AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

State Advocacy Priorities: **Indiana**

State-level advocacy is now more important than ever. Through the Center for State Policy, the AAFP is working with chapters to advance policy priorities and provide background research on a range of topics. Priority issues for the AAFP, and where your state stands on them, are listed below. Explore all the AAFP customizable advocacy resources at www.aafp.org/state-advocacy.

Administrative Simplification

The AAFP advocates for immediate reduction in the regulatory and administrative red tape family physicians and practices comply with on a daily basis. These burdens range from onerous documentation guidelines to cumbersome prior authorization criteria and the unrelenting frustrations associated with electronic health records. A 2016 study published in the Annals of Internal Medicine found that during a typical work day, primary care physicians spend 27 percent of their time on clinical activities and 49 percent on administrative activities. For every hour primary care physicians spend in direct patient care, they spend two hours engaged in administrative functions.

States are beginning to tackle administrative burden for physicians. Indiana follows the National Council for Prescription Drug Programs (NCPDP) guidelines on electronic prior authorization (ePA) to allow for a standard pathway to prior authorization approval. Indiana has also passed step therapy reform, which would limit insurance company requirements for patients to try one or more insurer-preferred medications prior to a physician recommendation. Indiana law allows physicians to “override” step therapy protocols if the required drug causes harm to a patient, is expected to be ineffective, or is not in the best interest of the patient. Insurers are required to respond within 72 hours, or 24 hours in an urgent situation. For more information on how to improve prior authorization or step therapy statutes at the state level, view our backgrounder.

Direct Primary Care

The AAFP supports physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model including the direct primary care (DPC) setting. DPC provides family physicians and patients with an alternative to fee-for-service insurance. DPC typically works by charging patients a fixed periodic fee that offsets primary care service costs. DPC is designed to remove financial barriers patients encounter in accessing routine primary care; including preventative, wellness, and chronic care services. DPC practices often suggest that patients acquire a high-deductible, wraparound insurance policy to cover subspecialty care, emergency room visits, and hospitalizations.

Legislation is needed in many states to appropriately define direct primary care. Indiana became the 19th state to enact legislation in 2015 to define DPC as “not insurance,” providing clarity for physicians and regulators on how to conform DPC practices. According to DPC Frontier, there are 18 DPC practices in the state. For more information, view our backgrounder on direct primary care.

Medicaid Expansion

The AAFP supports health care for all, recognizing that health is a basic human right for every person, and that the right to health includes universal access to timely, acceptable and affordable health care of appropriate quality. AAFP policy encourages the expansion of Medicaid and recommends all Medicaid programs include provisions whereby the homeless and medically uninsurable are covered. To accomplish this, states should expand Medicaid to avoid coverage gaps. Indiana expanded Medicaid through the Section 1115 process that expanded coverage to approximately 413,000 Hoosiers and instituted a limited premium on beneficiaries, with those making more than the federal poverty level subject to coverage loss for failure to pay premiums, As a result of Medicaid expansion, the uninsurance rate in Indiana dropped from 13 to seven percent.

For more information on Medicaid expansion, view our backgrounder or HealthLandscape maps which show the uninsurance rate among U.S. adults overlaid with state Senate and House boundary lines.

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Medicaid-to-Medicare Parity

Low Medicaid physician payment rates have historically created a barrier to health care access for Medicaid enrollees. Prior to the passage of the ACA, Medicaid physician payments were generally far lower than both Medicare and private insurance payment rates for the same services. Physicians cited low payment rates and administrative burden as the main reason for limiting access to a significant number of Medicaid patients. Increasing Medicaid payment has been suggested as a solution to increase fairness and eliminate some of the barriers to access for the Medicaid population. AAFP policy advocates for Medicaid payment for primary are services at least equal to Medicare's payment rate for those services when provided by a primary care physician.

On March 23, 2010, the *Health Care Education and Reconciliation Act* (HCERA) was signed into law as part of the *Patient Protection and Affordable Care Act*. The HCERA included a mandatory two-year increase in Medicaid primary care payment rates; however, this policy was not reauthorized by Congress in 2014. Following the end of the primary care pay bump, most states rolled back Medicaid physician rates for primary care services to 2012 levels. As of 2016, Indiana Medicaid pays for primary care services at 75% of the Medicare rate in fee-for-service. Rates at which primary care services are paid for in Medicaid managed care are not public. For more information, view our backgrounder on Medicaid primary care payment.

Medicaid Waivers

Section 1115 of the Social Security Act provides the U.S. Secretary of Health and Human Services with authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program and the Children's Health Insurance Program (CHIP). Through this state option, certain provisions of the Medicaid program may be waived by the federal government to allow states additional flexibility in designing and improving their programs. The Trump Administration views Section 1115 waivers as an important tool for Medicaid reform and has committed to a system "where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population." As a result, there have been new trends in Section 1115 waiver applications including changes to state Medicaid programs that affect non-expansion populations. These include work requirements as a condition of eligibility, time limits for coverage eligibility, and coverage lockouts for failure to pay premiums and/or failure to timely renew eligibility.

In January 2018, Indiana received federal approval for a Section 1115 waiver to impose work requirements on its Medicaid expansion population. Indiana's waiver, effective January 1, 2019, will gradually phase in work requirements and will eventually apply to approximately 130,000 Hoosiers. Additionally, individuals who fail to satisfy the new requirement will be locked out from seeking coverage for six months before being able to reapply. For more information, view our backgrounders on Section 1115 Waivers and Medicaid work requirements.

Primary Care Spend

Family physicians perform a wide range of services including general practice, labor and delivery, emergency medicine, surgery and other procedures, pediatrics, hospital medicine, and geriatrics. Collectively, they're responsible for approximately one in five office visits every year, yet there is currently no widely accepted metric to quantify the total cost of primary care delivered nationwide. The AAFP supports efforts to establish collaboratives requiring insurers to report and increase the amount they spend on primary care to sustain medical home transformation and reduce the income disparity between primary and subspecialty care.

According to a JAMA study, primary care spending in the United States accounts for only five to eight percent of overall health care costs, lagging most other high-income countries. Primary care spend legislation would establish state-level primary care collaboratives to assist in developing and sharing best practices and methods to quantify and increase resources for primary care. Indiana has not introduced legislation on this topic. For more information, view our backgrounder on primary care spend.