



2026  
HEALTH POLICY  
ADVOCACY PRIORITIES

**acofp** | AMERICAN COLLEGE  
OF OSTEOPATHIC  
FAMILY PHYSICIANS

## 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.

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## ACOFP 2026 HEALTH POLICY ADVOCACY PRIORITIES

The 2026 Advocacy Priorities of the American College of Osteopathic Family Physicians outline a comprehensive policy framework to strengthen primary care, support physician sustainability, and improve patient access and outcomes.

The priorities emphasize reducing unnecessary administrative burden, preserving the physician-led family medicine model of care, addressing the national shortage of family physicians, and promoting equitable access to high-quality health services for all populations.

Key themes include modernizing regulatory and reimbursement structures to enable physicians to devote more time to direct patient care, closing payment disparities between primary care and specialty care, supporting medical education funding and access to student loans, and protecting small, rural, and solo practices. The document also addresses the responsible use of emerging technologies such as artificial intelligence, recognizing their potential to reduce administrative workload while affirming that clinical decision-making must remain physician directed.

Additional priorities include protecting physicians from workplace violence, supporting evidence-based vaccination policies, improving behavioral health integration and opioid treatment strategies, encouraging appropriate and coordinated telehealth use, and promoting policies that recognize and address social determinants of health.

Collectively, these priorities advance patient-centered care while supporting the long-term viability of osteopathic family medicine across diverse communities.



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# REDUCE PRACTICE BURDEN

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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.”<sup>i</sup> 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.<sup>ii</sup>

Burdensome paperwork requirements are contributing to the physician shortage and are inhibiting appropriate patient care.<sup>iii</sup> Primary care physicians, who have substantial care management responsibilities and, consequently face greater administrative burden than other specialties, are choosing 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>iv</sup> As more of these practices are forced to close or relocate, healthcare shortages increase, and more communities lose access to care.

ACOFP supports several bills introduced in the 119th Congress that would address administrative burden by streamlining the requirements associated with prior authorization and step therapy processes. Specifically, ACOFP endorses the *Reducing Medically Unnecessary Delays in Care Act*, which would improve the prior authorization process in Medicare and Medicare Advantage (MA) programs by clarifying rules around “medically necessary” care and requiring that board-certified physicians in the relevant specialty make claim determinations.<sup>v</sup> ACOFP also endorses the *Improving Seniors’ Timely Access to Care Act*, which would establish electronic prior authorization processes in MA plans, increase transparency into how prior authorization is used in claims determinations, and establish mandatory timeframes for plans to respond to prior authorization requests.

Artificial Intelligence (AI) has the potential to assist with providing care and reduce time and resources spent on administrative tasks. Specifically, studies illustrate that AI has the potential to deliver value to physicians by automating routine tasks, streamlining critical workflows, and relieving administrative burden.<sup>vi</sup> ACOFP supports AI as a tool to reduce administrative burden and address physician burnout. AI also has the power to generate large amounts of information, which risks overwhelming physicians with unnecessary information, which could adversely affect physician decision-making or expose physicians to increased liability.

AI products must be implemented to augment, not supplant, the value of osteopathic physicians and comprehensive policies are needed to govern their safe use. One study illustrates that, if properly implemented, AI can enhance osteopathic medicine by providing diagnostic support and identifying pattern recognition. However, without adequate guardrails and user training, an over-reliance on empirical data may undermine the holistic, person-centered care philosophy of osteopathic patient care.<sup>vii</sup>

ACOFP also recognizes that AI can be expensive to deploy and that such costs could be a barrier to adoption for small, rural, and solo practices. We support policies that promote access to AI for small, rural, and solo practices so that physicians in practices of all sizes and in all geographic locations receive equal access and are not prevented from accessing tools that can reduce administrative burden and improve patient 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 Healthcare Experience and Interoperability,<sup>ix</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 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) awarded \$103 million from the *American Rescue Plan Act of 2021* (ARPA) to 44 grantees in an effort to strengthen resiliency and address burnout in the health workforce. ACOFP supports initiatives 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.
- ▶ Implement any major regulatory changes to Medicare in a manner such that physicians have time to familiarize themselves with new program rules and update their practices accordingly.
- ▶ Support the use of AI as a tool to reduce administrative burden, but with restrictions to preserve the physician-patient relationship as well as the physician's ultimate clinical decision-making authority.
- ▶ Support policies that ensure AI is accessible to all physicians, including those in small, rural, and solo practices.

# PRESERVE THE FAMILY MEDICINE MODEL OF CARE

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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 non-physician 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.<sup>x</sup>

Physician-led care teams are the gold standard for care delivery, and non-physician-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.<sup>xi</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. As a result, beneficiaries experience better health outcomes and Medicare realizes overall savings from healthier seniors.<sup>xii, xiii, xiv</sup> While the use of non-physician practitioners may be appropriate under certain circumstances and with adequate physician supervision, the non-physician practitioner model is not an equivalent substitute to the use of family physicians and necessary physician supervision is not always occurring to the level it should, thus necessitating greater regulatory oversight. Also, when a patient receives healthcare services from a non-physician 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.

ACOFPP also believes that Congress and the federal government 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 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.
- ▶ 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.
- ▶ Support DPC arrangements through appropriate tax treatment (e.g., allowing DPC models to be paid through health savings accounts).
- ▶ Require transparency so patients know when they are receiving care from non-physician practitioners instead of physicians.

# ADDRESS THE FAMILY PHYSICIAN SHORTAGE

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As more family physicians reach retirement age, the United States is facing shortages of 18,000 to 48,000 primary care physicians by 2034.<sup>xv</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. Primary care physicians are poorly compensated relative to their peers in specialty services, and medical students are financially incentivized to choose specialty training over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing, and procedures.<sup>xvi</sup> In AMGA's 2024 Medical Group Compensation and Productivity Survey<sup>xvii</sup>, medical groups and health care organizations reported a 5.6 percent increase in compensation for family medicine (\$312,672 to \$330,216). Comparatively, compensation for the top three medical specialties (cardiology, gastroenterology and hematology/oncology) increased 4.9 percent (\$469,301 to \$476,355). Despite encouraging trends, primary care physicians continue to earn considerably less than many of their medical colleagues, which 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>xviii</sup> Compensation between primary care physicians and specialists remains a concern that policymakers must address to incentivize physicians to pursue primary care.

Recent efforts to increase Medicare reimbursement for primary care, including through the calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) final rule, represent positive steps. Specifically, in the final rule, CMS implemented an efficiency adjustment that it estimates will result in an increase in work relative value units (RVUs) for specialties that more frequently bill timed codes, such as family medicine. 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. Needed incentives for medical students to choose family medicine include:

- Equalizing reimbursement between various settings of care, i.e., office, outpatient clinic, emergency department, and eliminate the compensation imbalance between family and specialty medicine;
- 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.

However, ACOFP is concerned about recent federal actions that may impact medical students' access to education and deter them from practicing in family medicine. The *One Big Beautiful Bill Act* (H.R. 1), signed into law on July 4, 2025, eliminated the Grad PLUS loan program beginning in the 2026-2027 academic year. This limits professional students, including medical students, to a \$50,000 annual borrowing cap and a \$200,000 lifetime cap for federal loans beginning in July 2026.<sup>xx</sup> ACOFP is concerned that this may pose disincentives for medical students to choose practicing family and osteopathic medicine and may prohibit diverse and low-income students from pursuing a career in medicine altogether.

Additionally, the Department of Education (ED) issued a final rule on October 31, 2025 that makes significant changes to the eligibility requirements to receive benefits from the Public Service Loan Forgiveness (PSLF) program to exclude individuals employed by organizations that “engage in activities that have a substantial illegal purpose”, which ED defined broadly to include providing gender-affirming care and engaging in diversity, equity, and inclusion policies, among other activities.<sup>xxi</sup> ACOFP is concerned that this will reduce medical students' access to loans and deter them from seeking employment at qualifying organizations, including nonprofit hospitals.

ACOFPP is also concerned about the impact of recent federal actions that may impact the ability to grow the healthcare workforce and, thus, may worsen the family physician shortage. The Trump Administration imposed new requirements on H-1B nonimmigrant visas on September 19, 2025, including an increased application fee of \$100,000 for new H-1B visa applications.<sup>xxii</sup> ACOFP is concerned this increased fee will impact our nation's ability to attract skilled and qualified health care workers, including physicians, which will exacerbate the family physician shortage and the U.S. health care workforce shortage overall.

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. Notably, the federal government previously sought to issue a rule against non-compete clauses, which was ultimately invalidated by the courts. In 2024, the Federal Trade Commission (FTC) announced a final rule banning non-compete clauses nationwide.<sup>xxiii</sup> The U.S. District Court for the Northern District of Texas, Dallas Division, and the U.S. District Court for the Middle District of Florida, Ocala Division, heard similar challenges to the rule, and both courts enjoined FTC from enforcing the rule.<sup>xxiv</sup> In September 2025, FTC dismissed its appeals in these cases and acceded to the final rule being vacated.<sup>xxv</sup> However, FTC has taken other steps to address non-compete clauses. In September 2025, FTC launched a public inquiry to understand the scope, prevalence, and effects of employer non-compete agreements and to gather information to inform future enforcement actions.<sup>xxvi</sup> Since September 2025, FTC has also pursued case-by-case enforcement actions ordering specific entities to halt the enforcement of their non-compete and no-hire agreements.<sup>xxvii</sup>

## ADVOCACY POSITIONS:

- ▶ Support policies that eliminate the imbalance of reimbursement and compensation between primary care and specialty care.
- ▶ Reward care, through reimbursement policies, when provided by family medicine and 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.
- ▶ Ensure that federal student loan programs are adequate for medical students pursuing careers in family and osteopathic medicine.
- ▶ Create exceptions to federal actions restricting visas for overseas physicians.
- ▶ Support efforts to ban the use of non-compete clauses for physician employment contracts.

# PROTECT PHYSICIANS FROM WORKPLACE VIOLENCE

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More needs to be done to protect family physicians from violence in the workplace. The rate of workplace violence is especially high among the healthcare workers and significantly impacts the mental health and wellbeing of the healthcare workforce. While healthcare workers make up 10 percent of the entire workforce, they experience 48 percent of nonfatal injuries as a result of workplace violence.<sup>xxviii</sup>

Healthcare workers who experience workplace violence may experience symptoms of depression, anxiety, post-traumatic stress, and suicidal ideation.<sup>xxix</sup> Specifically, a 2023 Centers for Disease Control and Prevention (CDC) Vital Signs report found that more than double the number of healthcare workers reported harassment at work in 2022 than in 2018, increasing from 6.4 percent in 2018 to 13.4 percent in 2022.<sup>xxx</sup> The report also highlights the substantial impact of harassment on healthcare worker mental health. Specifically, healthcare workers who experienced workplace harassment were more likely to report feelings of anxiety, depression, and burnout.<sup>xxxi</sup>

It is critical to protect family physicians from workplace violence especially because such violence can lead physicians and other healthcare workers to experience serious mental health conditions and burnout. It is imperative for Congress to take action to ensure all health care workers are safe from violence in the workplace and provide resources to family physicians and other healthcare workers who experience workplace violence and are in need of services and supports for recovery.

ACOFP supports the *Safety from Violence for Healthcare Employees (SAVE) Act*. The bill is modeled after existing protections for flight crews and attendants by establishing legal penalties for individuals who knowingly and intentionally assault or intimidate hospital employees. In addition to establishing federal protections for hospital employees, the bill would authorize the creation of a grant program designed to provide hospital workforce safety and security training.

While the SAVE Act is critical to protecting physicians from workplace violence, Congress must pass additional legislation to protect family physicians from workplace violence.



## ADVOCACY POSITIONS:

- ▶ Pass legislation, including the SAVE Act, to protect physicians and the healthcare workforce from workplace violence.
- ▶ Support policies that shield workers from violence in the health care setting.
- ▶ Ensure that physicians and other healthcare workers who experience workplace violence receive the necessary services and supports for recovery.
- ▶ Support outreach and awareness efforts on preventing workplace violence and where to receive services and supports if a family physician or healthcare worker is a victim of such violence.

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

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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 be promoted. Many studies show dramatic benefits in geographic areas that have higher primary care provider (PCP) use and higher ratios of PCPs per capita.<sup>xxxii</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 preventive care and lower hospitalization rates. This contrasts with areas where there are higher numbers of specialists—characterized by more spending and worse health outcomes.<sup>xxxiii</sup> ACOFP supports continuing to educate specialists about the vital role of PCPs in improving patient outcomes.

CMS provides reimbursement for several services, including transitional care management,<sup>xxxiv, xxxv</sup> chronic care management,<sup>xxxvi, xxxvii</sup> the Medicare Diabetes Prevention Program<sup>xxxviii, xxxix</sup> and advanced primary care management,<sup>xl</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. 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.<sup>xli</sup>

ACOFP supports CMS care models that emphasize the provision of primary care. Two such models, the Making Care Primary (MCP) Model and the Primary Care First Model, were concluded early on June 30, 2025 and December 31, 2025, respectively. However, the Accountable Care Organization (ACO) Primary Care (PC) Flex Model, launched on January 1, 2025, is currently operating and is expected to conclude on December 31, 2029. CMS is also launching a new model on July 5, 2026, the ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model, which provides a new co-management payment to primary care physicians for documented care review and coordination activities. Another Medicare value-based model (MAHA ELEVATE), launching September 1, 2026, is intended to support evidence-based, whole-person care approaches, including functional or lifestyle medicine interventions. 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. 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 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>xlii, xliii</sup>

An important aspect of primary care also includes the administration of vaccines. Vaccines have been proven to be safe and effective and are critical to protect patients from life-threatening illnesses and diseases. Family physicians utilize vaccines in their practices to ensure their patients receive the highest level of care. We oppose efforts to limit access to vaccines. Instead, Congress and the Administration should take steps to ensure vaccines are accessible to all patients. According to the CDC, "...vaccines are the safest, most effective way to protect yourself and your family from many preventable diseases."<sup>xiv</sup> Studies have also indicated that vaccines are considered "one of the most important advances in modern medicine and have greatly improved quality of life" because they have reduced or eliminated many serious infectious diseases.<sup>xlv</sup> High uptake of vaccines is critical to gaining herd immunity to protect vulnerable individuals and to public health. Many vaccine preventable diseases have no medication treatments because they have been so successful in prevention.

Moreover, recommendations regarding vaccines must be scientifically based. On January 5, 2026, the Trump Administration made dramatic changes in the childhood vaccine schedule. ACOFP strongly believes that any changes to vaccine recommendations in the United States must be based on scientific evidence to ensure that children continue to receive vaccines that have been proven to be safe, effective, and necessary to protect their health and wellbeing.

ACOFP is concerned that limiting access to vaccines could result in recurrences of infectious diseases that have been reduced or eliminated as a result of a vaccine. Congress and the Administration should not advance policies that could reduce access to vaccines.

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. However, the CY 2026 PFS final rule imposes an efficiency adjustment on non-time-based services, including OMT services, resulting in a 2.5 percent reduction in work RVUs for OMT services, with additional cuts proposed every three years. ACOFP is concerned that this reduction in payment for OMT services will lead to even greater underutilization of these services.

## 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.
- ▶ Recognize the significance of vaccination in primary care and their importance in ensuring patients receive the highest level of care from family physicians.
- ▶ Prove appropriate reimbursement to 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.
- ▶ Support access to vaccines as current evidence supports vaccine safety and efficacy.
- ▶ Recognize the clinical value and cost savings from physician-led care coordination and establish appropriate reimbursement policies for such activities.
- ▶ Address the compensation and reimbursement imbalance 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 deploy the most up-to-date technology that assists with improving quality and reducing costs.
- ▶ 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 ENSURE ACCESS TO CARE

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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 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 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.

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>xlvi</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>xlvii</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 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 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 (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals, and Disproportionate Share Hospitals).

## ENCOURAGE THE APPROPRIATE USE OF TELEHEALTH

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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. There continues to be widespread support for these telehealth flexibilities as Congress has passed legislation to extend them on numerous occasions since the end of the PHE.

There also are ongoing efforts to make these telehealth flexibilities permanent. 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 remains nearly two times higher than pre-pandemic levels, with more than one in ten (12.7%) eligible beneficiaries receiving a telehealth service in the final quarter of 2023.<sup>xlviii</sup> While ACOFP supports the use of telehealth, we also firmly believe 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. We believe it is critical that there are safeguards against the potential for telehealth to 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. We want to avoid situations in which telehealth is used as a replacement for in-person care delivered over time, as this is an important element of chronic condition management often performed by osteopathic family physicians. Further, while telehealth is convenient and necessary at times, it also may result in large national telehealth companies providing fragmented care with no coordination with a patient's primary care provider. Thus, ACOFP urges caution when establishing telehealth policies.



## 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.
- ▶ Ensure care provided via telehealth is properly coordinated with the patient's primary care physician.
- ▶ Allow continued 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.
- ▶ Rely on 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

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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 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.<sup>xlix</sup>

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, which should be considered when determining OMT reimbursement.



## 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.

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