MEETING MINUTES

Meeting Date: September 25, 2013
Meeting Time: 1:30 P.M.
Meeting Place: State House, 200 W. Washington St., Senate Chambers
Meeting City: Indianapolis, Indiana
Meeting Number: 2


Members Absent: Hugh Beebe; Michael Carmin; John Taylor.

Chairman Head called the meeting to order at 1:32 p.m.

Indiana Department of Insurance

Logan Harrison, Chief Deputy Commissioner of Insurance, Indiana Department of Insurance (IDOI), gave an overview of IDOI Bulletin 136, IDOI Bulletin 179, IDOI Bulletin 197, and the Indiana Essential Health Benefit Benchmark Plan. He also presented information on the implications of the Affordable Care Act (ACA) on Indiana. He highlighted the following responsibilities of Indiana as a participant in the federally facilitated marketplace (Exhibit A):

1 These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.
(1) Operate a toll-free call center and website.
(2) Determine eligibility for premium tax credits and cost-sharing reductions.
(3) Determine exemptions from the individual mandate.
(4) Manage Qualified Health Plans.
(5) Establish a federal navigator program.

Senator Breaux asked if the Indiana health insurance mandate for autism spectrum disorder (ASD) and pervasive developmental disorder (PDD) will be preserved once the ACA is implemented and how can individuals with ASD or PDD find out what services are covered under the ACA? Mr. Harrison replied that an individual with ASD or PDD, or the individual's family, should contact an advocate to find out details or talk to a licensed insurance professional.

Commission member Rosswurm asked if the insurance companies offering coverage under the ACA will cover applied behavioral analysis treatment for ASD as part of the essential health benefits? She also asked if IDOI will monitor compliance. Mr. Harrison replied that any services covered under IDOI Bulletins 136 and 179 will remain in effect and IDOI will monitor compliance.

**Indiana State Department of Health**

Robert Bowman, Director of Maternal and Child Health Division, Indiana State Department of Health (ISDH), presented information concerning the Indiana Birth Defects and Problems Registry (IBDPR). He stated the purpose of the IBDPR and its goals. He explained how data (including autism data) is collected and utilized by ISDH (Exhibit B).

**Indiana Prosecuting Attorneys Council**

Suzanne O'Malley, Assistant Executive Director, Indiana Prosecuting Attorneys Council, provided information concerning the definition of insanity and how it is used in prosecuting cases.

Representative Summers asked if individuals with developmental disabilities are categorized as insane by the criminal justice system. Ms. O'Malley stated that there is not a different category for developmentally disabled persons used in the criminal justice system for individuals with ASD who may not have had the intent to commit a crime at the time of an incident. Ms. O'Malley added that if the legislature decides to create a new category through legislation, then prosecuting attorneys may have additional options to place developmentally disabled individuals somewhere other than in the criminal justice system when an incident occurs.

**Indiana Sheriffs' Association**

Carolyn Elliott, Board Member, Indiana Sheriffs' Association, presented information concerning the autism training provided to law enforcement that is required under IC 5-2-1-9.

**Indiana Department of Corrections**
Tim Brown, Director of Legislative Services, Indiana Department of Corrections (IDOC), gave an overview of the mission and vision of IDOC (Exhibit C). He stated that new and veteran employees of IDOC are provided mental retardation and developmental disorder training. He explained certain terminology used by the IDOC and gave statistics concerning the following:

1. The population of adults and juveniles within IDOC.
2. The recidivism rate.
3. The ASD population within IDOC.

Carol Misetic, Corizon Health Services, stated that Corizon performs medical and mental health evaluations for IDOC. She gave an overview of the types of treatments provided and programs available to inmates within IDOC facilities (Exhibit C).

Craig Hanks, Director of Mental Health and Special Populations, IDOC, stated that adult inmates with mental health disorders within IDOC facilities are usually placed in the general population of IDOC facilities and managed by mental health personnel. He also stated that crisis intervention team training has recently been provided to IDOC staff to teach de-escalation skills. He added that IDOC has partnered with the following entities in the community to help inmates with reentry into society:

1. Mental Health America Indiana.
2. National Alliance of Mental Illness.
3. Indiana Criminal Justice Institute.
5. Public Defender of Marion County.
6. Family and Social Services Administration--Division of Mental Health and Addiction and Division of Disability and Rehabilitative Services (Exhibit C).

Kelly Whitcomb, Executive Director of Juvenile Services, IDOC, explained how information about juvenile inmates is obtained prior to their commitment to an IDOC facility. She stated that there are currently five juvenile inmates with ASD within IDOC. She also stated that new partnerships with the Autism Society of Indiana and Buddies has recently provided valuable autism training to staff within IDOC juvenile facilities. She added that there has been an increase in partnerships with other entities, including the Indiana Supreme Court, the Criminal Justice Institute, and the Indiana Department of Children Services, that has helped with wrap around services for disabled and troubled youth (Exhibit C).

**Commission discussion**

Commission members Rosswurm, Breaux, and Summers asked the IDOC staff questions concerning screening of inmates for developmental disability and ASD specifically. In response to the Commission members questions, the IDOC staff explained that there is no evaluation performed within IDOC facilities to determine if an individual has ASD. During intake, IDOC staff looks to see if the inmate shows signs of needing to be placed in a different environment other than the general population. The IDOC staff explained that unless the individual states that the individual is a person with ASD or law enforcement, the prosecutors office or the family notifies the staff at IDOC of the diagnosis, IDOC staff will
treat the individual the same as everyone else in the general population. The IDOC staff advised the Commission of the existence of a mental health model intake checklist that is used by IDOC employees. However, the checklist does not include ASD.

Chairman Head asked whether the reported low number of adults with ASD incarcerated in IDOC is a correct number since the number of individuals who are born with ASD (currently 1 in 88 births) is so high. IDOC staff responded that only the individuals with ASD in active treatment were counted in that number. The number of individuals with ASD that are incarcerated in IDOC but not in active treatment is unknown.

Representative Summers and Senator Miller commented on the need for wrap around services for the adult population of individuals with ASD.

Chairman Head asked Commission members to think about ideas for legislative bills to present at the next meeting.

Chairman Head adjourned the meeting at 3:55 p.m.
Indiana Department of Insurance

ACA Update

Indiana Commission on Autism

September 25, 2013

Logan P. Harrison
Chief Deputy Commissioner of Insurance
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IDOI Bulletin Overview
IDOI Bulletin 136

- Requires group accident and sickness insurance policies to provide coverage for the treatment of Pervasive Developmental Disorder ("PDD")

- Requires a Health Maintenance Organization ("HMO") that provides basic health care services to provide services for the treatment of PDD of an enrollee

- Coverage required may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable

- Coverage is limited to treatment that is prescribed by the insured’s treating physician in accordance with a treatment plan

I.C. 27-8-14.2-4 and I.C. 27-13-7-14.7
Bulletin 179

- Clarifies that in addition to general practitioners, treatment plan signatures from the following are acceptable for submission to the insurer or HMO:
  - Psychologists
  - Physicians specializing in the treatment of PDD and treating the covered individual with PDD
Essential Health Benefits
Indiana Essential Health Benefit ("EHB") Benchmark Plan

- Indiana’s EHB is the Anthem Blue Access PPO plan including state mandates
  - The benchmark plan must follow the autism mandate

- Plans must include the benefits in Indiana’s current EHB package as part of their plan design for 2014
  - This applies to all non-grandfathered, individual and small group plans
Federally Facilitated Marketplace

Understanding the Implications for Indiana
Federally Facilitated Marketplace Responsibilities

- Operate a toll-free call center and website
  - Allow consumers to compare information on all available health plans as well as apply for coverage

- Determine eligibility for premium tax credits and cost-sharing reductions
  - Applies to citizens and legal residents in families with household income between 100% to 400% of the Federal Poverty Level (FPL)

- Determine exemptions from the individual mandate

- Establish a federal navigator program

- Manage Qualified Health Plans (QHPs)
  - Certifying, recertifying, and decertifying QHPs
## Potential Marketplace Participants*

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<thead>
<tr>
<th>Company</th>
<th>Individual Marketplace</th>
<th>SHOP Marketplace</th>
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<tbody>
<tr>
<td>MD Wise (HMO)</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Coordinated Care (HMO)</td>
<td>X</td>
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*Pending Federal Marketplace Participation Approval*
## Plan Levels Offered

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### Level of Coverage
- **C** Catastrophic
- **B** Bronze
- **S** Silver
- **G** Gold
- **P** Platinum
Coverage Areas & Geographic Rating 8

45 CFR 51.47.102(b)

DOI Bulletin 1997
In March 2013, the Department of Insurance issued Bulletin 197 addressing the new geographical rating areas as prescribed by the Affordable Care Act:
- Including a map of Indiana’s new 17 regions or geographical rating areas

- Anthem plans will be available statewide*
- PHP will be available in regions 1–8, 10 and 11*
- MD Wise will be available in all regions, except for region 14*
- Coordinated Care will be available to regions 2, 3 and 4*

*Pending Federal Marketplace Participation Approval
Federally Facilitated Marketplace Website
How the Marketplace Works

Create an account
First provide some basic information. Then choose a user name, password, and security questions for added protection.

Apply
Starting October 1, 2013 you'll enter information about you and your family, including your income, household size, and more.
Visit HealthCare.gov to get a checklist to help you gather the information you'll need.

Pick a plan
Next you'll see all the plans and programs you're eligible for and compare them side-by-side.
You'll also find out if you can get lower costs on monthly premiums and out-of-pocket costs.

Enroll
Choose a plan that meets your needs and enroll!
Coverage starts as soon as January 1, 2014.
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Indiana Department of Insurance
Chief Deputy Commissioner
Logan P. Harrison

Contact
Report to the Commission on Autism

Indiana Birth Defects and Problems Registry (IBDPR)

September 25, 2013
Robert Bowman
Director of Maternal and Child Health Division
What is the Indiana Birth Defects and Problems Registry?

• The Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system designed to aid in the prevention of birth defects and childhood developmental disabilities and to enhance the quality of life of affected Indiana residents.
What is a birth defect?

- A birth defect is any condition present at birth that affects the structure or function of an infant’s body.

- Some birth defects, such as cleft lip or club foot, are easy to observe, but others, such as heart defects, can only be identified using special tests such as echocardiograms.
What is a birth defect?

• About one out of every 33 babies in the United States is born with a major birth defect.
• Birth defects are the leading cause of death in infants.
• Some of these defects are entirely preventable, while others could be identified early and treated or managed in order to improve the quality of life of affected infants and their families.
What is the purpose of the IBDPR?

According to IC 16-38-4-8, the purposes of the IBDPR is to:

1) Conduct epidemiologic and environmental studies and to apply appropriate preventative and control measures;

2) Inform parents of children with birth problems;

3) Inform citizens regarding programs designed to prevent or reduce birth problems.
How does the IBDPR collect data?

The IBDPR collects data by four different methods. These are:

1) Hospital discharge information

On a monthly basis, all 114 hospitals report the billing discharge information for all of the children diagnosed with at least one of the reported conditions.
How does the IBDPR collect data?

2) Chart auditing

The IBDPR has staff that go to hospitals and audit the charts of those children reported to the IBDPR with one of the 46 targeted conditions.

*Annually, ~7,500 unique children reported to the IBDPR with at least one targeted condition.
How does the IBDPR collect data?

3) Direct Physician reporting

Physicians are required by IC 16-38-4-8 to report children with birth defects to IBDPR

*Over the last 5 years 67 physicians have reported 2,224 unique children to the IBDPR with at least one targeted condition.
How does the IBDPR collect data?

4) Reported from the Indiana Newborn Screening Program

*The Critical Congenital Heart Disease (CCHD) Program shares information with the IBDPR on those children who did not pass their pulse oximetry screen.*
How is IBDPR data being utilized?

Data from the IBDPR is being used in many ways, including:

1. Assisting NBS program areas in follow-up
2. Providing information for infant mortality reports
3. Responding to requests from individuals outside of ISDH
4. Generating annual reports
Is the IBDPR achieving all of its established goals?

1) Conduct epidemiologic and environmental studies and to apply appropriate preventative and control measures;

2) Inform parents of children with birth problems;

3) Inform citizens regarding programs designed to prevent or reduce birth problems.
Autism and the IBDPR

How are children with Autism Spectrum Disorder (ASD) reported to use through IBDPR?

- The reports generated by the IBDPR focus more on children with autism. These children are reported to us either through the hospital discharge billing code or through physicians directly reporting a child they diagnosed with the condition.
Autism and the IBDPR

Do we feel that we have an accurate representation of what is really going on in the state as far as ASD?

- It is difficult to comment on the accuracy of a surveillance system when there is nothing else to compare it to. Based on our most recent numbers it appears the prevalence of autism in Indiana is 1.63 per 1000 live births. This is in-line with recent national estimates for autism (1-2 per 1000)
Autism and the IBDPR

How are you using your autism data?

• *The data that we collect on autism is included in our annual legislative report and we are providing the information to any individuals that request it.*
Autism and the IBDPR

Do you have any recommendations to improve the IBDPR?

• *The IBDPR is performing in a way that is consistent with its original intent. Over the past 10 years many things have changed and it may be beneficial to reevaluate the purpose of the IBDPR.*
Questions?

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Correctional Aim

◦ Mission
  • The Indiana Department of Correction advances public safety and successful re-entry through dynamic supervision, programming, and partnerships.

◦ Vision
  • The Indiana Department of Correction uses best correctional practices to protect the people of Indiana and ensure the consequence for criminal behavior is meaningful.”
Terminology

- Jails vs. Prison
  - Jail typically year or less, usually minor offenses in custody in local community administered by the county - no oversight by DOC
  - Prison/Correctional facilities - felony convictions at least a year, more serious offenses usually located in rural areas away from metropolitan areas - oversight is administered by DOC
Terminology-cont’d

- Probation- administered by Courts
  - Person can be supervised by probation after release from jail or prison.
  - No oversight by DOC

- Parole-administered by DOC Parole division upon release
  - Oversight by DOC
Terminology cont’d

- Division of Youth Services is operated by the state under the IDOC and houses Youth sent to the State.
  - 4 Juvenile correctional facilities
    - Camp Summit, Logansport, Madison and Pendleton Juvenile
- Juvenile Detention Centers can be locally or privately operated.
  - 18 locally operated by the local counties
  - 4 privately operated
DOC Statistics

- Reentry starts with Day 1
- 98% of the adult population will be released into 1 of 92 counties
  - Adult population -27934
    - Approximate yearly intake -14000
    - Approximate yearly release -18000
  - Juvenile population – 491
- Recidivism rate – 36.1%
Autism Spectrum Population within DOC

- Defined by IC 12-7-2-19(b)
- Medical Component
  - Total with a Autism Spectrum Disorder Diagnosis
    - Total- 19
      - 5 juveniles
      - 14 adults
Identification

- At intake, 100% of all offenders are seen by mental health staff for evaluation.
- Educational records are forwarded from the last school of record during the intake process.
- Inmates are able to request to be seen by medical.
- Staff can refer inmates to be seen by medical.
  - New Staff receive MRDD training during the Pre-service Academy and Veteran Staff receive a Computer Based Training during Annual In-service Training on MMRD population and identification.
Programs

- Educational
  - Evaluate educational record
  - Hold a case conference meeting
  - Develop an educational treatment plan

- Special Accommodations
  - American Disability Act (Sec. 504)
    - A person can request certain accommodations for learning purposes.
Medical Treatment

Offenders who are having problems adjusting to or functioning in the correctional environment are typically referred to MH staff.

All offenders are seen within 7 days of either staff referral or offender request for services.

Individualized treatment plans are designed to help address individuals' needs.
Treatment is patient and need specific

- Many individuals function without problems or distress in correctional setting
- For most in the system, the developmental or intellectual disability is not the primary focus of treatment – individuals typically have co-morbid diagnoses
Need specific Focus

• Focus of treatment typically includes:
  ○ Coping with emotions
  ○ Managing anger
  ○ Controlling impulsive behavior
  ○ Improving Social interactions
Types of Mental Health Treatment

- Psychotropic Medications
  - Most typically prescribed for co-morbid conditions such as an anxiety, mood, or psychotic disorder

- Individual Therapy and/or Individual MH Monitoring

- Group Therapy
Placement/Housing within IDOC

- Individuals with autism spectrum diagnoses are typically managed by MH departments in general population settings.
- For juveniles, there does not appear to be a similar pattern. However, programmatically students with significant known social, emotional or cognitive impairments have been housed at PNJCF on the Special Needs Unit.
Placement/Housing within IDOC

- For adults requiring specialized mental health units, there was typically a significantly complicating co-morbid condition such as Borderline Intellectual Functioning, Schizophrenia, Mild Mental Retardation, or a combination.
Reentry into the Community

- Barriers to Reentry for all inmates
  - Employment, Housing and Transportation
- Currently Casework Managers work with inmates to determine best transitional process.
- This could include contacting family members, health providers or assisting in finding housing and employment
Partnerships in 2013

1. MHAI/NAMI and Staff Development and Training.
2. TBI Pilot w/Indiana Criminal Justice Institute and Brain Injury Association of Indiana
3. DMHA, IntreCare, Public Defender for co-occurring mentally ill and substance abuse re-entry in Marion County
4. FSSA/DMHA/Parole, 75 dually diagnosed re-entry to Marion county
Re-Entry Special Needs

- 2013 – 84 referrals
- 39 successful mental health placements
- 2 assisted living
- 9 Nursing Home placements
- 34 mental health treatment and medical equipment.
Partnerships for Reentry

- DDRS and DOC are in the process of establishing an MOU geared at early identification of the DD population at intake.
- DDRS will complete eligibility determination to determine if the inmate is eligible for DDRS services upon release.
- DOC and DDRS will collaborate on transition planning to ensure appropriate supports are in place upon release.