




2022

Principles of  
Healthcare  
System Reform



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OF OSTEOPATHIC  
FAMILY PHYSICIANS

# Reduce Unnecessary Paperwork Requirements

Cumbersome electronic health record (EHR) systems, utilization management policies (e.g., prior authorization) and continuously changing regulatory rules are forcing doctors to spend more time on administrative tasks rather than patients. According to recent studies, doctors spend approximately half their time on EHRs and desk work, in addition to completing paperwork after hours. For every hour a physician spends on clinical time, nearly two hours are spent on EHR and administrative tasks every day.<sup>1</sup>

Burdensome paperwork requirements are contributing to the physician shortage and are inhibiting appropriate patient care.<sup>2</sup> Many physicians, burned out by paperwork requirements, decide to 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.<sup>3</sup> As more of these practices are forced to close or relocate, healthcare shortage areas widen, and more communities lose access to care.

Through the U.S. Health Resources and Services Administration, 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 wellness among the physician community.

While federal programs like the Medicare Quality Payment Program (QPP) 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<sup>4</sup>, 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 must be done to reduce administrative burdens.

## Advocacy Positions

- Reduce burdensome paperwork requirements across federal programs to allow physicians more time treating patients.
- Maintain and expand CMS's efforts to reduce burden, such as the Patients Over Paperwork initiative.
- Promote 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 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, which ensures improved patient outcomes and reduced healthcare costs. ACOFP is concerned about federal policies that incentivize replacing family physician services with those of non-physician practitioners, such as nurse practitioners and physician assistants.

Physician-led care teams are the gold standard for care delivery; non-physician-led care teams are not equivalent because they do not have the same training or education. A family medicine physician will spend an additional 18,900 hours on education and training than mid-level practitioners.<sup>5</sup> Decades of evidence have shown that physicians are better positioned to deliver high-quality care because of their demanding education and professional training requirements, and, as a result, beneficiaries experience better health outcomes and Medicare realizes overall savings from healthier seniors.<sup>6-8</sup> While the use of non-physician practitioners may be appropriate under certain circumstances and with adequate physician supervision, the model is not an equivalent substitute to the use of family physicians.

Furthermore, the number of small and solo family medicine private practices has declined in recent years. 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.

ACOFP also believes that Congress and the Biden administration should support opportunities for medical students to train in private practices and continue to support innovative payment models, like direct primary care (DPC) arrangements. Finally, ACOFP encourages policymakers to consider and take into account 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 non-physician 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.
- Support small and solo family medicine private practice access to federal resources, as well as administrative flexibility, especially during the COVID-19 pandemic.
- Support the provision of OMT as a high-value treatment option for patients.
- Continue to support DPC arrangements through appropriate tax treatment (e.g., allowing DPC models to be paid through health savings accounts).

## Address the Family Physician Shortage

As more family physicians reach retirement age, the United States is facing shortages of 18,000–48,000 primary care physicians by 2034.<sup>9</sup> 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. From 2003 to 2004, the ratio of average annual income for a specialty physician compared to a primary care physician in the United States was 1.6:1. In 2017, the median compensation in radiology, procedural and surgical specialties had an almost twofold difference compared to primary care physicians. Data from the Medical Group Management Association indicate that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent, while that for specialists increased by 37.5 percent. The median compensation for nonsurgical procedural specialties, surgical specialties and primary care in 2017 was \$426,000, \$420,000 and \$242,000, respectively. 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.<sup>10</sup>

A recent study in the 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 sizeable. Physician compensation—specifically, the differences in compensation between primary care physicians

and specialists—remains a concern that policy-makers must address to incentivize physicians to pursue primary care.<sup>11</sup>

Moreover, medical students are financially incentivized to choose specialty training (e.g., cardiology or pulmonary medicine) over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing and procedures.<sup>12</sup> Recent efforts to increase Medicare reimbursement, including through the calendar year (CY) 2020 Medicare Physician Fee Schedule 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 and 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 deferment and forgiveness of loans for medical students choosing family medicine.
- 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.

# 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, primary care must play a more prominent role. Many studies show dramatic benefits in geographic areas that have higher primary care provider (PCP) use and PCPs per capita.<sup>12</sup>

A retrospective literature review by Dr. Barbara Starfield found that overall health is better in areas in the United States 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, but worse health outcomes.<sup>13</sup>

CMS provides reimbursement for several services—including transitional care management<sup>14,15</sup>, chronic care management<sup>14,16</sup> and the Medicare Diabetes Prevention Program<sup>17,18</sup>—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 non-physicians. 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.<sup>19</sup>

While primary care physicians are demonstrated to be a critical asset for high-quality healthcare delivery, 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. A 2011 study estimated that EHR implementation in a five-physician practice would require an average cost of \$46,659 per physician.<sup>20</sup> Many small, rural and solo practices are unable to change their EHR system as rules shift annually, and any new EHR requirements should consider IT systems investments. It is essential that federal policy makers do not implement policies that require physicians to invest additional funds in EHR updates, management and repairs without adequate support.

The Commonwealth Fund's Task Force on Payment and Delivery System Reform recently emphasized that the United States 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.<sup>21,22</sup>

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. OMT is an underutilized service that improves health outcomes and must be protected and more available to patients.



## Advocacy Positions

- Support primary care models that empower and reward PCPs who focus on prevention of chronic illness, manage patients who have progressed and appropriately use 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 are proven to ensure 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.
- Appropriately reimburse family physicians through Medicare Part B, during and beyond the COVID-19 public health emergency (PHE), for the administration of medically necessary vaccines (beyond influenza, pneumococcal and the hepatitis B virus [HBV]) to reduce exposure to 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 and between primary care and specialty care so that primary care has 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.
- 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 the health and longevity of these populations.

Social determinants of health 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 may still not achieve the desired health outcomes because of their social determinants of health. 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 social determinants of health, 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 social determinants of health.

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 has 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) COVID-19 individuals are disproportionately higher than those of white individuals.<sup>22</sup> 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.

Other studies have shown that ethnic minorities are less likely to receive preventive 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 United States.<sup>23</sup> 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.<sup>24</sup>

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

## Advocacy Positions

- Ensure recognition and inclusion of social determinants of health 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 social determinants of health.
- 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, Federally Qualified Health Centers, Critical Access Hospitals and Disproportionate Share Hospitals).

## Encourage the Appropriate Use of Telehealth

In response to the COVID-19 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.<sup>25</sup> The new 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, most recently 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).

Although telehealth utilization is beginning to level off as in-person visits rebound, there is a paradigm shift that relies more on telehealth because it 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.<sup>26</sup> Additionally, there are concerns that telehealth could increase physician burden, which should be avoided as much as possible, especially during the COVID-19 pandemic.<sup>27</sup> 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. Contrary to traditional brick and mortar physician practices, there is a growing trend of telehealth-only providers who have limited encounters with patients and may not appropriately coordinate with family physicians—resulting in worsening 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

- 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.
- Reduce the administrative burden associated with telehealth, including burdensome state licensing requirements.
- 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.

# Protect Patients During the COVID-19 Pandemic

More than 800,000 Americans have died from COVID-19, with public health officials warning that cases and deaths will continue to rise.<sup>28</sup> The COVID-19 pandemic is the public health crisis of our generation, and family physicians are on the frontlines protecting patients across the country from the deadly virus.

In the face of this crisis, family physicians have prioritized patients and changed their practices to address the unique challenges of delivering care during the pandemic, quickly adopting telehealth to ensure patients can maintain their care, investing in personal protective equipment (PPE) and establishing safety protocols to protect their patients and staff. The response from family physicians and their staff has been heroic, but more must be done to ensure they can continue to serve patients.

In many areas, family physicians are the primary source of care, and even before the 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 during the pandemic; otherwise, patients across the country will lose access to care.

Congress acted swiftly in passing various COVID-19 relief legislation, including the *Coronavirus Aid, Relief, and Economic Security (CARES) Act*, the *Paycheck Protection Program and Health Care Enhancement Act (PPHCEA)*, the CAA and the ARPA. The CARES Act appropriated \$100 billion to the Public Health and Social Services Emergency Fund (Provider Relief Fund) to support healthcare providers. The PPHCEA replenished the Provider Relief Fund and other important programs (e.g., Paycheck Protection Program), adding \$75 billion to the Provider Relief Fund (PRF). The CAA provided an additional \$3 billion while making key policy changes to provide greater flexibility for PRF recipients to appropriately use these funds.

Finally, the ARPA added \$8.5 billion for providers who serve rural Medicaid, Children's Health Insurance Program or Medicare patients. However, it is critical that funds reach family physicians and that financial support does not come with overly burdensome requirements.

CMS also acted quickly to support providers, offering helpful regulatory actions, such as providing hardship exceptions for QPP reporting requirements and relaxing in-person physician supervision requirements. However, the COVID-19 telehealth flexibilities have been the most impactful and have been critical for many family physicians and patients.

ACOFP supports CMS taking measures to increase payments for vaccine reimbursement, especially due to the costs associated with maintaining COVID-19 vaccines. For example, some vaccine products require special storage and handling.<sup>29</sup> In the CY 2022 Medicare Physician Fee Schedule Final Rule, CMS developed a policy regarding vaccine administration. Effective January 1 of the year following the year in which the PHE ends, the \$40 payment for administering the COVID-19 vaccine will be adjusted to equal the payment rate for the administration of other Part B preventive vaccines. Beginning with services furnished in CY 2022, CMS finalized a uniform payment rate of \$30 for the administration of an influenza, pneumococcal or HBV vaccine covered under the Part B preventive vaccine benefit.<sup>30</sup> ACOFP has been an advocate for these changes to further support providers administering vaccines, and Congress and HHS must continue offering resources and regulatory flexibilities for providers to beat the virus.

## Advocacy Positions

- Provide financial support for family physicians through the PRF during the COVID-19 pandemic.
- Provide clear and consistent requirements for funding from the PRF that do not overly burden physicians or discourage them from accepting the funds.
- Advance appropriate yet fiscally responsible COVID-19 relief legislation that stimulates the economy and supports providers.
- Continue to promulgate appropriate administrative flexibilities to ensure physicians can respond to the COVID-19 pandemic.
- Ensure reimbursement for COVID-related treatments and vaccines are appropriate to ensure patients and seniors have access to care.
- Provide family physicians with adequate PPE and other resources to protect their staff and patients.

## Address the Opioid Crisis

As the United States 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.

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, the use of community support resources and federal actions, including additional funding and access to medication-assisted treatment (MAT), in the treatment of 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. 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, their 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 only will 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.<sup>31</sup>

In addition, ACOFP believes that reimbursement for non-opioid 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. Experts predicted that approximately 90,000 people died of a drug overdose in 2020, setting a record of the highest number of deaths and largest increase in deaths in one year.<sup>32</sup> CMS has established policies to address the opioid crisis during the COVID-19 pandemic, but ACOFP is concerned that such policies steer patients away from their family medicine physicians in a manner that may exacerbate sustainable improvements and turn back 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 more physicians trained 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 suffering from OUDs.
- Encourage CMS to reassess the value 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.
- Uphold measures to address the opioid crisis during the COVID-19 pandemic.

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<sup>26</sup>Castellucci M. Telehealth explosion points to need for more research on quality of care provided. Modern Healthcare website. Published June 18, 2020. <https://www.modernhealthcare.com/safety-quality/telehealth-explosion-points-need-more-research-quality-care-provided>

<sup>27</sup>Based on a 2020 ACOFP member survey, 26 percent of respondents reported administrative burden associated with obtaining state licensures for using telehealth across state lines.

<sup>28</sup>Centers for Disease Control and Prevention, COVID Data Tracker Weekly Review. Accessed January 1, 2022. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

<sup>29</sup>Centers for Disease Control and Prevention, CDC COVID-19 Vaccination Program Provider Requirements and Support. Last updated January 7, 2022. <https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html>

<sup>30</sup>Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 *Federal Register* 64996 (November 19, 2021).

<sup>31</sup>Thomas K, Ornstein C. Amid opioid crisis, insurers restrict pricey, less addictive painkillers. *The New York Times*. September 17, 2017. <https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html>

<sup>32</sup>Seervai S. "It's really, truly everywhere": How the opioid crisis worsened with COVID-19. The Commonwealth Fund website. Published June 4, 2021. <https://www.commonwealth-fund.org/publications/podcast/2021/jun/its-really-truly-everywhere-how-opioid-crisis-worsened-covid-19>

The background is a solid dark blue color. There are several large, abstract geometric shapes in shades of blue and black. A bright cyan shape is at the top left, overlapping a dark blue shape. A black shape is on the left side, overlapping the cyan one. Another black shape is at the bottom left, and a dark blue shape is at the bottom right. The logo is centered in the lower half of the page.

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