AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

August 12, 2022

The Honorable Miguel Cardona
Secretary
U.S. Department of Education
400 Maryland Avenue, SW, Room 7E307
Washington, DC 20202

Re: Docket ID ED-2021-OPE-0077: Student Assistance General Provisions, Federal Perkins Loan Program, Federal Family Education Loan Program, and William D. Ford Federal Direct Loan Program

Dear Secretary Cardona:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on the Student Assistance General Provisions, Federal Perkins Loan Program, Federal Family Education Loan Program, and William D. Ford Federal Direct Loan Program proposed rule. We understand the need to help ensure that individuals are given fair loan terms and that they are provided forgiveness under the public service loan forgiveness program when they are providing qualifying services. As such, we appreciate that the Administration is reviewing and refining the rules related to federally held student loans.

Public Service Loan Forgiveness (PSLF) Employee or Employed Definition Change

The AMA urges the U.S. Department of Education (Department or ED) to adopt language clarifying its definition of *employee or employed* so that Texas and California physicians working full-time in private non-profit hospitals and other organizations falling under the definition of "public service organization" (PSO) and meeting all the other PSLF requirements may lawfully participate in the PSLF Program. The AMA appreciates the Department's receptiveness to input regarding how to modify PSLF Program regulations so that private non-profit hospitals and physicians in California and Texas will be able to participate in the PSLF Program to the same extent that physicians, non-physician practitioners, and hospitals participate in the PSLF Program in other states.

In California and Texas, physicians working at private, non-profit 501(c)(3) hospitals, cannot be employed by the hospital under state laws known as the "bar on the corporate practice of medicine."[1] While not employed by a hospital, California and Texas physicians are required under state laws to practice in hospitals only by authority of staff privileges conferred as part of their membership on the hospital's medical staff. The Department has previously stated that individuals are not eligible for the PSLF Program if they "are contracted to work for the organization or individuals who are hired by a for-

[1] *See* California Business and Professional Code Section 2052 and 2400; Conrad v. Medical Board, 48 Cal. App. 4th 1038 (1996); 11 Ops. Cal. Atty. Gen 236 (1948) (private nonprofit hospital may not employ physicians and charge patients for services).

profit company that has a contract with the public service organization."[2] Moreover, because the current definition of "employee or employed" requires a private, non-profit hospital to hire and pay the physician, this definition, in conjunction with the Texas and California prohibitions, bars many physicians and private non-profit hospitals in California and Texas from taking advantage of the PSLF Program. In so doing, many Texas and California physicians are denied public health loan forgiveness benefits that would otherwise be available to them if they were practicing in any other state.

The United States faces a looming physician shortage, the most drastic effects of which will disproportionately fall on rural and underserved communities. The PSLF Program has the potential to incentivize physicians to work for qualifying employers, which ultimately will equate to more physicians practicing for 10 or more years in underserved communities. However, not all physicians are able to access this benefit even if they work with underserved populations or for non-profit entities per the bar on the corporate practice of medicine in California and Texas. Although over 44 percent of physicians are planning to participate, or are actively participating, in the PSLF Program, and about 68 percent of hospitals in the United States are qualifying employers, the institutional arrangements of "sponsoring" and "participating" institutions are not generally readily discernible to a medical student or resident investigating training options.[3,4] Moreover, as young physicians try to navigate the Department's complicated employment rules, other non-physician practitioners, including nurses, lab technicians, and physician assistants at the same hospitals are allowed to participate in the PSLF program due to their legal employment relationship with the hospitals. All non-physician practitioners in California and Texas may be employed by private, non-profit hospitals. Only physicians are barred from such employment.

These rules surrounding employment and loan forgiveness in California and Texas have dissuaded physicians from practicing in underserved communities or have resulted in detrimental effects on young physicians who had been planning on participating in the PSLF Program only to find out that they are not eligible even though their non-physician coworkers are. In 2019, 73 percent of medical students graduated with a median debt of $200,000.[5] Moreover, the rising cost of medical school is showing no signs of abating. In fact, the average cost of attending public medical schools for first-year students in 2020-2021 increased by 10.3 percent from the prior year.[6] As such, it is likely that medical students will have to carry even larger student loans in the future upon graduation. The enormous debt load medical students face is further compounded during their low-paying residency and fellowship training (which can last up to eight years post-graduation), especially for residents who are unable to begin repaying student debt immediately. In addition, even if they qualify to have their payments suspended during residency through deferment or forbearance processes, their loans continue to accrue interest that is added to their already staggeringly high student loan balance. This cycle can lead to tens of thousands of dollars of additional debt due to interest accrual. This large loan burden unfortunately pushes physicians in Texas and California out of serving in underserved communities, where they will likely be paid less, when they are unable to rely on the PSLF Program to forgive student loans.

These regrettable barriers to the PSLF Program have left California and Texas with dire access issues including 1,760 federally designated health professional shortage areas (HPSAs) in California and 1,182

[2] 73 Fed. Reg. 37694, 37705 (July 1, 2008).
[3] https://www.aha.org/statistics/faPst-facts-us-hospitals.
[4] https://pubmed.ncbi.nlm.nih.gov/34266790/.
[5] https://store.aamc.org/physician-education-debt-and-the-cost-to-attend-medical-school-2020-update.html.
[6] https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports.

HPSAs in Texas, making them the states with the highest number of HPSAs.[7,8] Moreover, California and Texas are projected to experience the largest physician shortages over the next decade with a shortage of 32,669 positions and 20,420 positions respectively.[9] With the existing and projected physician shortage and the increased demands that have been placed on physicians during the pandemic, the California and Texas state laws that prohibit some hospital employment of physicians need to be resolved within the PSLF Program so that more physicians are drawn to practice medicine in underserved communities in California and Texas.

Unfortunately, the revised definition of "employee or employed" in the proposed rule does not solve this issue, for several reasons. First, private non-profit hospitals and other PSOs in Texas and California do not, and should not, issue W-2s to physicians because state law prohibits such hospitals from directly employing physicians. Second, physicians do not contract with hospitals to provide "payroll or similar services." While some California and Texas physicians may have contractual arrangements with hospitals, those contracts are for the provision of medical services, not payroll services. Physicians often furnish health care services in private non-profit hospital facilities in the absence of any direct or indirect contractual arrangement or affiliation with the private non-profit hospital. Rather, most California and Texas physicians provide health care services solely based on clinical privileges granted to physicians by the private, non-profit hospital after undergoing rigorous credentialing processes. Therefore, the proposed language would not allow physicians and private non-profit hospitals to participate in the PSLF Program where public health services are provided pursuant to clinical privileges.

To ensure that communities in Texas and California may receive public health services to the same extent as those in other states, the AMA urges the Department to adopt the following clarifying language developed by the California Medical Association, Texas Medical Association, and provider organizations following the definition of "*Employee* or *employed*:"

"If state law prohibits a public service organization from directly employing a licensed physician, eligibility for loan forgiveness can be demonstrated by a written certification signed by an authorized official of the public service organization (e.g., hospital CEO, chief medical officer, or medical staff director). The written certification must verify that the physician has been granted authority to work at the public service organization as required by state law (i.e., clinical privileges) and that the physician works full-time, within the meaning of PSLF eligibility requirements, but is not able to be employed by the public service organization because of state law."

Additionally, conforming changes will need to be made to the Borrower Request, Understandings, and Certification, and the Instructions section. These changes should be made as follows:

Borrower Request, Understandings, And Certification

For physicians who are prohibited from being employed by state law, to qualify for loan forgiveness, I must work full-time at a private not-for-profit public service organization/qualifying employer when I apply for and get forgiveness.

[7] https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.
[8] https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[9] https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-020-0448-3.

Instructions Section: Employment Eligibility

If state law prohibits a public service organization from directly employing a licensed physician, eligibility can be demonstrated by a written certification signed by an authorized official of the public service organization (e.g., hospital CEO, chief medical officer, or medical staff director). The written certification must verify that the physician has been granted authority to work at the public service organization as required by state law (i.e., clinical privileges) and that the physician works full-time, within the meaning of PSLF eligibility requirements, but is not able to be employed by the public service organization because of state law.

Adopting this proposed language would not, as the preamble to the proposed rule notes, "expand the universe of qualifying employers but rather [would] adjust for whom a qualifying employer may sign a PSLF form." Instead, this language would merely accommodate a state law doctrine common to Texas and California in a way that would allow communities in those states to benefit from public health services under the PSFL in the same manner enjoyed by communities in every other state.

Extension of Current PSLF Waiver

There is currently a waiver in place that allows federal student loan borrowers to obtain credit for payments which previously did not qualify for PSLF or Temporary Expanded Public Service Loan Forgiveness (TEPSLF). Under the waiver borrowers can receive credit for past payments even if they did not make the payment on time, did not pay the full amount due, or were not on the right repayment plan.[1] However, this waiver is set to end on October 31, 2022. This quickly approaching deadline has unfortunately made it impossible for some employers to certify all of their employees' employment applications before October 31, resulting in some employees being granted the benefits of the waiver while their coworkers are unable to access this assistance. As such, in order for all individuals who are eligible to receive this waiver to take full advantage of it, the AMA urges the Administration to extend the deadline for the waiver.

PSLF Qualifying Employer and Definitions for PSLF (§ 685.219(b))

The Department is proposing to alter the definitions surrounding a qualifying employer for the purposes of the PSLF Program. The Department wants to define "non-governmental public service" as services provided directly by employees of a non-profit organization where the organization has devoted a majority of its full-time equivalent employees to work in at least one of the following areas: emergency management, civilian service to military personnel and military families, public safety, law enforcement, public interest law services, early childhood education, public service for individuals with disabilities and/or the elderly, public health, public education, public library services, school library, or other school-based services. In addition to defining a number of other qualifying areas, the Department proposes to define "public education service" as the provision of educational enrichment and/or support to students in a public school or a school-like setting, including teaching. Moreover, the Department wants to remove the current definition of "public service organization" and replace it with a definition of the term "qualifying employer." The proposed definition includes; (1) A United States-based Federal, State, local, or Tribal Government organization, agency, or entity, including the U.S. Armed Forces or the National Guard; (2) a public child or family service agency; (3) a non-profit organization under section 501(c)(3) of the Internal Revenue Code (IRC) of 1986 that is exempt from taxation under section 501(a) of the IRC; (4) a Tribal college or university; or (5) a non-profit organization that provides a non-governmental public

[1] https://studentaid.gov/articles/take-advantage-pslf-waiver/.

service, attested to by the employer on a form approved by the Department, and that is not a business organized for profit, a labor union, or a partisan political organization.

As the Department is considering changing the definition of qualifying employer, the Department should expand the PSLF Program so that more associations and a larger range of non-profits are considered "qualified employers" if their mission aligns with those laid out in 34 CFR § 685.219.[10] Currently, federal regulations at 34 CFR § 685.219 instruct that non-profit organizations that are not organized under Section 501(c)(3) of the IRC are qualifying employers if they provide certain public service activities. In addition, the U.S. District Court for the District of Columbia found in *American Bar Association v. United States Department of Education* that it was improper to interpret the PSLF qualifying criteria to require that an employer provide a qualifying public service as its "primary purpose." The inclusion of additional non-profits is important as many serve important public interests, and their employees would otherwise qualify for loan forgiveness but for their organizations' non-profit tax status.

However, despite the regulations at 34 CFR § 685.219 and the District Court's opinion, non-profit organizations that provide public services but are not organized under Section 501(c)(3) have been disqualified from the program by the Department. In particular, the AMA has been trying to become a qualified employer under the PSLF Program (see Appendix). The AMA is a 501(c)(6) organization whose mission is to promote the art and science of medicine and the betterment of public health. We are dedicated to removing obstacles that interfere with patient care and confronting the nation's greatest public health crises. We serve the public through a multitude of public service programs and, as such, the AMA meets all the necessary qualifications to be considered a public service organization for purposes of the PSLF Program. It is likely that many other non-profit organizations that are not 501(c)(3) organizations are facing this same challenge. By making it difficult for these organizations to qualify for the PSLF Program, employees, especially those that previously qualified for the PSLF Program at a different employer, are suffering from the disadvantage of not having this program count towards their loan forgiveness even though they are still working at a non-profit organization. The broader qualifying standard set forth in the *American Bar Association* case should be evenly applied to the AMA and other similar organizations that provide important public services so that a larger range of non-profits can attract talented employees to help carry out their public service missions.

Additionally, the proposed definition of "public education service" seems to be overly narrow and unclear. For example, the AMA is an accredited provider of continuing medical education (CME) and develops high-quality educational activities that enhance and expand the knowledge, skills, attitudes, and behaviors of all physicians. CME activities are offered live throughout the year and via the AMA Ed Hub, an educational platform that brings together diverse educational offerings on clinical, practice transformation, and professionalism. Furthermore, the AMA has a memorandum of understanding with the FDA to develop educational content for physicians and patients. Moreover, the AMA has developed multiple public education campaigns on public health issues, including COVID-19. Even though these services are not for students in public school or a school-like setting, they are important to the education of physicians and the public. As such, we would encourage the Department to broaden the proposed definition of "public education services" to include a wider range of education, especially now as COVID-19 is beginning to surge again and Monkeypox is on the rise. Public education must include the public health education of our nation.

[10] https://www.govinfo.gov/content/pkg/CFR-2010-title34-vol3/pdf/CFR-2010-title34-vol3-sec685-219.pdf.

Total and Permanent Disability (TPD) Discharge (§§ 674.61, 682.402, and 685.213)

The AMA understands the need to ensure that all those who are qualified for TPD discharge are given it in a timely and accurate manner. Though the AMA applauds the Department for considering the importance of TPD discharge and agrees with some of the other provisions surrounding TPD discharge in this rule, the AMA does not believe that non-physician practitioners (NPPs) should be allowed to make TPD determinations.

Sections 437(a)(1) and 464(c)(1)(F) of the Higher Education Act of 1965 (HEA) provide for a discharge of a borrower's Perkins or Federal Family Education Loan (FFEL) if the borrower becomes totally and permanently disabled as determined in accordance with the Secretary's regulations, or if the borrower is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 60 months. Currently, a TPD discharge may be certified by a doctor of medicine (MD) or a doctor of osteopathy (DO). In addition, under certain circumstances, a borrower may currently qualify for a TPD discharge based on a Social Security Administration (SSA) notice of award indicating that the borrower qualifies for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits.

However, under proposed §§ 674.61(b)(2)(iv), 682.402(c)(2)(iv), and 685.213(b)(2), a TPD discharge application would be able to be certified by a nurse practitioner (NP), a physician's assistant (PA) licensed by a State, or a licensed certified psychologist at the independent practice level, in addition to an MD or DO. If this proposed rule is implemented as currently written, conforming changes identifying the additional medical professionals who would be authorized to certify a TPD discharge application and the additional SSA documentation that would be acceptable for a TPD discharge would be made throughout §§ 674.61(b), 682.402(c), and 685.213(b) of the Perkins, FFEL, and Direct Loan regulations.

Current law prohibits non-physician health professionals from making TPD determinations and reserves this function to physicians who have the education, training, and expertise to make these evaluations. The AMA remains steadfast in its commitment to patients who have said repeatedly that they want and expect physicians to lead their health care team and participate in their health care determinations. In a recent survey of U.S. voters, 95 percent said it is important for a physician to be involved in their diagnosis and treatment decisions.[11] However, by removing the requirement that those individuals that are potentially totally and permanently disabled see a physician to determine TPD, this rule could be effectively removing physicians from the care team and set up our TPD discharge determination system for suboptimal health outcomes and increased costs, without improving access to care.

The AMA is concerned that, though well-intentioned, the proposed rule will jeopardize patient care. State scope of practice laws have certain limitations when it comes to NPs, PAs, and psychologists diagnosing, prescribing, treating, and certifying an injury and determining the extent of a disability. The federal government, by allowing NPPs to make TPD discharge determinations, would be setting a precedent that is antithetical to state scope of practice laws and could set the benchmark for the states. This has happened repeatedly with Medicare coverage determinations, for example, setting the benchmark for private plan coverage determinations. It is extremely important to keep physicians at the center of the health care team, especially when making decisions as important as TPD. By potentially removing physicians from this decision-making process the federal government would be setting a dangerous precedent that could dissuade these patients from seeing physicians for their care and encourage other

[11] https://www.ama-assn.org/system/files/scope-of-practice-protect-access-physician-led-care.pdf.

federal agencies and states to make similar changes due to the misconception that it will increase access and decrease cost.

Moreover, while all health care professionals play a critical role in providing care to patients, and NPs, PAs, and psychologists are important members of the care team, their skill sets are not interchangeable with those of fully educated and trained physicians. This is fundamentally evident based on the difference in education and training between the distinct professions. Physicians complete four years of medical school plus three to seven years of residency, including 10,000-16,000 hours of clinical training.[12] By contrast, NPs, complete only two to three years of education, have no residency requirement, and have only 500-720 hours of clinical training.[13] Moreover, the current PA education model is two years in length with only 2,000 hours of clinical care and no residency requirement.[14] Patients expect the most qualified person—physician experts with unmatched training, education, and experience—to be diagnosing and treating injured or sick individuals and making often complex clinical determinations on the nature of an injury and extent of disability. NPPs do not have the education and training to make these determinations and we should not be offering a lower standard of care or clinical expertise during TPD discharge determinations.

It is more than just the vast difference in hours of education and training that matter, but also the difference in rigor and standardization between medical school/residency and NP and PA programs that matter and must be assessed. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients.[15] During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess their readiness for licensure. At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. NP programs do not have similar time-tested standardizations. For example, between 2010-2017, the number of NP programs grew by more than 30 percent, with well over half of these programs offered mostly or completely online, meaning less in-person instruction and hands-on clinical experience.[16] In addition, many programs require students to find their own preceptor to meet their practice hours requirement, resulting in variation among students' clinical experiences. This variation in preceptorship and lower educational standard creates difference in qualifications among NPs and leaves a large gap in the knowing-doing bridge which leaves NPs unable to handle the complexity of the clinical environment, inexperienced in teamwork, and lacking knowledge about patient care.[17] This difference in education highlights the lack of ability for these NPPs to make complex medical determinations such as TPD on their own.

---

[12] https://www.ama-assn.org/system/files/scope-of-practice-physician-training.pdf.
[13] *Id*.
[14] https://college.mayo.edu/academics/explore-health-care-careers/careers-a-z/physician-assistant/.
[15] https://medicine.vtc.vt.edu/content/dam/medicine_vtc_vt_edu/about/accreditation/2018-19_Functions-andStructure.pdf.
[16] David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger. Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US 10.1377/hlthaff.2019.00686 HEALTH AFFAIRS 39, NO. 2 (2020): 273–279.
[17] https://vdocument.in/closing-the-education-practice-gap-toward-nursing-education-according-to-the-survey.html?page=4.

Moreover, NPPs are less accurate than physicians in their medical determinations, including prescribing, ordering x-rays, and engaging specialists. As such, since it is important to make TPD determinations that are the most accurate for the sake of the patient and the Administration, NPPs should not be allowed to make TPD determinations.

NPPs' lower medical decision-making accuracy can be seen through multiple examples, including the strong evidence that increasing the scope of practice of NPs and PAs has resulted in overprescribing and overutilization of diagnostic imaging and other services. For example, a 2020 study published in the *Journal General Internal Medicine* found that 3.8 percent of physicians (MDs/DOs) compared to 8.0 percent of NPs and 9.8 percent of PAs met at least one definition of overprescribing opioids and that 1.3 percent of physicians compared to 6.3 percent of NPs and 8.4 percent of PAs prescribed an opioid to at least 50 percent of patients.[18] The study further found that in states that allow independent prescribing, NPs and PAs were 20 times more likely to overprescribe opioids than those in prescription-restricted states.[19]

Additionally, multiple studies have shown that NPs order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering x-rays increased substantially—more than 400 percent—by non-physicians, primarily NPs and PAs, during this time frame.[20] A separate study published in *JAMA Internal Medicine* found NPs ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[21] The authors opined this increased utilization may have important negative ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding NP scope of practice alone. In addition, a recent study from the Hattiesburg Clinic in Mississippi found that allowing NPs and PAs to function with independent patient panels under physician supervision in the primary care setting resulted in higher costs, higher utilization of services, and lower quality of care compared to panels of patients with a primary care physician.[22] Specifically, the study found that non-nursing home Medicare Accountable Care Organization (ACO) patient spend was $43 higher per member, per month for patients on a NP/PA panel compared to those with a primary care physician. Similarly, patients with an NP/PA as their primary care provider were 1.8 percent more likely to visit the ER and had an 8 percent higher referral rate to specialists despite being younger and healthier than the cohort of patients in the primary care physician panel. On quality of care, the researchers examined 10 quality measures and found that physicians performed better on 9 of the 10 measures compared to the non-physicians.[23]

---

[18] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." Journal General Internal Medicine. 2020; 35(9):2584-2592.

[19] *Id*.

[20] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.

[21] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101-07.

[22] https://ejournal.msmaonline.com/publication/?m=63060&i=735364&view=contentsBrowser.

[23] *Id*.

Additionally, a Mayo Clinic study compared the quality of physician referrals for patients with complex medical problems against referrals from NPs and PAs for patients with the same problems. Blinded to the source of the referrals, a panel of five experienced physicians used a seven-instrument assessment to determine the quality of each referral. Physician referrals received "significantly higher" scores in six of the seven assessment areas: (1) referral question clearly articulated; (2) clinical information provided; (3) documented understanding of the patient's pathophysiology; (4) appropriate evaluation performed locally; (5) appropriate management performed locally; and (6) confidence returning patient to referring health care professional. Physician referrals were also more likely to be evaluated as necessary than NP or PA referrals, which were more likely to be evaluated as having little clinical value.[24]

This sampling of studies clearly shows that NPs and PAs tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, overprescribe antibiotics, and are less able to understand and diagnose complex medical problems[25]—all which increase health care costs and threaten patient safety. Before expanding the scope of practice of all NPs and PAs and essentially removing physicians from TPD determinations, we encourage the Administration to carefully review these studies. These studies have shown that PAs and NPs are significantly less accurate in their diagnoses and treatment when they are not part of a physician lead care team. As such, it would be detrimental to expand NPPs' scope by allowing them to determine TPD and could lead to worse patient outcomes as well as increase the cost associated with TPD determinations since it is likely the NPPs will be less accurate in their determinations, just as they are less accurate in their diagnosis and prescribing.

Furthermore, the AMA notes that one of the main reasons that the expansion of NPPs' ability to make TPD determinations is being considered is a concern for patient access, especially in rural communities. However, expanding the scope of practice for NPPs does not increase patient access in rural or underserved areas. In reviewing the actual practice locations of primary care physicians compared to NPs and PAs, it is clear that physicians and non-physicians tend to practice in the same areas of the state.[26] This is true even in those states where, for example, NPs can practice without physician involvement. The Graduate Nurse Demonstration Project (the Project), conducted by the Centers for Medicare & Medicaid Services, confirmed this finding.[27] One goal of the Project was to determine whether increased funding for Advanced Practice Registered Nursing (APRNs) programs would increase the number of APRNs practicing in rural areas. The results found that this did not happen. In fact, only 9% of alumni from the program went on to work in rural areas. In short, the evidence is clear that expanding scope for NPs and PAs will not necessarily lead to better access to care in rural America. Rather than supporting an unproven path forward, the Administration should consider proven solutions to increase access to care, including supporting physician-led team-based care and increasing the cap.

Therefore, due to the increased education and training of physicians, the ability of physicians to more accurately treat and diagnose disabilities, the lack of additional access provided by expanding scope of

---

[24] Lohr RH, West CP, Beliveau M, et al. Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners. Mayo Clinic Proceedings. 2013;88:1266-1271.

[25] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4. Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.

[26] https://www.ama-assn.org/system/files/scope-of-practice-access-to-care-for-patients.pdf.

[27] The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf.

practice laws, and the negative consequences of removing physicians from the care team, it is imperative that the Administration continue to require that only physicians make TPD determinations.

We appreciate the opportunity to provide information and urge the Department to help ease the pathway to PSLF for physician borrowers, expand the qualifying employers, and respect state scope of practice laws. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org, or by calling 202-789-7409.

Sincerely,

James L. Madara, MD

Appendix

July 20, 2022

U.S. Department of Education
State of Missouri Higher Education Loan Authority
633 Spirit Drive
Chesterfield, MO 63005-1243

Dear State of Missouri Higher Education Loan Authority:

This letter describes the public services provided by the American Medical Association (AMA), which we believe make the AMA a qualifying employer for purposes of the Public Service Loan Forgiveness (PSLF) Program under U.S. Department of Education (DoE) regulations.

The PSLF Program forgives the remaining balance on a student loan borrower's eligible loan after 120 qualifying payments have been made under a qualifying repayment plan while working full-time for a qualifying employer. Federal regulations at 34 CFR § 685.219 instruct that nonprofit organizations that are not organized under Section 501(c)(3) of the Internal Revenue Code are qualifying employers if they provide certain public service activities, among them public safety, public health, and public education.

The AMA is a 50l(c)(6) nonprofit organization whose mission is to promote the art and science of medicine and the betterment of public health. We are dedicated to improving patient care, driving the modernization of medical education, and confronting the nation's greatest public health crises. We serve the public through a multitude of public service programs and, as such, the AMA meets all the necessary qualifications to be considered a qualifying employer for the PSLF Program.

We believe that, because of our public service programs, not only does the AMA meet all the qualifications of a public service organization, but it does so in multiple ways. We respectfully request your consideration of the AMA's eligibility status and our employee's ECF.

We also note that the AMA provides similar public services as other 501(c)(6) organizations, such as the American Bar Association, that have been deemed qualified employers. The PSLF program should allow for more associations and a larger range of nonprofits to be considered a "qualified employer" if their mission aligns with those laid out in 34 CFR § 685.219. Currently, federal regulations at 34 CFR § 685.219 instruct that nonprofit organizations that are not organized under Section 501(c)(3) of the Internal Revenue Code are qualifying employers if they provide certain public service activities. In addition, the U.S. District Court for the District of Columbia found in *American Bar Association v. United States Department of Education* that it was improper to interpret the PSLF qualifying criteria to require that an employer provide a qualifying public service as its "primary purpose." We agree that inclusion of additional nonprofits is important as many serve important public interests, and their employees would otherwise qualify for loan forgiveness but for their organizations' nonprofit tax status.

To assist in your review, we describe below some of the AMA's public service activities that support the AMA's qualification as a qualifying employer.

Public Education

Education is an integral part of the AMA's work to promote the art and science of medicine and the betterment of public health. We support undergraduate medical education (UME) and graduate medical education (GME) in a variety of ways, as well as education of physicians throughout their careers, and education of the public about important issues affecting health.

Medical School Accreditation

The AMA sponsors the Liaison Committee on Medical Education (LCME) in conjunction with the Association of American Medical Colleges, which is an accrediting body for medical educational programs at schools of medicine in the United States. Through the LCME, the AMA currently accredits 143 schools in the United States.

Continuing Medical Education

The AMA is an accredited provider of continuing medical education (CME) and develops high-quality educational activities that enhance and expand the knowledge, skills, attitudes, and behaviors of all physicians. CME activities are offered live throughout the year and via the AMA Ed Hub, an educational platform that brings together diverse educational offerings on clinical, practice transformation and professionalism. The AMA Ed Hub includes education from the JAMA Network, the AMA's STEPS Forward Practice Transformation series, and other signature AMA content covering such areas as ethics, and health care trends. The AMA has a memorandum of understanding with the FDA to develop educational content for physicians and patients. AMA/FDA content developed to date addresses *Talking to Patients About Using the Nutrition Facts Label to Make Healthy Food Choices; Identifying and Treating Foodborne Illness, and Talking to Patients About Food Safety; and Dietary Supplements: What Physicians Should Know*. Ed Hub content is available to physicians and medical students, as well as the general public.

Because of the AMA's work in and commitment to health equity, one of our most popular educational resources is the "Prioritizing Equity" video series, available free without login to the general public, illuminating how COVID-19 and other determinants of health uniquely impact marginalized communities, public health and health equity, with an eye on both short-term and long-term implications. The AMA now offers free CME for the Prioritizing Equity video series, numbering 36 episodes, as well as additional health equity education on the Ed Hub including Health Equity 101 and eight interactive "COVID Black" modules.

The AMA also offers practicing physicians a resource called STEPS Forward, a collection of interactive, educational toolkits offering innovative strategies to allow physicians and their staff to thrive in the evolving health care environment by working smarter, not harder. Clinicians, care team members, administrators, and organizational leaders can use these toolkits to help improve practice efficiency and ultimately enhance patient care, physician satisfaction and practice sustainability. This series includes a CME module on "Addressing Social Determinants of Health: Beyond the Clinic Walls." The interactive module helps physicians identify how to best understand the needs of their community, define a plan to begin addressing SDOH, and explains the tools available to screen patients and link them to resources.

Medical Education

In 2013, the AMA launched the "Accelerating Change in Medical Education" initiative. Today, the 37-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually. One of the earliest innovations to come from the Consortium was the new and innovative curriculum on health systems science, which includes a chapter on social determinants of health (SDOH). Nearly all of the 37 schools in the consortium are addressing SDOH with a focus on ensuring that students recognize the impact of SDOH on health outcomes and are working with inter-professional colleagues to address them. Additionally, several projects are addressing the ongoing shortages of practitioners in primary care, rural-based practice, and community-engaged practice. These projects are working in part with universities to create pathways for residents and students to train in rural, tribal, urban, and other disadvantaged communities to help increase care in those communities and to increase the likelihood that these physicians will remain practicing in these communities post-training. All UME and GME partners in the consortium participated in a series in the fall of 2020 entitled "Combatting Structural Racism in UME and GME" which addressed the pressing need to eradicate racial essentialism in medical education, create more inclusive training environments, and strive for educational equity in our profession.

In addition, in 2019, the AMA announced its Reimagining Residency Initiative, designed to transform residency training to address the workforce needs of our current and future health care system. Many of the applications to the GME initiative have included health systems science training in their proposals.

The AMA Health Systems Science Academy provides faculty development and curricular resources to teach Health Systems Science. The academy serves as a community for national medical educators and health care leaders to work together on an ongoing basis to advance the field through curricular implementation and research development. The AMA also offers a series of free, online education modules—called the Health Systems Science Learning Series—to help students develop competencies in Health Systems Science. The series is available on the AMA Ed Hub. Additionally, the AMA recently collaborated with the National Board of Medical Examiners (NBME) to develop a standardized exam aimed at assessing medical student readiness for residency in Health Systems Science.

FREIDA, developed by the AMA, allows individuals to search from among more than 12,000 programs, all accredited by the Accreditation Council for Graduate Medical Education (ACGME), for a residency or fellowship to support their ongoing training. Users can easily search by specialty and personalize their search with more than 35 filters. Additionally, the FREIDA Residency Calculator allows individuals to estimate expenses, work on a budget, and see how various choices change their total cost.

Public Health and Public Safety

Providing services for the betterment of public health and safety is foundational to the mission of the AMA. For more than 160 years, we have worked to create a healthier future. In fact, the AMA's work to protect the public dates back to the 19th century, when the AMA established a board to analyze quack remedies and nostrums and warn the public about the nature and danger of such remedies. Our public health and safety work continues to be central to our mission today and spans a broad spectrum of issues. This work is done, in large part, by supporting the work of physicians and working to strengthen public health systems. Our physician employees provide the necessary clinical expertise to enable the AMA to develop clinical tools for direct patient care.

Evidence-Based Preventive Services

Preventive care reduces the risk for diseases, disabilities, and death, yet millions of people in the United States do not get recommended preventive health care services. The AMA serves as a liaison to the US Preventive Services Task Force, the Community Preventive Services Trask Force, and the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The AMA works to ensure that evidence-based prevention recommendations are disseminated to physicians and works to ensure that clinicians have the information they need to implement these recommendations in practice. Physicians are a trusted source of information for patients and their strong recommendation for evidence-based care is important.

Chronic Disease Prevention

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. In collaboration with health care leaders and organizations, the AMA is developing and disseminating new approaches to prevent progression of prediabetes to type 2 diabetes and to achieve better control of high blood pressure, two of the nation's most common chronic diseases. The AMA engages in this work on its own and through strategic alliances with various organizations including the CDC and the American Heart Association. This work includes public service announcement campaigns to targeted audiences via radio, billboard advertisements and other media.

To help prevent Type 2 diabetes, the AMA, in coordination with the CDC, offers a clinical toolkit for physicians and other health care practitioners entitled, Prevent Diabetes STAT. The toolkit helps health care teams screen, test, and refer at-risk patients to in-person or online diabetes prevention programs. The toolkit includes, among other things, a patient questionnaire, a point-of-care prediabetes identification algorithm, steps to generate a registry of patients at risk for Type 2 diabetes, and a guide to adapt and incorporate an identification and referral process into electronic health records.

In response to the high prevalence of uncontrolled blood pressure and to support physicians in managing their patients' high blood pressure, the AMA, in collaboration with the American Heart Association, developed Target: BP, a national initiative offering a series of online tools and resources, using the latest evidence-based information. Target: BP helps health care organizations and care teams, at no cost, to improve blood pressure control rates through an evidence-based quality improvement program and recognizes organizations committed to improving blood pressure control.

Because high blood pressure disproportionately affects Black adults, AMA, along with physician groups and heart health experts, launched the Release the Pressure campaign. The campaign has reached over 300,000 Black women, encouraging them to take a pledge to "know your numbers, talk with your doctor, bring your squad," trained 75,000 individuals to track their blood pressure via self-monitoring blood pressure tracking tools, and engaged 40,000 physicians to improve patient care. Through Release the Pressure, the AMA is also working with GirlTrek, the largest public health nonprofit for African American women and girls that encourages women to use walking as a practical first step to inspire healthy living, to support Black women's health.

The AMA's philanthropic arm, The AMA Foundation, launched the Community Health Program in 2019 to further increase health equity and improve health outcomes by creating a cohort of community-based organizations throughout the country to prevent and manage Type 2 diabetes and hypertension for vulnerable and underserved populations. The cohorts utilize a variety of approaches with their patient clients—health screenings, nutrition classes, cooking demonstrations, physical fitness options and access

to healthy foods—all delivered in a manner uniquely suited to the needs of their communities. The program provides technical assistance webinars and other educational resources, along with financial support.

Infectious Diseases and Immunizations

The AMA has a long-standing history of working to protect the public from infectious disease threats, including through vaccination. The AMA was a founding member of the National Adult and Influenza Immunization Summit, which is dedicated to addressing and resolving adult and influenza immunization issues and improving the use of vaccines recommended by CDC's Advisory Committee on Immunization Practices. The AMA has partnered with the CDC and the Ad Council for the past two flu seasons on a campaign to raise awareness regarding the flu vaccine. As many as 45 million people in the US get sick with the flu each season, resulting in up to 810,000 hospitalizations. Black and Latinx/Hispanic communities have lower vaccination rates than other groups and are vulnerable to disproportionate impact from flu. The "No Time for Flu" campaign encourages Black and Latinx adults to get a flu shot to protect themselves, their families, and their communities. Campaign highlights for the 2021-22 flu season include $7.2 million in donated media, 271,000 unique campaign website visits, 1.8 million media broadcast impressions, and more than 40 percent PSA awareness among Black and Hispanic audiences. The AMA will be continuing this campaign in collaboration with the Ad Council and CDC for the 2022-23 flu season.

The AMA currently has a five-year cooperative agreement with the CDC focused on "Improving Clinical and Public Health Outcomes through National Partnerships to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats." Through this work the AMA is a collaborator in CDC's Project Firstline, a group of diverse health care and public health partners that aims to provide engaging, innovative, and effective infection control training for millions of frontline U.S. health care workers as well as members of the public health workforce. Project Firstline's innovative content is designed so that—regardless of a health care worker's previous training or educational background—they can understand and confidently apply the infection control principles and protocols necessary to protect themselves, their facility, their family, and their community from infectious disease threats, such as COVID-19. Through this work, the AMA has made infection control content available on the AMA Ed Hub, developed a podcast series, "Stories of Care," that explores the intersection of infection control and equity through the voices of health care experts and frontline personnel, and is working with the American Society of Nephrology to develop educational content on infection prevention and control for health care personnel in dialysis centers.

The AMA is also working with the CDC to improve routine screening for infectious diseases. We recognize that every year, millions of Americans are diagnosed with human immunodeficiency virus (HIV), sexually transmitted infections (STIs), viral hepatitis or tuberculosis (TB), and tens of thousands die from their infection. Most of these infections share commonalities, from modes of transmission to demographic, social and economic conditions that increase risk. The asymptomatic nature of HIV, STIs, hepatitis C (HCV) and latent tuberculosis infection (LTBI) makes it difficult for a patient to understand their risk, the disease incidence in their population as well as making it difficult for them to seek the testing needed. Persons unaware of their health status cannot take advantage of the treatment needed to improve their health and can unknowingly transmit the virus to other individuals.

While significant progress has been made in diagnosing and treating individuals with these infections, routine screening and early detection are critical to ensure individuals receive the appropriate treatment and lower the risk of transmission of these infectious diseases. The AMA has conducted in-depth

interviews with physicians, members of the health care team, health system representatives, electronic health record vendors, community health center representatives, and health departments to identify the drivers and barriers to routine screening and we held virtual clinic site visits to identify optimal approaches to screening. A toolkit has been developed highlighting best practices to improve routine screening. The AMA will be pilot testing the toolkit with six community health centers across the country that will implement each of the elements of the toolkit to determine the impact on routine screening for these infectious diseases. Based on lessons learned from the pilot sites, we will disseminate the toolkit more broadly.

Responding to Public Health Crises

Physicians are on the front lines in the effort to address the major issues that impact the health of the nation—from the COVID-19 pandemic, firearm violence, the climate crisis and beyond. The AMA has consistently offered physicians tools and resources they need to face these challenges head on.

COVID-19

Throughout the COVID-19 pandemic, the AMA has been the leading ally for physicians and patients and a trusted source for clear, evidence-based COVID-19 guidance. As the nation's largest physician organization, the AMA is uniquely qualified and equipped to provide accurate science and medical information to physicians, policymakers, the media, and the public. For the past two years, the AMA has worked non-stop to defend science and provide evidence-based information to the public. Throughout the crisis, we led a comprehensive, multi-pronged campaign to remove obstacles to prevention, diagnosis, and treatment, providing support for front line health care workers, and addressing patient concerns.

Early in the pandemic, the AMA recognized there was going to be a shortage of personal protective equipment (PPE) in the Strategic National Stockpile (SNS). Once supplies improved, the AMA supported local distribution of 100,000 masks for community health and social service providers, in collaboration with Project N95, and launched the #MaskUp campaign, a robust effort to encourage mask wearing among the public and to debunk myths associated with masks. The #MaskUp campaign followed an important collaboration between AMA, American Hospital Association, and American Nurses Association on a public service announcement (PSA) urging the American public to take three simple steps to help stop the spread of COVID-19: wear a mask, practice physical distancing, and wash hands frequently.

To further advance COVID-19 vaccine education and boost confidence in the safety and effectiveness of vaccines authorized by the U.S. Food and Drug Administration and recommended by the CDC, we worked with the Ad Council and the COVID Collaborative, a coalition of the nation's experts in health, education, and the economy, to launch "It's Up to You." Created in close cooperation with the CDC, the campaigns urged the American public to visit GetVaccineAnswers.org (DeTiDepende.org in Spanish) for information about COVID-19 vaccines, with the ultimate goal of helping the public feel confident and prepared to get vaccinated.

The AMA developed a COVID-19 resource center for physicians to provide the latest guidance on infection prevention and control, vaccines, and therapeutics as well as foundational guidance in medical ethics for health care professionals and institutions responding to the COVID-19 pandemic. The AMA also led efforts to disseminate information and best practices during the public health emergency. Hosted by AMA physician leaders, each installment of the "COVID-19: What Physicians Need to Know" webinar series provided fact-based insights from the nation's highest-ranking subject matter experts

working to protect the health of the public. In addition, the AMA created public-facing repositories of COVID-19 health equity resources and initiatives. We also advanced knowledge around COVID-19 through creating reports and supporting local and national data efforts. Reports included Latinx COVID-19 Health Inequities and Experiences of racially and ethnically minoritized and marginalized physicians in the U.S. during the COVID-19 pandemic. AMA staff served on Chicago's Rapid Response Committee via West Side United, the task force that set up the Morehouse Health Equity tracker, the APHA Latinx COVID-19 Task Force, and the RWFJ National Commission to Transform Public Health Data Systems. Later in 2022, we will launch a guide on Centering Equity in Crisis Preparedness and Response.

Overdose Epidemic

The AMA is committed to reversing the nation's drug-related overdose and death epidemic that killed more than 107,000 Americans in 2021. In 2014, the AMA convened the AMA Substance Use and Pain Care Task Force to coordinate ongoing efforts among more than 25 leading national, specialty, and state medical associations. Task Force activities and recommendations have contributed to a nearly 50 percent reduction in opioid prescribing since 2012, more than 900 million queries of state prescription drug monitoring programs, and certification of more than 100,000 physicians and other health care professionals to provide buprenorphine in-office for the treatment of opioid use disorder. The AMA also has developed specific recommendations that employers can take to help end the epidemic. The AMA is also a member of the National Academy of Medicine Action Collaborative on Countering the US Opioid Epidemic, which is committed to developing, curating, and disseminating multi-sector solutions designed to reduce opioid misuse and improve outcomes for individuals, families, and communities affected by the opioid crisis.

Climate Crisis

The AMA has declared climate change a public health crisis that threatens the health and well-being of all people. The AMA supports policies that limit global warming to no more than 1.5 degrees Celsius and is committed to reducing U.S. greenhouse gas emissions, aimed at carbon neutrality by 2050. We recognize and support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. The AMA is a member of the Steering Committee for the Medical Society Consortium on Climate and Health, which recognizes climate change is harming Americans today and doctors have a crucial part to play in raising awareness of the public about these issues. As part of AMA's ongoing commitment to address climate change, the AMA is also a member of the National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector—a public-private partnership among the health sector aimed at mitigating climate change and protecting human health, well-being, and equity by addressing the sector's environmental impact.

Firearm Violence

The AMA has a long history of addressing firearm violence. We acknowledged the epidemic of firearm violence when, in 1987, our House of Delegates first set policy on firearms. The House recognized the irrefutable truth that "uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and death." In 1993 and 1994, we resolved that the AMA would, among other actions, "support scientific research and objective discussion aimed at identifying causes of and solutions to the crime and violence problem." In 2016, the AMA House of Delegates again declared firearm violence a public health crisis.

We know that each year more than 45,000 Americans die from firearm violence, and recent data from the Centers for Disease Control and Prevention indicate that firearm deaths are increasing, and disparities are widening, with young people, males, and Black people experiencing the highest firearm homicide rates.

In addition to developing numerous policy recommendations to reduce firearm trauma, injury and death, the AMA has also developed resources to help physicians address firearm violence, including a continuing medical education (CME) module designed to assist physicians in recognizing risk factors and effectively communicating with patients to reduce the risk of firearm injury and death. The AMA will continue to support policies and advocate for initiatives aimed at encouraging firearm safety and preventing firearm-related injuries and deaths.

Tobacco

A prime example of the AMA's efforts to improve public safety is our work to reduce smoking, which began with an official acknowledgement of the harms of smoking in 1964 and continued with a "war on smoking" launched in 1972. Tobacco remains the leading cause of preventable death worldwide. Over the past five decades, we have continued to work to prevent another generation from becoming addicted to nicotine by, among other things, raising public awareness via a report published in *JAMA* in 1995 that revealed tobacco companies' deceptive practices to hide the dangers of smoking and a mass transit ad campaign encouraging commuters to quit smoking. The AMA encourages clinicians to ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA approved pharmacotherapy for cessation to adults, including pregnant persons, who use tobacco.

Most recently the AMA supported the FDA's proposal to ban menthol-flavored cigarettes, a move that will save hundreds of thousands of lives in the coming decades while reducing health inequities. If the sale of menthol-flavored cigarettes is indeed banned, the FDA projects a 15.1% drop in smoking within 40 years, which would help save between 324,000 to 654,000 lives. The agency also projects the ban would stop between 92,000 and 238,000 smoking-related deaths among African Americans—that is up to 6,000 Black lives saved each year.

The AMA has also warned of the dangers of electronic nicotine delivery systems and long called for these products to have the same marketing and sales restrictions that are applied to tobacco cigarettes, including bans on TV advertising. This year the AMA successfully pressured social media companies to reject advertisements of e-cigarettes to youth. The AMA also recently applauded the FDA's decision ordering the removal of all JUUL Labs Inc. e-cigarette products from the U.S. market, recognizing that for too long, companies like JUUL have been allowed to sell e-cigarettes that appeal to our nation's youth—ultimately creating another generation of young people hooked on tobacco products.

Behavioral Health Integration

The AMA is committed to combatting the nation's growing behavioral health crisis by helping physician practices expand access to safe, equitable, high-quality behavioral health care for their patients. Specifically, we are focused on accelerating the adoption of effective and sustainable integration of behavioral health care into physician practices, particularly in primary care. This includes providing physician practices with free education on the critical importance of behavioral health integration (BHI), along with open-source tools and practical strategies for overcoming obstacles to accessible and equitable treatment for their patients' behavioral needs.

Additionally, the AMA led the formation of, and continued financial support for, the BHI Collaborative, a collection of eight of the nation's leading physician organizations with the mission of empowering physicians and their care teams to improve the quality of care and expand patients' access to behavioral health services.

The AMA has also identified a set of practical solutions that key stakeholders—physician practices and health systems, health plans and coverage programs, federal and state policymakers, employers, and private or publicly-traded behavioral health companies—can pursue in order to accelerate the widespread adoption of sustainable BHI.

Strengthening Public Health Systems

The AMA regularly collaborates with national public health organizations to promote the betterment of public health. The Association of State and Territorial Health Officials, National Association of City and County Health Officials and the American Public Health Association (APHA) are all designated as formal public health liaison organizations to the AMA's Council on Science and Public Health.

In 1994, the AMA and the APHA co-convened the Medicine and Public Health Initiative (MPHI). In 1996, MPHI hosted a Congress inviting 400 representatives from Medicine & Public Health and provided grants at the state/local level to build sustainable, collaborative partnerships. In 2002, following the September 11 attacks, the presidents of the AMA and APHA reiterated their dedication to MPHI leading to the 2004, AMA and CDC hosted the First National Preparedness Congress.

In 2020, in the midst of the COVID pandemic, the AMA's Council on Science and Public Health conducted a series of qualitative interviews with subject matter experts to:

- Understand the current challenges faced by public health professionals and health departments in preventing, detecting, and responding to emerging infectious disease threats and other public health crises.
- Understand physician and public health professionals' perspectives on what solutions need to be implemented to strengthen public health infrastructure to carry out the 10 essential public health services to improve disease and injury prevention and the health of the public
- Identify barriers and opportunities for improved and increased linkages between the public health and health care systems.
- Understand opportunities for the public health system to protect and promote the health of all people in all communities by removing systemic and structural barriers that have resulted in inequities.
- Identify opportunities for the AMA in supporting, developing, and implementing solutions.

The public health infrastructure interviews identified eight major gaps or challenges in the U.S. public health infrastructure. These include: (1) the lack of understanding and appreciation for public health; (2) the lack of consistent, sustainable public health funding; (3) legal authority and politicization of public health; (4) the governmental public health workforce; (5) the lack of data and surveillance and interoperability between health care and public health; (6) insufficient laboratory capacity; (7) the lack of collaboration between medicine and public health; and (8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes. The AMA is currently working to address these gaps.

The AMA also has a five-year cooperative agreement with the CDC focused on "Strengthening Public Health Systems and Services Through National Partnerships to Improve and Protect the Nation's Health." Through this agreement the AMA has been working to build relationships between state medical societies and state health departments to increase screening and referral to CDC-recognized lifestyle change programs among eight states. Through this mechanism, the AMA also directly supported and provided technical assistance to health service organizations during COVID-19, including by being the technical assistance and evaluation lead in collaboration with the American College of Preventive Medicine, which supports adaptation to COVID-19 for physicians at over a dozen community health centers and small practices across the country serving historically minoritized and marginalized populations.

Health Equity

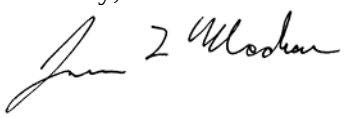
The AMA acknowledges that racism and unconscious bias within medical research and health care delivery have caused, and continue to cause, harm to marginalized communities and society as a whole, and recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and as a barrier to appropriate medical care. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA. Our goals are to champion health equity and promote greater diversity within the medical workforce.

To promote optimal health for marginalized and minoritized people and communities, the AMA is offering intensive health equity education and training for physicians and health systems. In collaboration with the Satcher Health Leadership Institute of the Morehouse School of Medicine, the AMA launched the inaugural cohort of the Medical Justice in Advocacy Fellowship in 2021, a first of its kind post-doctoral educational initiative. Through mentoring and a training platform, the fellowship equips physician participants with the foundational skills, tools, knowledge, and leadership skills to improve health outcomes and advance health equity within their institutions and communities. Also, in collaboration with Brigham and Women's Hospital and the Joint Commission, the AMA in 2022 launched the inaugural cohort of the Peer Network for Advancing Equity through Quality and Safety, a yearlong educational program designed to help health systems apply an equity lens to all aspects of quality and safety practices and embed equity into organizational structures, processes, and infrastructure.

Locally, the AMA is working with stakeholders in Chicago to confront SDOH on the city's West Side. The AMA has made a $2 million investment in a Chicago-based collaborative, West Side United, that is working to promote health and well-being for a portion of the city where life expectancy is far below the national average. Formed in 2017, West Side United's mission is to improve social, economic, and structural determinants of health, particularly through improving access to care and community resources, improving mental and behavioral health, and preventing and reducing chronic disease. More specifically, West Side United's primary goal is to reduce the life expectancy gap between Chicago's Loop and 10 West Side neighborhoods by 50 percent by 2030.

We hope that this information is helpful in deeming the AMA a qualifying employer and in processing our employees' ECFs and applications for forgiveness. On behalf of the AMA's employees who seek loan forgiveness under the PSLF Program, we thank you for your attention to this important matter. If the AMA can provide additional information, please contact Toni Canada, Senior Vice President of Human Resources at toni.canada@ama-assn.org or via phone at 312-464-5534.

Sincerely,



James L. Madara, MD

cc: Dr. Miguel Cardona, U.S. Department of Education
Richard Cordray, U.S. Department of Education
Scott D. Giles, Missouri Higher Education Loan Authority