American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 17, 2025 **RIN 1801-AA28**

The Honorable Linda E. McMahon
Secretary
Department of Education
400 Maryland Ave., SW
Washington, DC 20202

RE: William D. Ford Federal Direct Loan (Direct Loan) Program

Dear Secretary McMahon:

On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment the proposed rule entitled "William D. Ford Federal Direct Loan (Direct Loan) Program." This proposed rule would amend the regulations on the Public Service Loan Forgiveness (PSLF) program to exclude employers that engage in activities that have a "substantial illegal purpose."

ACEP understands the intent of the proposal and appreciates the need for efforts to prevent abuse or misuse of federal programs and taxpayer dollars, but we are deeply concerned about the impact that the proposed changes to redefine a "qualifying employer" under the PSLF program could have on physicians who rely on this longstanding program to repay their student loans, particularly for reasons that may be entirely outside of their control or unrelated to the care they provide to patients in their communities. We therefore urge the Administration to reconsider its approach.

Public Service and Individual Eligibility

Public service is a laudable cornerstone of our health system, and PSLF appropriately recognizes individuals who dedicate much of their careers to serving the public. That service should be judged by the care clinicians provide, not on who signs their paycheck. Outside of their immediate clinical responsibilities, physicians rarely control, direct, or even influence what their employer does. This is particularly true for trainees and those practicing in safety-net setting. Tying PSLF eligibility to an employer's unrelated policies or service lines would unfairly penalize clinicians for decisions they do not make and cannot control or change.

Use Objective, Clinical Criteria

PSLF credit for clinicians should be based on what the individual has actually done during their service: providing medical care to patients that meets recognized standards

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

of care as determined by their specialty. Those objective, specialty-driven criteria—rather than an employer's separate activities—are the appropriate measures for determining whether a participating physician's work constitutes qualifying public service.

EMTALA Considerations

In defining a "substantial illegal purpose," the proposed rule introduces a new definition of "aiding or abetting" under § 685.219(b)(1) that could possibly impact emergency physicians' ability to comply with the Emergency Medical Treatment & Labor Act (EMTALA). As physicians dedicated to providing emergency care to anyone, anytime, we are deeply concerned that the proposed definition of "aiding or abetting"—particularly the inclusion of immigration law violations—are ambiguous and risk capturing activities inherent to the provision of lawful, lifesaving medical care. EMTALA requires hospitals with dedicated emergency departments (EDs) to provide access to emergency services and stabilizing treatment for all individuals. It is possible—and indeed common—for undocumented immigrants to present to EDs and emergency physicians to provide them with stabilizing care, as federal law requires. Under the proposed definition, such lawful care could be construed as "aiding" undocumented individuals. If the provision of such medical care were indeed to fall within the definition of "aiding or abetting," nearly every hospital with an ED would be disqualified as PSLF employers. This would undermine the very purpose of PSLF by stripping eligibility from the clinicians most committed to caring for underserved populations.

We appreciate that this administration is a strong proponent of EMTALA. In the spirit of preserving this essential law, we urge the Department to clarify in the final rule that no policy or definition in the rule will impede the ability of physicians to carry out their obligation under EMTALA to stabilize all patients that come to the ED.

Impacts on Physicians and Trainees

Under the proposed policy, physicians who are employed by a PSLF-qualifying employer may find themselves in a situation where, through no fault of their own, they would lose their eligibility to the PSLF program. While some physicians could possibly change jobs to preserve their access to the PSLF program, that could be difficult or impossible in many circumstances, especially for emergency physicians who face unique employment dynamics compared to other specialties that often limit their ability to find new opportunities in their community. In addition, residents are not able to just "switch" residency programs. Once applicants match to a residency program, they are expected to complete their entire residency in that same position. Switching residency programs midstream (when even possible) often requires forfeiting prior training credit, repeating rotations, relocating on short notice, and in some cases jeopardizing visa status for international medical graduates—at a time when off-cycle positions are exceedingly scarce and contractual obligations limit flexibility. For those unable to switch, they can face career defining consequences including an inability to practice independently and an inability to become board certified.

Additionally, the closure of a residency program is a highly disruptive process for hospitals, residents, and the community. The demand for patient care does not diminish when a residency program ends, which means hospitals must adapt to continue delivering care. This often involves recruiting and onboarding new staff, a process that can take weeks or even months. While hospitals make every effort to maintain continuity, delays and disruptions can occur.

From the residents' perspective, a program closure is not just disruptive; it can be life-altering. Residency training is much more than a job or an educational program. In some cases, there may be only one program available in a specific geographic area, necessitating a move to a new town or city. This is only the beginning of the challenges faced. A major hurdle is finding a program that has the capacity and resources to accept the resident. For instance, residents in training need access to a certain number of cases and procedures, such as intubations, but these procedures may be limited.

Once a new program is identified, the resident must secure approval from the Accreditation Council for Graduate Medical Education (ACGME) to allow the program to increase their resident count. After the resident arrives at the new program, a new educational plan and schedule of rotations must be created. This curriculum may differ from what the resident experienced in their previous program, since the topics they covered might not align with the sequence of the new program.

For example, imagine switching schools where you were supposed to learn Spanish in the first year and French in the second. If your new school teaches French first and Spanish second, you would end up learning two years of Spanish while speaking French. In the context of residency, this could mean that you receive extensive training in trauma but none in cardiology.

Transferring residency programs midway often requires forfeiting previous training credits, repeating rotations, and relocating on short notice. For international medical graduates, this shift can jeopardize visa status. For those unable to transfer, there can be significant career consequences, such as an inability to practice independently or become board certified.

Recent data shows that the average medical school debt is nearly $235,000, and the average debt of medical school graduates with both medical school and premedical debt is nearly $265,000. In addition, a RAND report from April 2025 found that concerns about the high costs of medical school and the debt burden graduates are faced with (among others) were cited as factors that make it more difficult to recruit and retain a sufficient number of residents in emergency medicine. Our emergency physician members have often noted that the PSLF program has been their lifeline, and we believe that it must be preserved and even strengthened. Finalizing this proposal could wind up dissuading a new generation of physicians from pursuing emergency medicine and could jeopardize the pipeline of those willing to serve in these critical safety net roles. This is also especially true for many physicians pursuing careers in primary care in rural or underserved communities who may suddenly find their desired specialty, practice model, or practice location is simply not financially viable long-term. This will further exacerbate the already significant barriers many patients face accessing primary care, and will in turn drive more patients to emergency departments (EDs), increasing the burden on our already-strained EDs throughout the country, thereby limiting access to lifesaving emergency care for our patients and worsening overall health outcomes.

We are also concerned about the impact this policy could have on the overall physician workforce. As the population in the United States continues to grow and age, demand is greater than ever for physicians in every corner of the country. Yet, according to a report from the Association of American Medical Colleges (AAMC), the United States will face a shortage of up to 86,000 physicians by 2036. To address this shortage, we must not only sustain but grow the number of students graduating from medical school. We fear that this policy could lead to a decline in medical school enrollment and exacerbate already painful shortages.

ACEP strongly urges the Department of Education to consider how its proposal could affect physicians and the patients they serve prior to finalizing any policy so that we can sustain a well-trained, dedicated, and robust physician workforce. The Department should ensure that medical students, residents, and physicians are not negatively impacted by these proposed changes and instead are provided with wide availability in terms of employers so that physicians can successfully enter and fulfill their obligations to the PSLF program. To safeguard the PSLF program's purpose while addressing program integrity, we urge the Department to consider:

1. Clarifying that no definitions or policies in the rule would limit hospitals' or clinicians' ability to fulfill all their EMTALA obligations.
2. Basing clinician eligibility on individual service that meets evidence-based, specialty-recognized standards of care, not on an employer's separate activities.
3. Including clear safe-harbor protections so that clinicians are not penalized for employer actions outside their control, including a non-retroactivity provision for previously accrued qualifying payments.
4. Providing transition flexibility for trainees and early-career physicians, recognizing the limited availability of off-cycle positions, contractual constraints, and immigration considerations.

Emergency physicians serve every community, every day, and often under the most difficult circumstances. ACEP supports the Administration's goal of a healthy America and is deeply concerned that jeopardizing support for physician training will only deepen access gaps, strain the health care system further, and endanger the health and safety of our nation as a whole.

We appreciate the opportunity to provide comments. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Advocacy and Practice Affairs at lwooster@acep.org.

Sincerely,

L. Anthony Cirillo, MD, FACEP
President, American College of Emergency Physicians