financial aid programs. However, the proposed GE regulation fails to adequately account for many nuances unique to medical education. Policies and regulations proposed by ED related to loan repayment rate calculations, debt-to-earnings (D/E) rates, and Title IV eligibility decisions should not be applied to physicians in the same way that they are applied to other occupations. These policies would severely jeopardize or penalize medical students who rely on federal programs to finance their education and thereby exacerbate the nation's shortage of physicians.

ICOM's purpose is to help prepare the next generation of competent and caring physicians with a special focus on serving Idaho and the rural mountain west. Idaho ranks 50th—last in the nation in total active physicians per capita. ICOM's other mission states, including Montana, Wyoming, North Dakota, and South Dakota also continue to suffer an acute and growing shortage of physicians.

ICOM receives over 3,500 well-qualified applicants to fill 162 newly matriculated seats each year. The College currently serves over 600 students across our 5+ state region.

ED's proposed rule recognizes the delay in the cohort reporting period for debt-to-earning rates (D/E) calculations for reporting purposes. ED is proposing to extend the start of the D/E reporting period beginning between six and nine years from a student's start of medical school. Unfortunately, this rule inaccurately assumes that all students complete medical school in four years, and post-graduation residencies in three-to-five years.

The proposed nine-year reporting period does not account for the many students who do not complete medical school in four years. In fact, the 4-year graduation rate for both allopathic and osteopathic students in roughly 85%, meaning many students (roughly 95%) complete the undergraduate portion of their medical education in 5-6 years. Also, the typical post-graduate

residency is 4.5 years; some, like orthopedics and neurology, last significantly longer. Some students may also continue their education by participating in a fellowship, extending the reporting period to an unspecified time.

A physician-resident's modest income is generally insufficient to begin full repayment of educational loans. Medical students and residents depend on federal financial aid options, such as income-based repayment and forbearance, to postpone or reduce their obligations until they become licensed physicians earning a full salary. As a result, *ED should not consider income during residency training as an appropriate measure of D/E rates.*

Imposing GE standards on medical students harms the disadvantaged applicants who rely on Title IV funding and who otherwise might not attend medical school. ICOM urges ED to consider the uniqueness of medical education training and adjust the proposed GE calculation timeframe within the proposed rule to begin upon the completion of post-graduate student's completion of their medical residency.

Thank you for your consideration. Please do not hesitate to contact me at tfarnsworth@icom.edu or via cell at (208) 705-4916 with questions or to request further information.

Sincerely.

Tracy J Farnsworth, EdD, MHSA, FACHE
President and CEO
tfarnsworth@icom.edu

ROCKY VISTA UNIVERSITY
OFFICE OF THE PRESIDENT AND PROVOST
Achieving new heights in medical education

June 16, 2023

Joe Massman and Vanessa Gomez
U.S. Department of Education
Office of Postsecondary Education
400 Maryland Avenue SW, 5th floor
Washington, DC 20202

Dear Ms. Massman and Ms. Gomez:

Thank you for the opportunity to comment on the issues of gainful employment (GE), financial value transparency, certification procedures and administrative capability as part of the recently proposed notice of proposed rulemaking on these and other topics. I am writing to express concern that the proposed GE rules and changes to certification procedures and administrative capability would undermine the ability of Rocky Vista University (RVU) to educate future osteopathic physicians and physician assistants, despite decade-long successes of this institution in producing the health care personnel our nation so desperately needs.

RVU is a for-profit health sciences university located in Parker, Colorado; Ivins, Utah and Billings, Montana. RVU is one of two medical schools in Colorado and one of three schools in Utah. RVU's Billings campus is one of only two medical schools in Montana. The Mountain West region of our country has a severe shortage of primary care physicians and other medical providers, causing many families in rural areas to travel long distances to receive medical care. RVU works to remedy these issues in the region and across the nation by educating graduates to serve in rural and underserved areas as primary care physicians.

At RVU we take great pride in being one of the most successful medical schools in the country. The institution has had a greater than 99 percent residency placement rate since its first graduating class. This means nearly every graduate of RVU has been "gainfully employed" through participation in a residency – the next step for any medical school graduate. In addition, RVU students have demonstrated mastery of the knowledge we teach them by achieving a 97 percent first time pass rate on national licensing exams.

RVU also has the honor of enrolling the highest percentage of students on military scholarship of any civilian medical school in the country. These military students choose to attend our institution due to the focus and quality of the education they receive. Post residency, these students fulfill the service commitments required by their scholarships by practicing medicine in our nation's armed services.

These outcomes and our focus on military medicine lead to thousands of applicants each year despite only approximately 450 open slots for our Doctor of Osteopathic Medicine program at our three campuses. This allows RVU to be selective in our admissions process to foster quality and excellence in our graduates. Our participation in the Title IV student loan program allows us to enroll the most

qualified students, regardless of their income status. This ensures that future doctors are more racially and economically representative of all Americans – not just those that have the financial means to attend medical school.

With respect to the NPRM's provisions related to gainful employment, RVU urges the Department to exempt medical schools from having to comply with its requirements. The NPRM does not properly account for both the higher levels of borrowing necessary to attend medical school and the high earnings afforded medical school graduates. Instead, the rule seems largely intended to compare borrowing costs for undergraduate programs and expected income of such students. While medical school is indeed a costly graduate degree to obtain, primary care physicians can earn salaries of $140,000 a year and more once they complete their residency and optional fellowships. This income level permits graduates to afford their monthly student loan payments.

The debt to earnings ratios required by the NPRM, again adopting the Obama-era approach, may needlessly jeopardize the ability for RVU to continue to participate in Title IV and train tomorrow's physicians. A rule intended to reign in high debt and low earnings programs should not be applicable to graduate medical education. This is not the situation in which we find ourselves at RVU or at medical schools generally in our country - for-profit and nonprofit alike. We urge ED to exempt graduate medical education programs from the GE requirements.

With respect to the financial value transparency provisions, we do want to compliment ED for attempting to apply, in a fashion, the GE debt to earnings and earnings metrics to all Title IV programs. The added transparency and labeling of such programs under the NPRM is justified in giving students comparable information at the program level across sectors of higher education institutions. If the Department insists on maintaining GE requirements for all for-profit institution programs, transparency of non-profit and public institution programs on such metrics is necessary.

With respect to the NPRM's certification procedure provisions, we are concerned about the inclusion of § 668.14(a)(32) pertaining to the applicability of State consumer protection laws. This new provision would require institutions to certify compliance with state consumer protection laws related to closure, recruitment and misrepresentation. This would seem to undermine the concept of state reciprocity agreements as operationalized through the National Council of State Authorization Reciprocity Agreements and the four regional compacts. The proposed § 668.14(a)(32) would undermine this concept of reciprocity by allowing individual states to enforce certain consumer protection laws on out-of-state institutions. This will only make it harder for institutions to operate across state lines – something that is critically necessary to ensure students have the best educational opportunity.

Rather than include this additional program participation agreement item, we urge the Department to consider forgoing its inclusion in the final version of this regulation and instead debate any such related matters as part of the forthcoming negotiated rulemaking sessions on state authorization and distance education. In these sessions, the Department will have the correct stakeholders to negotiate the impact of the NPRM's provisions and other related matters.

Lastly, we request that the Department clarify the intent of the proposed § 668.16(r) requiring institutions to provide students geographically accessible clinical or externship opportunities related to completion of a credential or licensure. Graduate medical students attend medical school for four years and then participate in three-to-seven-year residencies depending on their intended specialty of medicine. In the third and fourth year of medical school, students participate in clinicals where they are

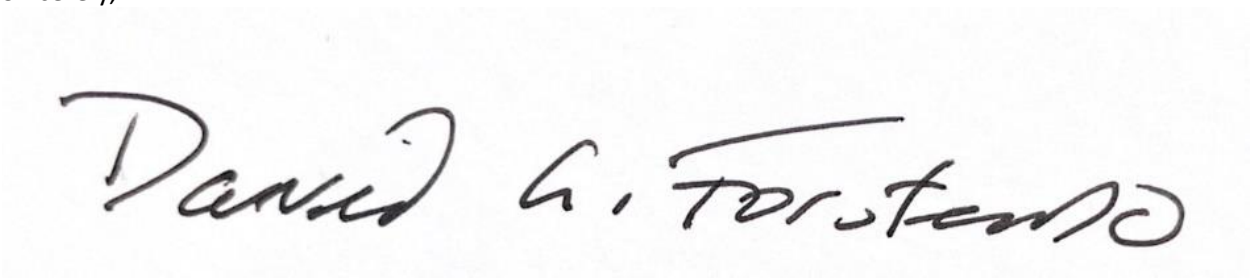
exposed to different medical environments while furthering their knowledge and skills. Under these clinicals, which take place in hospitals, clinics and doctor's offices, students learn under the supervision of doctors and other health professionals who evaluate and assess how students are progressing in the studies required by their medical schools.

It is unclear to us what the NPRM is seeking to cover regarding the provision of clinical opportunities through the proposed § 668.16(r). The clinicals that third- and fourth-year medical students participate in are often in close proximity to the geographic location of the medical school, but this cannot be guaranteed based on medical facility availability and the preference of the medical student. Medical schools partner with such clinical locations but have no ability to force the participation of a specific medical school student. Third- and fourth-year students also have not yet "completed" medical school, which raises questions about the applicability of the proposed provision in this situation. For these reasons, we expect that the proposed § 668.16(r) would not apply to such situations but would urge the Department to clarify this lack of applicability in the final rule.

In addition, with the requirement to obtain a residency post-graduation, medical school students will seek to match with the program that best fits their needs. This program may or may not be in close geographic proximity to the medical school the graduate attended. Equally important is that graduate medical schools do not control whether a student receives a residency slot as this is the next phase in the requirements a physician must meet to eventually be licensed to practice by a state. This is a requirement former students complete after their medical school studies and is no longer under the control or supervision of the student's former school. Likewise, a small portion of graduating medical school students do not match with a residency program each year. Additionally, some medical school graduates do not pursue residency, but rather pursue careers in public health policy, biotech, research, teaching, etc. The graduate medical school such students attended has no ability to "force" a residency program to take any student – students earn these slots based on their interest and merit. For these reasons, we expect that proposed § 668.16(r) would also not apply to such situations but would urge the Department to also clarify this lack of applicability in the final rule.

Thank you for your attention to this matter and for considering the concerns of our school and the way in which the NPRM would impact our ability to educate future physicians.

Sincerely,



David Forstein, DO, FACOOG
President and Chief Executive Officer