acofp | AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS

2024

HEALTH POLICY ADVOCACY PRIORITIES

OUR MISSION & VISION

About ACOFP

Founded in 1950, the American College of Osteopathic Family Physicians (ACOFP) is a community of 26,000 physicians, residents, and students that champions osteopathic principles and supports its members by providing resources such as education, networking and advocacy, while putting patients first.

ACOFP empowers its members with education and resources that allow them to adapt to new models of care and quickly changing government policy.

Mission: ACOFP works to promote excellence in osteopathic family medicine through quality education, visionary leadership, and responsible advocacy.

Vision: The vision of the ACOFP is to be the professional home for all individuals with a commitment to osteopathic primary care.

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REDUCE UNNECESSARY PAPERWORK REQUIREMENTS

Cumbersome electronic health record (EHR) systems, utilization management policies, (e.g., prior authorization), and continuously changing regulatory rules are forcing physicians to spend more time on administrative tasks rather than spending time with patients. Even more time is spent on these burdensome tasks after hours. According to recent studies, physicians spend approximately half of their time working on EHRs and administrative work, in addition to completing paperwork after hours. In a 2023 study, 89 percent of practices surveyed responded that prior authorization requirements are, "very or extremely burdensome."[1] Another study revealed that for every hour a physician spends on clinical time, nearly two hours are spent on EHR and administrative tasks every day.[2]

Burdensome paperwork requirements are contributing to the physician shortage and are inhibiting appropriate patient care.[3] Many physicians, burned out by paperwork requirements, retire early or leave medical practice for another profession, especially those in small, rural, and solo practices where they do not have the resources to manage all the paperwork requirements.[4] As more of these practices are forced to close or relocate, healthcare shortages increase, and more communities lose access to care.

Although federal programs like the Medicare Quality Payment Program (QPP) and value-based care payment models are intended to improve health outcomes and reduce spending, these initiatives have significantly increased administrative burdens for physicians. The U.S. Centers for Medicare & Medicaid Services (CMS) has taken steps to reduce paperwork requirements through programs like the Patients Over Paperwork initiative and the creation of offices such as the Office of Burden Reduction and Health Informatics,[5] in addition to developing outcome measures that are clinically appropriate through the Meaningful Measures Framework. While ACOFP appreciates CMS's commitment to allowing more time to be devoted to providing care, more action needs to be taken to achieve the goals of these programs and to reduce administrative burdens.

Through the U.S. Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS) announced plans to distribute $103 million from the American Rescue Plan Act of 2021 (ARPA) over a three-year period to strengthen resiliency and address burnout in the health workforce. ACOFP supports funding efforts to address physician burnout and promote physician wellness to establish a culture of wellbeing among the physician community.

ADVOCACY POSITIONS:

- Reduce burdensome paperwork requirements across federal programs to allow physicians to spend more time treating patients.
- Maintain and expand CMS's efforts to reduce administrative burden, such as the Patients Over Paperwork initiative.
- Require EHR interoperability and standardize reporting requirements to reduce time spent on EHRs.
- Develop meaningful EHR reporting requirements to replace those that do not contribute to patient outcomes.
- Allow physicians to be reimbursed promptly for time spent preparing for patient visits and logging medical information into the electronic medical record beyond the day of the patient visit.
- Streamline utilization management policies across payers in a way that all stakeholders can quickly and efficiently address patient needs.
- Thoughtfully implement any major regulatory changes to Medicare to increase program certainty and to ensure that physicians have time to familiarize themselves with new program rules and update their practices accordingly.

PRESERVE THE FAMILY MEDICINE MODEL OF CARE

Family medicine plays a critical role in the provision of primary care, contributing to improved patient outcomes and reduced healthcare costs. ACOFP is concerned about federal policies that incentivize replacing family physician services with those of nonphysician practitioners, such as nurse practitioners and physician assistants. For example, a study found that from 2013 to 2019, the proportion of all visits delivered by nurse practitioners and physician assistants in one year increased from 14 percent to 25.6 percent.[6]

Physician-led care teams are the gold standard for care delivery, and nonphysician-led care teams are not equivalent because they do not have the same training or education. A family physician will spend an additional 18,900 hours on education and training compared to mid-level practitioners.[7] Decades of evidence have shown that physicians are better positioned to deliver high-quality care because of their demanding education and professional training requirements. As a result, beneficiaries experience better health outcomes and Medicare realizes overall savings from healthier seniors.[8910] While the use of nonphysician practitioners may be appropriate under certain circumstances and with adequate physician supervision, the nonphysician practitioner model is not an equivalent substitute to the use of family physicians. Also, when a patient receives healthcare services from a nonphysician practitioner, it should be made clear to the patient that the practitioner is not a physician.

Furthermore, the number of small and solo family medicine private practices has declined in recent years. More and more of these practices are being acquired by larger practices, private equity, and hospitals because of their inability to compete financially with these organizations. Other practices are closing altogether. ACOFP believes it is essential that policymakers support private practices—especially small and solo family medicine practices in rural and underserved areas—which can tailor how they provide care to best meet the needs of the communities they serve and remain a critical access point for primary care. In many areas, family physicians are the primary source of care, and even before the COVID-19 pandemic, small, independent, and solo practices faced barriers, including physician shortages, low reimbursement, and overly burdensome regulations. It is critical that Congress and the federal government support family medicine; otherwise, patients across the country will lose access to care.

ACOFP also believes that Congress and the Biden administration should support opportunities for medical students to train in private practices and should continue to support innovative payment models, like direct primary care (DPC) arrangements. Finally, ACOFP encourages policymakers to consider the clinical value and benefit to patients of osteopathic manipulative treatment (OMT). OMT is an important, but underutilized, tool that should be supported through appropriate reimbursement policies.

ADVOCACY POSITIONS:

- Support policies, including reimbursement policies, that do not create incentives to use nonphysician practitioners in lieu of family physicians.
- Deliver the highest quality care for patients through physician-led teams.
- Establish physician supervision and scope-of-practice requirements through state medical regulatory entities.
- Provide small and solo family medicine private practices with direct access to federal resources, as well as administrative flexibility.
- Ensure access to OMT as a high-value treatment for patients.
- Continue to support DPC arrangements through appropriate tax treatment (e.g., allowing DPC models to be paid through health savings accounts).
- Support transparency requirements that ensure patients know when they are receiving care from nonphysician practitioners instead of physicians.

ADDRESS THE FAMILY PHYSICIAN SHORTAGE

As more family physicians reach retirement age, the U.S. is facing shortages of 18,000–48,000 primary care physicians by 2034.11 More needs to be done to address this shortage and increase the number of residents choosing family medicine. Significantly higher reimbursement for specialists relative to primary care physicians contributes to the current imbalance between primary and specialty care.

In addition, primary care physicians are poorly compensated relative to their peers in specialty services. In 2017, the median compensation for physicians in radiology, procedural, and surgical specialties had an almost twofold difference compared to primary care physicians. This compensation gap is associated with the reduction in medical students choosing primary care careers and the shift of hospital graduate medical education (GME) priorities away from primary care.[12]

A recent study of compensation trends for primary care and specialist physicians after implementation of the Affordable Care Act found that from 2008 to 2017, specialist compensation increased by a weighted mean of 0.6 percent (1.2 percent) per year, from $378,600 to $399,300, whereas primary care compensation increased by a weighted mean of 1.6 percent (2.2 percent) per year, from $214,100 to $247,300. Although there was a larger increase in compensation for primary care physicians during this time, the gap between specialty and primary care salaries remains sizable. Physician compensation—specifically, the differences in compensation between primary care physicians and specialists—remains a concern that policymakers must address to incentivize physicians to pursue primary care.[13]

Also, ACOFP is concerned about the use of non-compete clauses in employment contracts for physicians. These clauses limit or prevent the ability of employees to join or start a competing firm after separating from their jobs. As a result, physicians subject to a non-compete clause must either move geographic locations or stop practicing medicine, which only serves to exacerbate the family physician shortage. ACOFP supports ongoing efforts among federal and state policymakers to ban the use of non-compete clauses.

Moreover, medical students are financially incentivized to choose specialty training such as cardiology or pulmonary medicine, over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing, and procedures.[14] Recent efforts to increase Medicare reimbursement, including through the calendar year (CY) 2020 Medicare Physician Fee Schedule (PFS) final rule, have been positive steps toward payment equalization.

However, a significant reimbursement differential still exists between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients and to the Medicare program overall. Incentives for medical students to choose family medicine include:

- Equalizing reimbursement between various settings of care, i.e., office, outpatient clinic, emergency department, and between family medicine and specialty medical services;
- Enhancing reimbursement by rewarding care that is proven to ensure high-quality patient outcomes and patient satisfaction; and,
- Providing financial support in the form of loans, loan forgiveness, and loan deferment.

In addition, more training opportunities are needed for medical students choosing family medicine, and medical education funding programs must be preserved and expanded, including Medicare GME, Teaching Health Center GME (THCGME), and Title VII.

ADVOCACY POSITIONS:

- Support policies that equalize reimbursement for primary care and specialty care.
- Through reimbursement policies, reward care provided by family medicine that is proven to ensure high-quality patient outcomes and patient satisfaction.
- Expand access to loans for medical students and support deferment and forgiveness of loans for medical students who commit to specializing in primary care.
- Increase financial support to hospitals, especially those in rural areas, to establish residency programs in family medicine.
- Protect and expand medical education funding, including Medicare Direct and Indirect GME funding, and preserve existing alternative GME programs, such as the THCGME program and Title VII.
- Support policies that equalize compensation for primary care and specialty care.
- Support efforts to ban the use of non-compete clauses for physician employment contracts.

IMPROVE OUTCOMES AND REDUCE COSTS THROUGH PRIMARY CARE AND SUPPORT FOR FAMILY PHYSICIANS

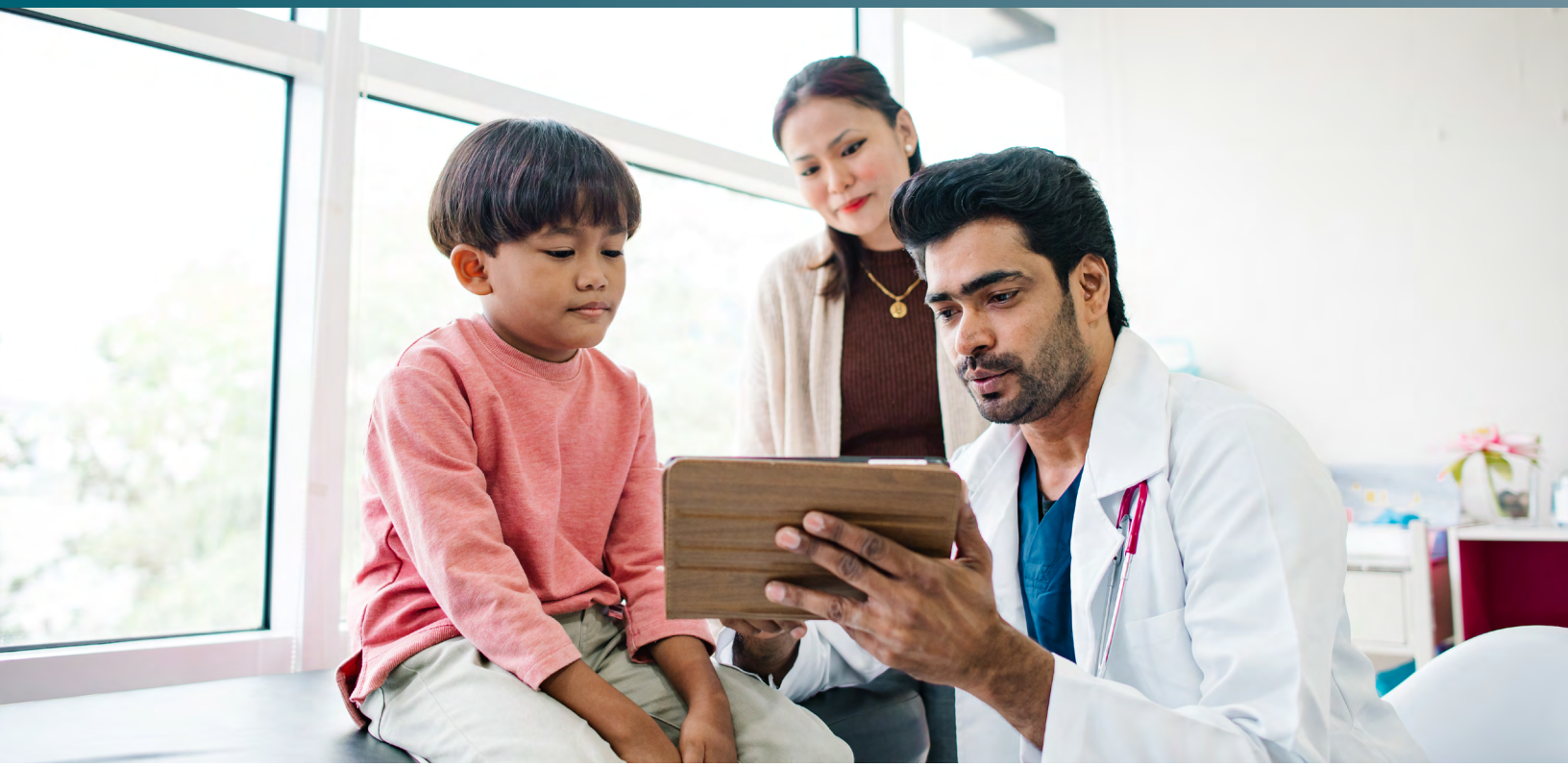
The goal of any healthcare system is to improve the overall health of the patients it serves, and to achieve this goal, the importance of primary care must be recognized and its greater use must promoted. Many studies show dramatic benefits in geographic areas that have higher primary care provider (PCP) use and higher ratios of PCPs per capita.[15]

A retrospective literature review by Dr. Barbara Starfield found that overall health is better in areas in the U.S. with more PCPs. Areas with higher ratios of PCPs per capita had better health outcomes, including lower rates of all-cause mortality, mortality from heart disease, cancer, and stroke, as well as infant mortality. In addition, areas with higher ratios of PCPs per capita had lower healthcare costs than other areas, possibly due to better preventative care and lower hospitalization rates. This contrasts with areas where there are higher numbers of specialists—characterized by more spending and worse health outcomes.[16]

CMS provides reimbursement for several services, including transitional care management,[17][18], chronic care management,[19][20] and the Medicare Diabetes Prevention Program[21][22], to support the delivery of primary care, improve patient outcomes, and reduce costs. In addition, these programs provide physician payments for care coordination activities, which normally are not covered. Family physicians devote considerable time to ensuring patient care is efficiently and effectively coordinated among specialists and nonphysicians.

However, family physicians still face administrative challenges obtaining records and results when there are multiple physicians involved a patient's care. The timely sharing of this information must be promoted or incentivized. These activities drive down costs for payers and hospital systems, while improving health outcomes for patients. With nearly half of primary care clinicians employed in health systems, attention should be paid to primary care payment methods in such settings.[23]

ACOFP supports CMS care models that emphasizes the provision of primary care such as the Making Care Primary (MCP) model. However, the participation of solo, small, and rural physician practices may be limited because of the resources necessary to implement these types of models. The agency therefore must provide these physician practices with the resources necessary to participate in these models.



More needs to be done to support family physicians who have upgraded their EHR systems in compliance with federal programs, including QPP, at great expense. Implementing EHR software is both incredibly time consuming and costly. A 2014 study found that small and rural hospitals were noticeably delayed compared to larger hospitals in terms of EHR implementation rates; further, only 5.8 percent of hospitals were able to meet all of the EHR stage two meaningful-use criteria.[24] Many small, rural, and solo practices are unable to change their EHR system as rules shift annually, so policymakers should consider whether any new EHR requirements will require additional information technology (IT) systems investments. It is essential that federal policymakers do not implement policies that require physicians to invest additional funds in EHR updates, management, and repairs without adequate financial and technical support.

The Commonwealth Fund's Task Force on Payment and Delivery System Reform recently emphasized that the U.S. will only achieve its goals to create a healthier population with more consistent access to primary care and a more equitable distribution of health care through changes in how and how much primary care is paid. Thus, focusing on primary care physician payment is a critical issue for the future of health care that must be addressed.[2526]

ACOFP also supports measures to increase payments for vaccine reimbursement, as well as resources and regulatory flexibilities for providers administering vaccines—especially due to the costs associated with maintaining COVID-19 vaccines.

In addition, OMT, a clinically appropriate pain management treatment that can help reduce the need for addictive medications, is a valuable tool that can be used to provide holistic care and treatment to all patients. This underutilized service improves health outcomes and must be protected and made more available to patients.

ADVOCACY POSITIONS:

- Support primary care models that empower and reward PCPs who focus on preventing chronic illness, managing patients, and appropriately using specialists.
- Educate specialists on the role of PCPs in coordinating care to ensure the patient is receiving high-quality care.
- Support reimbursement policies that reward care provided by family physicians who provide high-quality and improved patient outcomes.
- Ensure physicians are incentivized to perform care coordination activities, which are essential for improved outcomes and reduced healthcare costs.
- Ensure the timely sharing of patient information from specialists to family physicians.
- Appropriately reimburse family physicians through Medicare Part B for the administration of medically necessary vaccines (beyond influenza, pneumococcal, and the hepatitis B virus [HBV]) to reduce COVID-19 and maintain appropriate care coordination.
- Recognize the clinical value and cost savings from physician-led care coordination and establish appropriate reimbursement policies for such activities.
- Equalize reimbursement across settings of care, including rural practices, across state lines, and between primary care and specialty care, to encourage high-quality care.
- Ensure that primary care practices have the resources to obtain and provide the newest technology that assists with improving quality and reducing costs.
- Carefully consider how new federal health program policies will affect EHR systems and provide support to physicians for any new policy that requires changes to existing EHRs.
- Support measures to increase payments for vaccine reimbursement, as well as resources and regulatory flexibilities for providers administering vaccines.
- Protect reimbursement for OMT and encourage OMT to be utilized as a tool to improve patient care.

FOCUS ON VULNERABLE POPULATIONS AND ADDRESS RACIAL DISPARITIES

Osteopathic family physicians are committed to treating vulnerable populations, such as rural patients, uninsured/underinsured individuals, and racial/ethnic minorities. ACOFP believes there are several ways to improve family physicians' ability to ensure health and longevity for these populations.

Social determinants of health (SDOH) have been shown to have a major impact on patients' overall health. Even when a physician provides high-quality care, follows evidence-based guidelines, and provides access to community resources, patients still may not achieve the desired health outcomes because of their SDOH. Making changes to a patient's social environment is key. This includes utilizing social services to ensure access to adequate housing, good nutrition, language interpreter services, and transportation.

While physicians may direct patients to community resources that can assist them with services to address SDOH, it is beyond the capacity of physicians and the healthcare system alone to completely address these factors. Physicians should not be held accountable for eliminating or mitigating that which is in the social environment, nor should they be penalized for failing to fully ameliorate a patient's SDOH.

Additionally, ACOFP strongly believes all individuals—regardless of race, color, religion, sex, gender identity, sexual orientation, age, or disability—should have access to high-quality health care. As an organization, we have expressed disapproval of federal efforts to restrict or otherwise limit care based on immutable characteristics of an individual. Congress and the federal government must uphold the rights of all individuals and ensure there are no discriminatory laws or regulations.

The COVID-19 outbreak highlighted systemic inequities in our country's healthcare system. Studies have found that COVID-19 death rates of Hispanic, Black, and American Indian/Alaska Native (AI/AN) individuals are disproportionately higher than those of white individuals.27 Specifically, Hispanic, Black, and AI/AN individuals are at least twice as likely to die from COVID-19 than white individuals, and Hispanic and AI/AN individuals are at nearly two times greater risk of contracting COVID-19 than white individuals. In addition, rural and urban healthcare discrepancies have been highlighted throughout the COVID-19 pandemic, including disproportionately high incidence and mortality rates in nonurban areas during some periods of the pandemic.[28]

Other studies have shown that ethnic minorities are less likely to receive preventative care, and despite improvements in the overall health of the American population, ethnic and racial minorities are not receiving the same quality of care in the U.S.[29] These same disparities exist in the maternal mortality context with data showing that Black women have higher rates of pregnancy-related deaths than white women.[30]

As osteopathic family physicians, we have been trained to treat the patient holistically and look beyond the disease. We pride ourselves on understanding the SDOH for our patients, and we embrace diversity and inclusion in our profession. Our foundational principles require us to treat all patients, regardless of their ethnicity or racial background. ACOFP encourages policymakers to create meaningful changes that improve the lives of minority populations in our country and, in turn, all Americans.

ADVOCACY POSITIONS:

- Ensure recognition and inclusion of SDOH and their overarching impact on health care in policymaking.
- Advocate for federal health program policies that assist and support, rather than financially penalize, physicians for unmet patient needs related to SDOH.
- Expand physician knowledge of population health and how it relates to the understanding of patient outcomes.
- Develop and advocate for policies ensuring access to equitable and high-quality health care.
- Encourage Congress to recognize and act on racial health disparities to improve health outcomes for minority populations.
- Advocate for healthcare workforce and education programs that increase diversity among family physicians, (e.g., programs that recruit students from underserved or diverse communities to practice in their community).
- Preserve and enhance Medicare and Medicaid reimbursement for rural and underserved area physicians, including the facilities where they provide care (e.g., Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals, and Disproportionate Share Hospitals).

ENCOURAGE THE APPROPRIATE USE OF TELEHEALTH

In response to the COVID-19 public health emergency (PHE), CMS loosened its telehealth rules and expanded the types of telehealth services that are reimbursable by Medicare. According to HHS, telehealth utilization increased 63-fold, from approximately 840,000 in 2019 to 52.7 million in 2021.31 These flexibilities have been critical for seniors, especially during the early months of the outbreak when in-person visits dropped dramatically.

Congress continues to recognize the importance of telehealth, including in the Consolidated Appropriations Act, 2021 (CAA), which permanently expanded the use of telehealth to provide mental health services. This expansion is noteworthy because of its permanence and because it does not subject these services to geographic restrictions, while also maintaining certain protections to guard against fraudulent activity (i.e., requirements that the clinician must have furnished an in-person item or service within the past six months prior to the first telehealth service). In addition, the CY 2024 Medicare PFS final rule finalized the implementation of telehealth-related provisions of the CAA, 2023, including the expansion of the definition of telehealth practitioners and the continued payment for telehealth services furnished by RHCs and FQHCs.

Although telehealth utilization has leveled off as in-person visits have rebounded, there has been a paradigm shift where the healthcare system now relies more on telehealth. Telehealth provided by a patient's established provider can be a powerful tool for care delivery due to its potential to improve access to care for countless Americans. However, telehealth is particularly vulnerable to fraud and abuse and could lead to higher costs for patients.

There is also limited data on the quality of telehealth.[32] Additionally, there are concerns that telehealth could increase physician burden, which should be avoided as much as possible.[33] ACOFP firmly believes that in-person care is the gold standard for care and that telehealth is a tool to improve care delivery when in-person care is not possible—not a silver bullet.

ACOFP is also concerned that the growth of telehealth could inadvertently disrupt existing physician-patient relationships and care coordination. Telehealth-only providers may have limited encounters with patients and may not appropriately coordinate with family physicians so that this trend could result in worsening medical conditions and poor health outcomes. ACOFP believes telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth.

ADVOCACY POSITIONS:

- Require physicians who practice telehealth outside of interstate compacts to be licensed in the state in which they are practicing telehealth.
- Ensure accountability for out-of-state telehealth providers to safeguard patient safety and quality of care.
- Prioritize telehealth services for the patient's primary care physician and ensure care is properly coordinated with the primary care physician.
- Continue to allow reimbursement for audio-only telehealth services in a manner that protects program integrity.
- Establish appropriate rules to curb fraud and abuse and protect patients from unnecessary charges.
- Use data and evidence to develop a telehealth coverage policy that ensures patients are receiving the highest quality care possible.
- Allow patients to use telehealth from their home by reforming or eliminating originating site requirements.
- Establish payment rates that reflect the resources and expertise necessary to deliver high-quality care via telehealth.
- Ensure that family physicians have sufficient resources to invest in new technologies to provide effective telehealth services.

ADDRESS THE OPIOID CRISIS

As the U.S. continues to confront the opioid crisis, attention has been focused on prescribing and dispensing these drugs. Despite the risk for abuse, opioids play a legitimate role for many patients with chronic pain and cancer pain. Federal efforts to combat the abuse of opioids should not pose a barrier to access for those who truly need these drugs to treat chronic pain. Failing to do so will result in a crisis of untreated chronic pain.

Primary care physicians are on the frontlines of the opioid epidemic and have been instrumental in treating patients with substance use disorders (SUDs) and opioid use disorders (OUDs). Osteopathic family physicians support behavioral health as part of the whole-person approach to care and the use of community support resources and federal actions, including additional funding and access to medication-assisted treatment (MAT) to treat mental health and SUDs.

However, some well-intentioned efforts to improve OUD treatment may push patients away from their family physicians. Specifically, bundled payments for opioid treatment assumes there is a standardized way to treat OUD and SUD patients. Osteopathic family physicians understand that each patient is different, and as a result, they are in the best position to address individual patient needs. Because OUD patients are members of the physicians' community, osteopathic family physicians understand the patient's unique clinical needs and social factors that may impact substance use.

CMS must carefully consider new payment models to ensure the agency does not drive patients to non-primary care for OUD services. Currently, insurance coverage is counter to efforts to combat the opioid crisis. For example, some insurers will only cover the less-expensive (and highly addictive), short-acting opioids, but will not cover long-acting hydrocodone with abuse deterrent or alternatives, such as a buprenorphine (Butrans®) patch.[34]

In addition, ACOFP believes that reimbursement for nonopioid pain management therapies needs to be revisited and updated. There are opportunities to change routine practices and work toward addressing and treating root causes of pain through non-pharmacological interventions, such as OMT. OMT has many clinical benefits that improve patient outcomes. The clinical benefits OMT provides should be considered when determining OMT reimbursement.

Reports show that the opioid crisis worsened during the COVID-19 pandemic. The Centers for Disease Control and Prevention (CDC) estimates there were 107,622 drug overdose deaths in the U.S. during 2021, which represents an increase of nearly 15 percent from the 93,655 deaths estimated in 2020.[35] ACOFP is concerned that some of CMS's policies steer patients away from their family physicians in a manner that may erode sustainable improvements and undo inroads made in resolving the opioid crisis.

ADVOCACY POSITIONS:

- Support federal legislative and regulatory actions that combat the opioid crisis, but do not impede access to opioids for legitimate indications and patients.
- Encourage federal action on behavioral health, including additional funding for mental health facilities and training more physicians to manage these patients.
- Support additional reimbursement for family physicians to provide high-level, in-office screening and make appropriate referrals to behavioral health specialists.
- Provide parity in reimbursement for behavioral health screening and services.
- Support greater access to MAT by loosening prescribing rules and expanding telehealth services, especially in rural areas.
- Ensure that family physicians are leading care for patients experiencing OUDs.
- Encourage CMS to reassess the appropriateness of bundling for payment of OUD services.
- Leverage existing primary care-focused codes that support family physicians' ability to treat OUDs.
- Increase access to and knowledge of OMT as a pain management treatment option.
- Ensure OMT reimbursement is appropriate for the clinical benefit it provides.

REFERENCES

[1]Medical Group Management Association. Annual Regulatory Burden Report. November 2023. Available at https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf

[2]Sinsky C., Colligan L., Li L., *et al*. Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Ann Intern Med*. 2016;165(11):753–760. doi:10.7326/M16-0961

[3]Top challenges 2021: #1 administrative burdens and paperwork. *Medical Economics*. 2021;98(1):7–8. Accessed January 12, 2023. https://www.medicaleconomics.com/view/top-challenges-2021-1-administrative-burdens-and-paperwork

[4]Freeman L. Is your doctor at risk? Burnout could drive physicians from field, jeopardize patient. *Northwest Florida Daily News*. December 1, 2021. Available at https://advance.lexis.com/api/permalink/c8add16f-3f89-498f-be29-ae05fcda77a0/?context=1000516

[5]Centers for Medicare & Medicaid Services. Office of Burden Reduction and Health Informatics. Functional statement. Last modified December 12, 2021. Accessed January 12, 2023. https://www.cms.gov/About-CMS/Agency-Information/CMSLeadership/Office_OBRHI

[6]National Institutes of Health, National Library of Medicine, National Center for Biotechnology Information. Provision of evaluation and management visits by nurse practitioners and physician assistants in the USA from 2013 to 2019: cross-sectional time series study. Published September 14, 2023. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10498453/

[7]Primary Care Coalition. Compare the education gaps between primary care physicians and nurse practitioners. Texas Academy of Family Physicians website. Accessed January 20, 2023.https://tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf

[8]Lohr RH, West CP, Beliveau M, et al. Comparison of the quality of patient referrals from physicians, physician assistants, and nurse practitioners. *Mayo Clin Proc*. 2013;88(11):1266–1271. doi:10.1016/j.mayocp.2013.08.013

[9]Hughes DR, Jiang M, Duszak R Jr. A comparison of diagnostic imaging ordering patterns between advanced practice clinicians and primary care physicians following office-based evaluation and management visits. JAMA Intern Med. 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349

[10]Muench U, Perloff J, Thomas CP, Buerhaus PI. Prescribing practices by nurse practitioners and primary care physicians: a descriptive analysis of Medicare beneficiaries. *Journal of Nursing Regulation*. 2017;8(1):21–30. doi:10.1016/S2155-8256(17)30071-6

[11] *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* Association of American Medical Colleges. June 2021. Accessed January 12, 2023. https://www.aamc.org/media/54681/download

[12]National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care. Robinson SK, Meisnere M, Phillips RL Jr, McCauley L, eds. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. National Academies Press; 2021. doi:10.17226/25983

[13]Hsiang WR, Gross CP, Maroongroge S, Forman HP. Trends in compensation for primary care and specialist physicians after implementation of the Affordable Care Act. *JAMA Netw Open*. 2020;3(7):e2011981. doi:10.1001/jamanetworkopen.2020.11981

[14]Shi L. The impact of primary care: a focused review. *Scientifica (Cairo)*. 2012;2012:432892. doi:10.6064/2012/432892

[15]Shi L. The impact of primary care: a focused review. *Scientifica (Cairo)*. 2012;2012:432892. doi:10.6064/2012/432892

[16]Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457–502. doi:10.1111/j.1468-0009.2005.00409.x

[17] Centers for Medicare & Medicaid Services. Care Management. Updated January 5, 2023. Accessed January 12, 2023. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

[18]Centers for Medicare & Medicaid Services. Medicare Learning Network. Transitional Care Management Services. 2022. Accessed January 11, 2023. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

[19]Centers for Medicare & Medicaid Services. Care Management. Updated January 5, 2023. Accessed January 12, 2023. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

[20]Centers for Medicare & Medicaid Services. Medicare Learning Network. Chronic Care Management Services. 2022. Accessed January 11, 2023. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

[21]Centers for Medicare & Medicaid Services. Medicare Diabetes Prevention Program (MDPP) Expanded Model. Updated January 5, 2023. Accessed January 11, 2023. https://innovation.cms.gov/innovation-models/medicare-diabetes-prevention-program

[22]Centers for Medicare & Medicaid Services. Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet. Accessed January 11, 2023. https://innovation.cms.gov/files/x/mdpp_overview_fact_sheet.pdf

[23]National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care. Robinson SK, Meisnere M, Phillips RL Jr, McCauley L, eds. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. National Academies Press; 2021. doi:10.17226/25983

[24]Adler-Milstein J, DesRoches CM, Furukawa MF, et al., *More than half of US hospitals have at least a basic EHR, but stage 2 criteria remain challenging for most*, *Health Aff (Millwood)*, 33(9):1664–71 (September 2014). https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0453

[25]Commonwealth Fund Task Force on Payment and Delivery System Reform. Health care delivery system reform: Six policy imperatives. 2020. Accessed January 11, 2023. https://www.commonwealthfund.org/publications/fund-reports/2020/nov/commonwealth-fund-task-force-payment-and-delivery-system-reform

[26] Hill L, Artiga S. COVID-19 cases and deaths by race/ethnicity: Current data and changes over time. Kaiser Family Foundation, August 22, 2022. Accessed January 20, 2023. https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/

[27]Hill L, Artiga S. COVID-19 cases and deaths by race/ethnicity: Current data and changes over time. Kaiser Family Foundation, August 22, 2022. Accessed January 20, 2023. https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/

[28]Ullrich F, Mueller K. COVID-19 Cases and Deaths, Metropolitan and Nonmetropolitan Counties Over Time (update). RUPRI Center for Rural Health Policy Analysis Rural Data Brief. January 2023. Accessed January 12, 2023. https://rupri.public-health.uiowa.edu/publications/policybriefs/2020/COVID%20Longitudinal%20Data.pdf

[29]Hostetter M, Klein S. In focus: reducing racial disparities in health care by confronting racism. The Commonwealth Fund. September 27, 2018. Accessed January 12, 2023. https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism

[30]Howell EA. Reducing disparities in severe maternal morbidity and mortality. *Clin Obstet Gynecol*. 2018;61(2):387–399. doi:10.1097/GRF.0000000000000349

[31]Centers for Medicare & Medicaid Services. New HHS study shows 63-fold increase in Medicare telehealth utilization during the pandemic. December 3, 2021. Accessed January 12, 2023. https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic

[32]Castellucci M. Telehealth explosion points to need for more research on quality of care provided. Modern Healthcare. June 18, 2020. Accessed January 12, 2023. https://www.modernhealthcare.com/safety-quality/telehealth-explosion-points-need-more-research-quality-care-provided

[33]Based on a 2020 ACOFP member survey, 26 of respondents reported administrative burden associated with obtaining state licensures for using telehealth across state lines.

[34]Thomas K, Ornstein C. Amid opioid crisis, insurers restrict pricey, less addictive painkillers. *The New York Times*. September 17, 2017. Accessed January 12, 2023. https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html

[35]U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020 – But are Still Up 15%. News release. Centers for Disease Control and Prevention; May 11, 2022. Accessed January 12, 2023. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm

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