

How ACP's "Big Tent" Advocacy Agenda is Helping Internists, and Your Patients

ACP Colorado Chapter
February 9, 2018



Big Tent defined:

- A widely inclusive composition or character that allows people of differing backgrounds, opinions, and interests to be members of a group or organization (such as a political party). *Mirriam-Webster*
- A group, especially a political coalition, that accommodates people who have a wide range of beliefs, principles, or backgrounds. *American Heritage Dictionary of the English Language*

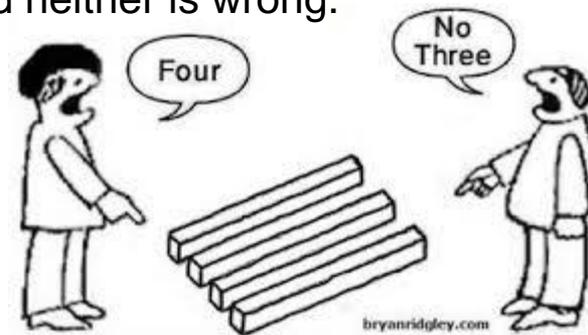
ACP is as *Big Tent* as they come

- We represent 152,000 IM physician and medical student members:
 - in **small private practices** and **large health systems, independent** and **hospital-owned, salaried** and **FFS, single** and **multi-specialty**; in **academic medical centers**, in concierge and **direct primary care**, in the **VA and armed forces**; and every other type of practice setting arrangement.
- We represent physicians who **teach** medical students and the **students** who learn from them.
- We represent **general IM, hospital medicine** and every **subspecialty** of internal medicine.
- We represent **physicians and medical students** from every **demographic category possible**, by race, ethnicity, gender, gender identity, sexual orientation, and other personal characteristics.
- We represent both **U.S.-born and foreign-born** physicians and medical student members, and Dreamers.
- We represent members from every state and territory; urban, suburban, and rural; from **GOP-leaning** and **Democratic-leaning** states; from **conservative** to **liberal-leaning** communities, cultures and traditions. We represent members who are Democrats, Republicans and independents; who voted for President Trump, Hillary Clinton, Bernie Sanders, or Jill Stein.

Is it any wonder that our 152,000 members don't agree on every aspect of ACP policy?



But sometimes it means looking at the same thing from a different perspective. And neither is wrong.



So how do we bring them all into our *Big Tent*?

- By having a policy process that is “widely inclusive by character and composition” to ensure that the wide spectrum of members’ opinions, interest, beliefs, principles, and backgrounds are considered . . . as informed by a rigorous review of the evidence of what works and doesn’t work to improve patient care.



Our policy process in a nutshell.



- Where does our policy come from? *Our members.*
 - BoG resolutions, strategic direction from the BoR; individual member communications (does ACP have policy on X, Y, or Z?); and members on our councils and policy committees.
 - As trusted advisors, ACP staff will also recommend gaps in policy that should be addressed, driven largely by the external political environment.

Our policy process in a nutshell.



- How do we develop policy? *Through member consensus and review of the evidence.*
 - Once an issue is selected for policy development, staff brings back to the committee a proposed outline of possible content, with an initial evidence-base literature review.
 - The committee members review the outline and initial research, and give direction on proceeding with further policy development. The committee chair is responsible for ensuring that all views within the committee are heard on the direction of such policy.
 - Issues selected for policy development are then subjected to a more thorough *evidence review* by the staff.

Our policy process in a nutshell.



- Staff then brings back to the policy committee a draft position paper, or in some cases, a shorter policy statement. The draft position paper includes recommended statements of policy, with supporting background information and review of the evidence.
- The policy committee thoroughly discusses the proposed statements of policy and the supporting background and evidence. *The committee chair is responsible for ensuring that all committee members are heard; the vice-chair for ensuring that the governors' perspectives are considered.*
 - Staff provides expertise on the issue and the external political and policy environment.

Our policy process in a nutshell.



- The policy committee members may ask staff to come back with a revised paper, or vote to approve the draft position statements in the paper as amended by the committee in a series of votes. Committee minutes reflect the total of the votes for and against each position statement.
- Because all proposed policies are informed by the staff's rigorous review of the evidence on what is effective in improving patient care, the individual committee members may at times find that the evidence challenges their own personal perspectives on an issue.
 - Examples: evidence of the impact of climate change on human health, or the association between gun violence and weak regulation of firearms. Most individual committee members, and the committees as a whole, will arrive at a conclusion that is supported by the evidence.

Our policy process in a nutshell.



- All draft position papers and the policy recommendations within, as approved by the committee, are then sent out to the entire Board of Governors, Board of Regents, Councils, external expert reviewers, and when appropriate, a sister committee (e.g. ethics) for review and comment. If Annals is interested in publishing it, the paper is simultaneously submitted for Annals review by editors and its expert reviewers. A minimum of 30-days of review is given.
 - ACP has a fast-track process for approval of policy by the ECBOR when external circumstances so require.
- Staff reviews every comment received, makes revisions as appropriate based on such review, and brings back a revised, final draft to the committee for review and approval. The committee is provided with a summary of every one of the comments received and the revisions made in response.

Our policy process in a nutshell.



- The committee then votes to approve the final paper or send it back to the staff for further revision.
- The paper is then voted on by the Board of Regents at its next face-to-face meeting or webinar.
 - Regents receive from the staff a summary of the comments received during the 30-day review and suggested changes that were incorporated, or were not incorporated, in the final draft.
 - If approved by the Board of Regents by a majority vote, the paper and the policy statements within are then official ACP policy.

Our policy process in a nutshell.



- Approved papers become publicly available when Annals publishes them (if accepted by Annals) or when ACP releases them on our own if not submitted to or accepted by Annals.
- Communications plans and FAQs for ACP spokespersons, regents and governors are developed by our communications and policy staff for each paper, especially the more controversial ones.

Translating *policy* into *advocacy*:

Advocacy (n): *Public support for or recommendation of a particular cause or policy.*
English Oxford Living Dictionaries

- Once approved as policy, staff and ACP's spokespersons will use it as the basis for advocacy on proposed legislation, regulation, or other actions, by government or non-governmental entities like health insurers.
- Because we can't effectively advocate on every possible policy issue, we prioritize our advocacy agenda, through an annual process where staff reviews the external political environment, provides our policy committees (HPPC and MPQC) with an assessment of threats and opportunities, and recommends the issues that likely will require the greatest advocacy response. Committee review ensures that the issues selected for priority are informed by governance. *Priorities change as circumstances change.*
- *Leadership Day on Capitol Hill* priorities are selected based on (1) priorities identified through above process; (2) staff assessment of external political environment (which issues are currently or likely will be addressed by Congress and the administration at that time or near future) (3) which issues are most likely to enjoy bipartisan support in Congress, even if a few are contentious.

This entire process results in a Big Tent advocacy agenda to improve the live of patients and the professional lives of our members!



big tent

Column A

Expand access and coverage
Improve public health
Support research and science
Oppose discrimination
Reduce health care disparities
Support primary care workforce
Lower Rx drug prices

The issues in column A affect the overall health and well-being of patients and the public.

Column B

Improve EHRs
Reform and improve payments
Improve Medicare's Quality Payment Program
Improve quality measures
Reform medical liability system
Reduce crushing administrative burden

The issues in column B affect the health, well-being, professional and career satisfaction of our members.

ACP 2017 Achievements

Advocacy In Focus



Staved off potential repeal of the ACA, protecting pre-existing conditions, patient access, and costs



Preserved tax deductibility of student loan interest payments, tuition waivers, and medical expenses in the tax reform legislation

Supported The Chronic Care Act to improve care coordination



Influenced CMS to decrease administrative burdens resulting in Patients Over Paperwork and Meaningful Measures initiatives



Developed Forward-Looking Agenda to improve American health care



Worked closely with Dept of Justice to protect patient choice by blocking health insurance mergers



Secured a bonus for complex patients and new options for small practices under the QPP Medicare payment program



Achieved simplification of the care management code set



ACP member, Dr. Louis Friedman testified before a key House subcommittee on how Medicare can better support participation in alternative payment models

8

ACP Policies Published

U.S. Immigration Policy

1

Reducing Administrative Tasks in Health Care

2

Funding for Women's Health Clinics

3

Prevention and Treatment of Substance Use Disorders

4

Patient Safety in the Office-Based Practice Setting

5

Transparency and Alignment in Medicare Advantage

6

Improving Health Care Through Increased Transparency

7

Compensation Equity and Transparency

8

ADVOCACY IN ACTION

500K 17 9 54 45 400+

Doctors represented in Coalition of 6 professional organizations co-founded by ACP

Comment Letters to CMS

Written Statements Submitted to Congressional Hearings

Letters sent to Congressional Leadership

Advocacy Alerts in the Advocates for Internal Medicine Network (AIMN)

Meetings with Congressional Offices held on Leadership Day

Click on each achievement to learn more.



MD7023

Highlights:

ACA not repealed: essential benefits, ban on charging more for preexisting conditions or imposing annual/lifetime benefit caps, and Medicaid expansion all preserved.

Patients Before Paperwork: based on ACP's 2-year old initiative, CMS Administrator Verma announced Patients Over Paperwork, to reduce administrative tasks imposed on doctors. Care management codes simplified. CMS to review E/M documentation requirements.

Quality Payment Program: bonus for complex patients, new options for smaller practices, exemptions for natural disasters.

Health care tax deductions: deductibility of student loans and medical expenses was preserved., ACP resolution adopted by AMA.

Insurer mergers: The courts blocked two mega insurer mergers that would have harmed physicians and patients. DOJ reached out to ACP to help make the case.

Rx pricing: The National Academy of Medicine issued a report that closely reflected ACP's recommendations

Opioids crisis: The President's Commission issued a report that is largely consistent with ACP's recommendations; funding still needed.

Advocacy priorities: 2018

- Preserve and expand coverage.
- Fund essential health programs.
- Protect “Dreamers” and offer pathway to citizenship.
- Lower prescription drug costs.
- Reduce administrative tasks and improve payments.

Preserve and expand coverage

- As part of the tax reform law, Congress repealed the individual insurance mandate.
 - This will cause premiums to increase on average another 10% for the 2019 enrollment period (CBO), on top of premium increases from elimination of cost-sharing reduction payments to health plans.
 - The mandate remains in effect for the *2017* tax year being filed now.
- While persons eligible for premium subsidies are mostly protected from paying more, those who are ineligible because they earn too much (\$98,400 for family of four) will be hurt the most.

Preserve and expand coverage

- With Congress *unlikely* to pursue repeal and replace again in 2018, ACP's efforts will be focused on:
 - Stabilizing the individual insurance market by advocating for bipartisan approaches (reinsurance, restore cost-sharing reduction payments, other) to keep premiums down and make it attractive for insurers to offer plans.
 - Offering advice to ACP chapters on policies that could be adopted in your own states to stabilize markets.
 - Opposing regulations to allow sale of health plans that do not cover essential benefits.
 - Opposing Medicaid waivers that will create more barriers to coverage.

What are Medicaid Waivers?

- A state can request that certain aspects of Medicaid law be waived providing the changes:
 - Further the objectives of Medicaid
 - Are approved on a demonstration basis and evaluated
 - Budget neutral to federal government
 - Provide an opportunity for public comment
- Waivers have been used to broaden managed care, test delivery and payment system reforms, expand coverage

Under President Trump, CMS Takes a Different Direction

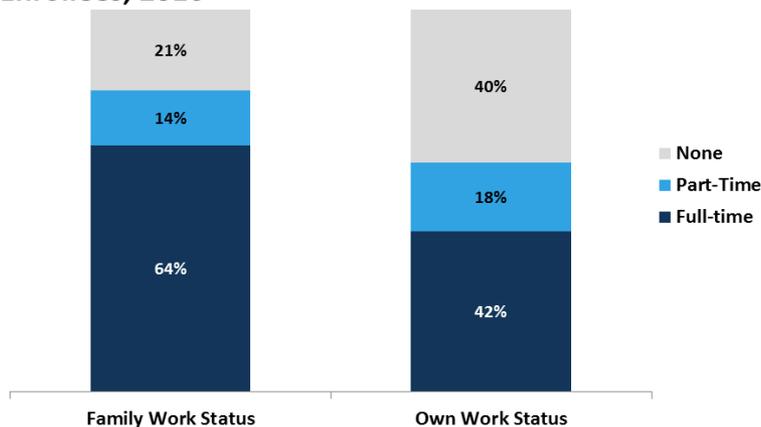
- In November, CMS Admin Verma [said](#) that CMS would focus on “flexibility, accountability, and integrity” and give states more say in how they operate their Medicaid program.
- In January, CMS issued [guidance](#) to states interested in requesting a waiver to make Medicaid eligibility contingent on work, volunteering, job search, etc.
- [10 states](#) have recently submitted 1115 waiver proposals that include work requirements. Only KY’s waiver has been approved so far.

Work Requirements: A Solution Searching for a Problem?

- ACP policy states that work-related or job search activities should not be a condition of eligibility for Medicaid. **Voluntary** enrollment in skills- and interview-training programs can be made available.
- Why? 60% of adult Medicaid enrollees are already working and 80% are in a family where at least one person works.
 - Many work in small firms or industries that do not offer job-based health insurance, such as restaurants or food services.
 - 51% of working Medicaid enrollees are employed full time, yet their income is still low enough to be eligible for Medicaid.
- If they aren't working they may have a valid reason: ill or disabled, taking care of family, going to school, can't find work, etc.
- ***Medicaid enrollees report that coverage enabled them to search for work or enhanced their ability to work.***

Most Medicaid recipients work, and when they don't, it's usually for good reasons

Figure 1
Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016

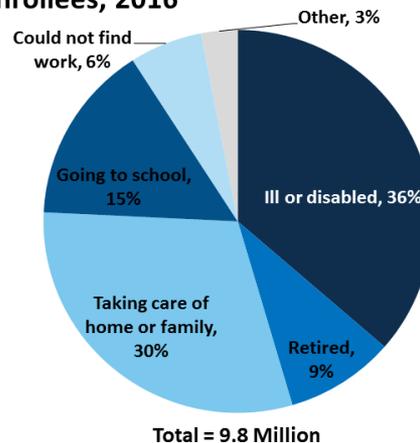


Total = 24.6 Million Non-Elderly Adults without SSI

NOTE: Totals may not add due to rounding. Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
 SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



Figure 6
Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
 SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



"THE FEDERAL GOVERNMENT MUST
STOP HANDING OUT MONEY TO
PEOPLE WHO REFUSE TO DO
MEANINGFUL
WORK!"

"BUT, SENATOR,
WOULDN'T THAT
ELIMINATE
CONGRESSIONAL
SALARIES?"



Work Requirements = More Paperwork

- Work requirements may mean more **administrative burdens** for:
 - Enrollees, who will have to prove that they're working
 - Physicians, who may have to provide disability assessments or other medical exemptions for patients
 - Potential conflict with medical ethics, if a patient asks a physician to certify that they are too frail to work in order to keep Medicaid. If the physician declines, the patient loses coverage, and is at greater risk of preventable death. If the physician agrees, *even though the patient may not meet the definition of "frail"*, he/she is intentionally deceiving the government.
 - State programs may have to develop new capacities to track and enforce new requirements.

Are Work Requirements Legal?

- Shortly after the KY waiver was approved, a group of Medicaid enrollees sued the federal gov't
 - Group argues that waiver is against law b/c work req. do not promote goal of Medicaid to furnish medical assistance, among other reasons.
 - CMS says work/volunteering improves health and well-being
 - KY Gov. Bevin has threatened to end Medicaid expansion if work req. aren't approved.

Other Waiver Requests Raise Concerns

- Many waiver requests also include other changes that are counter to ACP recommendations:
 - Onerous premiums and cost-sharing
 - Benefit cuts (non-emergency transportation)
 - Lock-out periods
 - Time limits on enrollment

Approved and Pending Coverage Waivers

Features	Approved		Pending											
	KY	AR	AZ	IN	MA	MI	ME	MS	MT	NC	NH	NM	UT	WI
Premiums (some states with lockout)	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓		✓
Cost Sharing	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Work Requirements	✓	✓	✓	✓			✓	✓		✓	✓		✓	✓
Healthy Behavior Incentives	✓	✓	✓	✓		✓						✓		✓
Non-Emergency Medical Transportation Waiver	✓			✓	✓									
Institution for Mental Disease Exclusion Waiver	✓		✓	✓	✓	✓				✓		✓	✓	✓
Retroactive Coverage Waiver	✓	✓		✓	✓		✓				✓	✓	✓	
Prompt Enrollment Waiver	✓			✓								✓		
Drug Screening														✓
Limits on Enrollment Duration			✓										✓	✓
Partial Expansion		✓			✓									
Health Savings-Like Accounts	✓		✓	✓		✓								
Late Renewal Paperwork Penalty/Lockout	✓			✓										
1927 Waiver for Closed Formularies					✓									

Approved: KY; submitted to DHS: AR, AZ, IN, KS, MA, MI, MN, NC, NH, NM, UT, WI
 Note: Chart includes approved and pending waiver features; some states are seeking amendments or extensions to current demonstrations while others are seeking new demonstrations; populations impacted by waiver features vary across states; chart does not include all waiver features.
 As of 1/22/2018



How Can Chapters Get Involved?

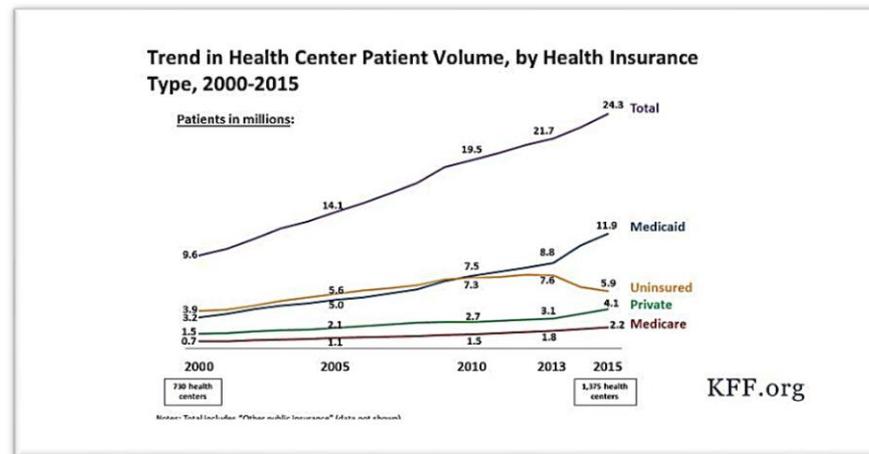
- State chapters can comment on proposed waivers! Typically, the state will have a public comment period, make changes to waiver, submit to CMS, and CMS will accept comments.
- National has already commented on KS, NM waivers; governors signed on. Upcoming opportunities for AZ and MS waivers.
- ACP is developing a **chapter action plan** to help chapters develop their comment letters.
- We provide summary of the waiver, relevant ACP policy, and draft policy language to plug into your letter.
- Fortunately, Colorado seems unlikely to seek a work requirement waiver!

Fund essential health programs

- Current temporary resolution will expire at midnight, February 8; another government shut-down is possible.
- To end previous shut-down, Majority Leader McConnell promised Democrats that there would be debate and possibly votes on DACA legislation (no comparable commitment from Speaker Ryan, however).
- Democrats want to ensure that this time, agreement is reached on legislation to protect and provide a pathway to citizenship for DACA recipients that can pass both chambers and be signed into law by the president. President Trump has stated that he can support such legislation only if tied to changes in other immigration policies that Democrats oppose.
- Also, Democrats want budget caps on both domestic and defense spending to be raised; conservative Rs want to raise only defense caps.

Fund essential health programs

- Authorization (and funding) for Community Health Centers, National Health Services Corps, and Teaching Health Center GME expired on 9/30/17; current temporary authorization and funding ends in March.
 - Community Health Centers are the largest source of comprehensive primary care for medically underserved communities <http://kaiserf.am/2Dtdsot>



- Also, Congress must begin to set appropriations levels for Title VII primary care training grants, NIH, AHRQ, CDC, other essential programs.

Fund essential health programs, protect DACA recipients

- ACP is advocating for long-term budget agreement that will reauthorize expiring programs, and raise the discretionary spending-caps for defense and non-defense on an equal basis for at least two fiscal years, so that Congress can swiftly pass into law the fiscal year 2018 appropriations bills and begin work on fiscal year 2019.
 - Our priorities for funding include: Title VII primary care training grants, AHRQ, CDC, and NIH, and opioids epidemic response.
- Lastly, Congress must act quickly to ensure that individuals with deferred action for childhood arrival status remain in the United States and are offered a path to permanent legal status and U.S. citizenship.

Lower prescription drug prices

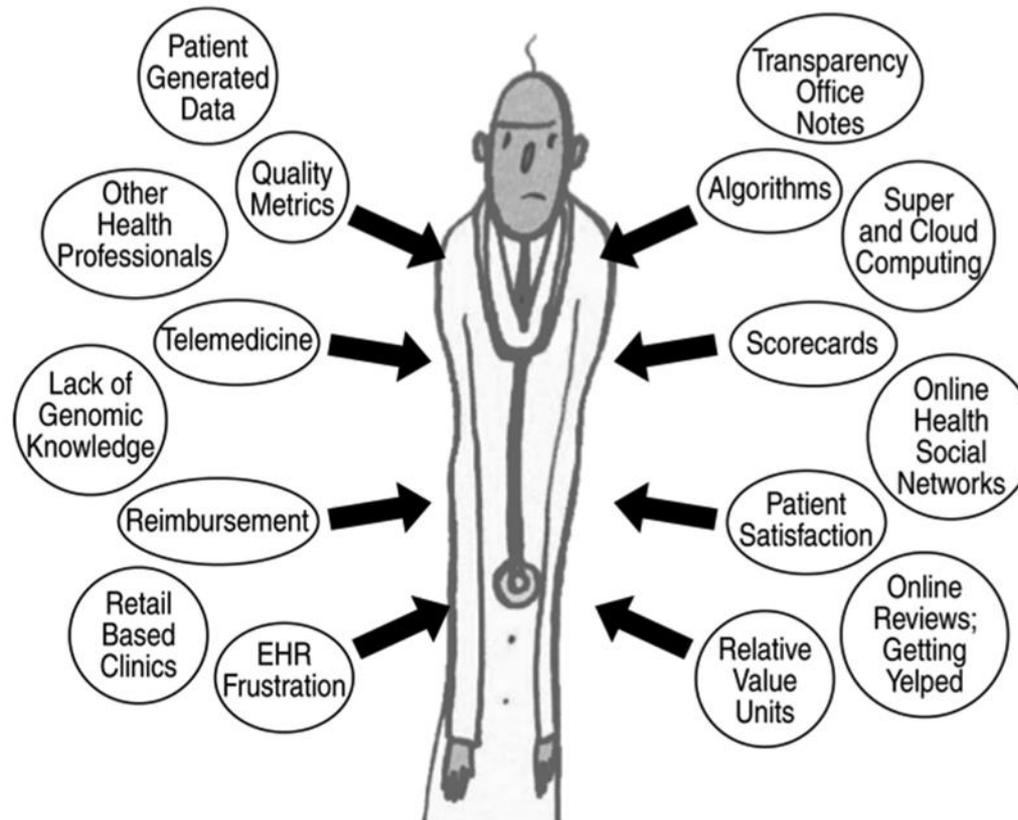
- President Trump, State of the Union: *“One of my greatest priorities is to reduce the price of prescription drugs. In many other countries, these drugs cost far less than what we pay in the United States. And it is very, very unfair. That is why I have directed my administration to make fixing the injustice of high drug prices one of our top priorities. Prices will come down.”*
- U.S. Senate Democratic Whip Dick Durbin has introduced the **Drug Price Transparency in Communications Act**, which requires drug companies to disclose the Wholesale Acquisition Cost of an Rx in Direct-to-Consumer Advertising; the bill was strengthened in response to ACP input. *Senator Durbin’s remarks on Senate floor cited ACP’s support for the bill.*
- ACP is also supporting the bipartisan CREATES Act, which prohibits abuse of the patient safety REMS process by name-brand manufacturers to stop generic competitors from obtaining the samples need to manufacturer a generic version.
- National Academy of Medicine just released a ground-breaking report on solutions to the crisis in drug prices; *ACP was a financial sponsor of the report, and its recommendations are closely aligned with ACP policy.*

Reduce administrative burdens and improve payments.

ACP's *Patients Before Paperwork* initiative and policy paper makes the case for reduce the crushing administrative burden on physicians and patients.

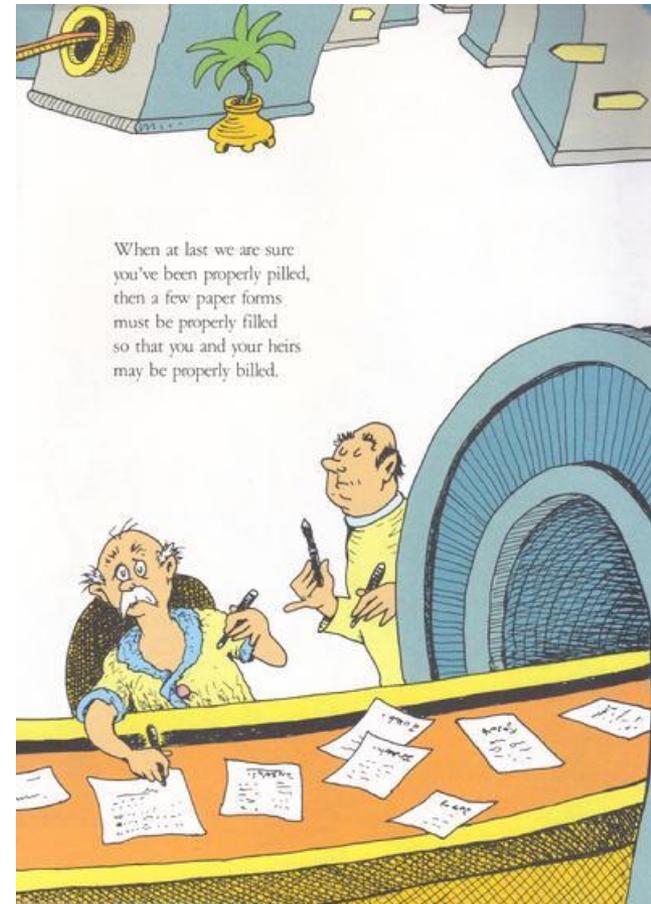
- Unnecessary regulation (and other administrative tasks) takes time away from patients, creates barriers to care, results in unnecessary spending, and contributes to professional burn-out.
- In ACP's view, the most effective approach will be to create an entirely new framework to assess regulations: *intent, impact, and alternatives*.

Isn't this how *you* feel?



And its not just physicians who are dissatisfied. *A patient's perspective:*

“When at last we are sure you’ve been properly pilled, then a few paper forms must be properly filled, so that you and your heirs may be properly billed.”



Dissatisfaction with EHRs is a major contributor to burn-out

- Takes away time from patients, diverts physicians' attention to looking at a screen instead of the patient.
- Does not produce clinically useful information in a user-friendly way.

Or as *The Kinks* sang:



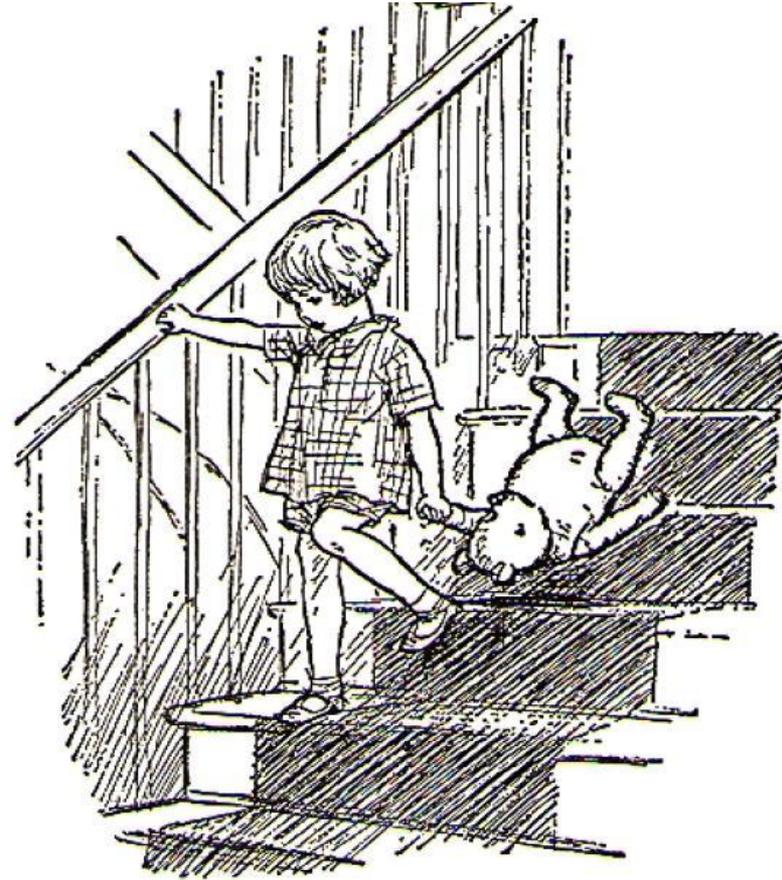
“He’s caught in a mass of computerized trivia,
Deciphering data for mechanical minds.
He’s lost in the paperwork and up to his eyes,
He’s checking a list that’s been checked out before,
He’s starting to lose his mind.”

The Kinks, Nine to Five



Easing regulatory burdens on physicians requires that we consider *another way* of looking at them

“Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it.”



A.A. Milne, 1920
illustration by E. M. Shepard

POSITION PAPERS | 28 MARCH 2017

Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians FREE

Shari M. Erickson, MPH; Brooke Rockwern, MPH; Michelle Koltov, MPH; Robert McLean, MD; for the Medical Practice and Quality Committee of the American College of Physicians (*)

Article, Author, and Disclosure Information

FULL ARTICLE

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Appendix: Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians

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Abstract

This American College of Physicians (ACP) position paper, initiated and written by ACP's Medical Practice and Quality Committee and approved by the Board of Regents on 21 January 2017, reports policy recommendations to address the issue of administrative tasks to mitigate or eliminate their adverse effects on physicians, their patients, and the health care system as a whole. The paper outlines a cohesive framework for analyzing administrative tasks through several lenses to better understand any given task that a clinician and his or her staff may be required to perform. In addition, a scoping literature review and environmental scan were done to assess the effects on physician time, practice and system cost, and patient care due to the increase in administrative tasks. The findings from the scoping review, in addition to the framework, provide the backbone of detailed policy recommendations from the ACP to external stakeholders (such as payers, governmental oversight organizations, and vendors) regarding how any given administrative requirement, regulation, or program should be assessed, then potentially revised or removed entirely.

The American College of Physicians (ACP) has long identified reducing administrative tasks as an important objective, maintaining significant policy and participating in many efforts with this goal in mind, including developing the "Patients Before Paperwork" initiative in 2015. The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In

<http://annals.org/aim/article/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper>

Figure 1: Framework for Analyzing Administrative Tasks

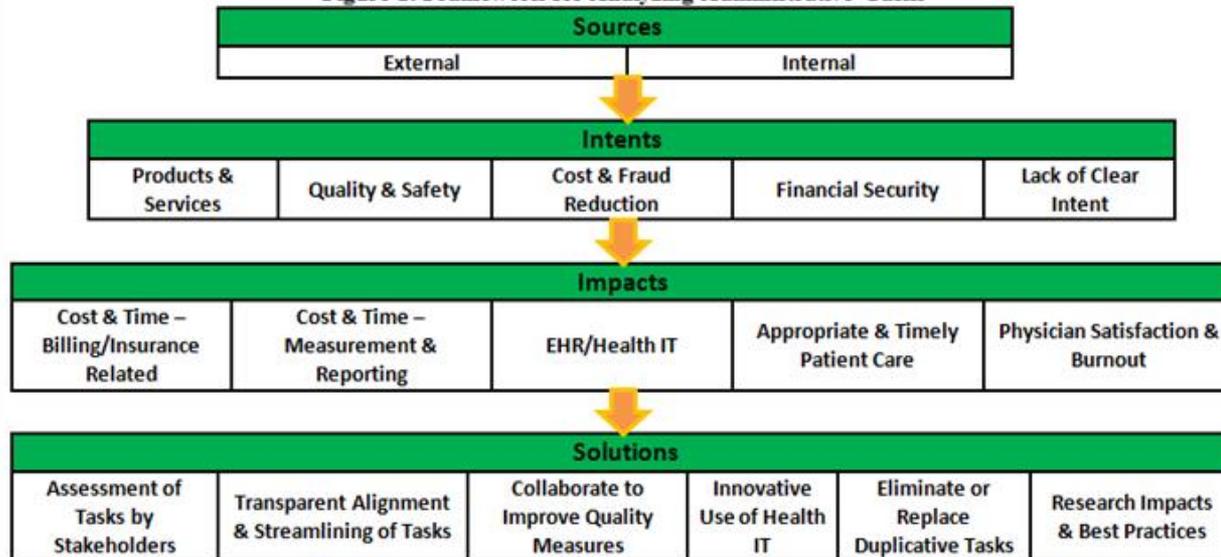
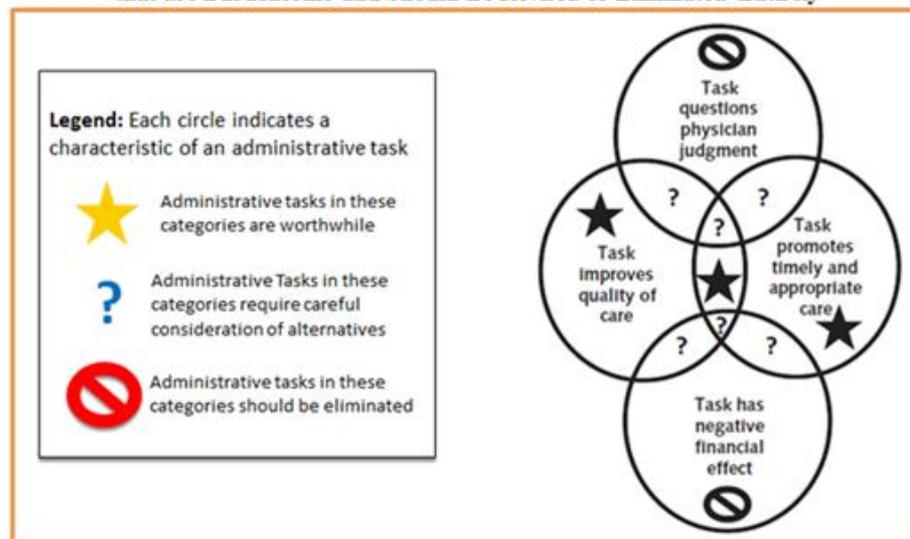


Figure 2: Taxonomy for Categorizing Administrative Tasks as Worthwhile and Should Remain in Place, or Tasks that are Burdensome and Should Be Revised or Eliminated Entirely



The administration agrees: Call it Patients *Before* Paperwork (ACP), or Patients *Over* Paperwork (CMS), the goal is the same!

October 30, 2017, Remarks by CMS Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit:

Doctors are frustrated because they got into medicine to help their patients. But, paperwork has distracted them from caring for their patients, who often have waited weeks, if not months, for the brief opportunity to see them.

We have all felt this squeeze in the doctor's office...we have all seen our doctors looking at a computer screen instead of us. I hear it from patients across the country. This must change. The primary focus of a patient visit must be the patient.

*Just last week, CMS announced our new initiative "**Patients Over Paperwork**" to address regulatory burden. This is an effort to go through all of our regulations to reduce burden. Because when burdensome regulations no longer advance the goal of patients first, we must improve or eliminate them.*

Our door is open to your ideas and we invite a two-way discussion about how we can accomplish our shared mission of delivering the best possible care at the lowest cost.

Reduce administrative tasks and improve payments.

- The administration has accepted many of ACP's recommendations to simplify the Medicare Quality Payment Program and to ease burdens on physicians.
 - MIPS bonus for complex patients.
 - Exemptions for physicians affected by natural catastrophes.
 - More flexibility for small practices.
 - CMS is soliciting comments on easing Evaluation and Management document requirements.
 - CMS has reduced the burdens associated with care management codes, including allowing some or all care planning to be performed on the same day.
- ACP will continue to advocate for policies to reduce administrative tasks and improve payments.

What ACP Advocacy Did For You and Your Patients in 2017

ACP's advocacy efforts strive to achieve policy change that makes a difference in your daily practice and improves American health care.

[Learn More](#)



In This Section

- Where We Stand
- ACP Advocate Newsletter
- Advocates for Internal Medicine Network
- State Health Policy
- Advocacy in Action
- Current Public Policy Papers
- ACP Policies & Recommendations

Where We Stand

Learn about how ACP is advocating for internists and their patients, and find out where ACP stands on various timely issues and current ACP priorities.

- Affordable Care Act/Access to Care
- Medical Liability Reform
- Workforce
- Medicare Reform
- Medicaid Reform
- Payment/Delivery System Reform
- Health Information Technology
- Federal Budget/Appropriations
- Patients Before Paperwork
- Other Issues
- What ACP Advocacy Did For You and Your Patients in 2017

ACP Advocate Blog

What did ACP advocacy achieve in a year of unparalleled challenge?
01/04/18

Warning: Congress' tax reform bill is bad for your health
11/30/17

Before Patients Over Paperwork, there was Patients Before Paperwork
10/31/17

[VISIT THE ACP ADVOCATE BLOG](#)

The ACP Advocate Newsletter

Health Care Funding in Congress, Compensation Equity and What's New at the AMA
01/12/18

Health Care Issues Remaining in Congress, and Increasing Transparency in Pricing
12/15/17

Health Care in the Tax Bill, ACP Testifies to Congress, and ACP on Patient Safety
12/01/17

[VISIT THE ADVOCATE NEWSLETTER](#)

Advocates for Internal Medicine Network

ACP's continued success on Capitol Hill greatly depends upon year-round grassroots support from the College's more than 15,000 participants in the Advocates for Internal Medicine Network.

[ENROLL NOW](#)

[LEARN MORE](#)

State Health Policy

The State Health Policy program is designed to help internists gain influence in their state capitols on issues affecting them and their patients.

- ACA Enrollment: Help Your Patients Enroll in Health Insurance Marketplaces
- Hot Topics (Take Action)
- Other Issues of Interest
- Education and Events
- State Advocacy Tools

Current Public Policy Papers

Policy papers summarize and examine published research and discussion on current issues, and make specific recommendations for practitioners, patients, and policy makers.

[BROWSE CURRENT POLICIES](#)

Search the ACP Policy Library

A collection of ACP's clinical guidelines, ethical guidelines, policy statements, and copies of testimony and letters to government and non-government officials.

Enter Keywords

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Leadership Day

An annual advocacy day on Capitol Hill where ACP staff and members strive to increase our presence in Washington, D.C., and bring visibility to issues of common concern. Participants are briefed on ACP's top legislative priorities and meet with legislators on Capitol Hill.

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ACP Health Policy Internship Program

Develop legislative knowledge and advocacy skills working with ACP's staff in Washington, D.C. A special opportunity for Resident/Fellow and Medical Student members.

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ACP Advocacy Resources

Where We Stand: chronological listing of official communications on key topics

ACP Advocate Blog: Bob Doherty's blog on ACP policy and advocacy and the external political environment

The ACP Advocate Newsletter: Official bimonthly e-newsletter to all ACP members

Advocates for Internal Medicine Network: ACP's grass roots Advocacy network; Link to alerts/action center

State Health Policy: advocacy resources for chapters and governors and their members

Current Public Policy Papers: all official BoR-approved position papers published in last 10 years

Search the ACP Policy Library: Google-type search engine to research all ACP advocacy communications by key word, both historical and current.

Leadership Day, May 22-23, 2018; Information

Twitter: @BobDohertyACP; @acpinternists; @AdvocatesIM; @AnnalsofIM

Concluding thought: our *Big Tent* agenda does not fall into the usual left-right, liberal vs conservative divide.

- Is it liberal or conservative to advocate to lower Rx drug prices, to reduce administrative burdens, to improve payments, to streamline and improve quality measures, to reform the medical liability system, to advocate for programs to address the opioid epidemic, and to reduce barriers to chronic care management?
- Is it liberal or conservative to oppose efforts to rollback coverage and consumer protections for millions? And to support a framework, the Affordable Care Act, which was based on a program first implemented in Massachusetts Governor Mitt Romney, a Republican? Is it liberal or conservative to support the bipartisan Alexander-Murray bill to shore up the individual insurance market? To advocate for CHIP, which long has had bipartisan support in Congress?
- Is it liberal or conservative to base policy on science? To support expanded background checks for firearms, which more than 90% of the public support? To protect and conserve our planet from climate change and environmental policies that adversely affect human health?

Rather than thinking about ACP's policy agenda through the usual partisan and ideological lenses, how about this?

- ACP's *Big Tent* Advocacy Agenda is all about doing what's right for patients and their doctors, based on policies established by our members through an inclusive and deliberative development process, as informed by evidence on what work's best in improving the health of patients.
- Isn't that something that every ACP member can support?