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Sen. Patricia Miller, Chairperson
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Sen. Vaneta Becker
Sen. Rodric Bray
Sen. Ed Charbonneau
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Sen. Jean Leising
Sen. Pete Miller
Sen. Jean Breaux
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Rep. David Frizzell
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Rep. Eric Turner
Rep. Dennis Zent
Rep. Charlie Brown
Rep. B. Patrick Bauer
Rep. Gregory Porter
Rep. Robin Shackleford

LSA Staff:

Casey Kline, Attorney for the Commission
Kathy Norris, Fiscal Analyst for the Commission
Al Gossard, Fiscal Analyst for the Commission

Authority: IC 2-5-23

HEALTH FINANCE COMMISSION

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**September 16, 2013**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., the Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**4**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Vaneta Becker; Sen. Ed Charbonneau; Sen. Ron Grooms; Sen. Jean Leising; Sen. Pete Miller; Sen. Mark Stoops; Sen. Greg Taylor; Rep. Ed Clere, Vice-Chairperson; Rep. Steven Davisson; Rep. Robert Behning; Rep. David Frizzell; Rep. Donald Lehe; Rep. Dennis Zent; Rep. Charlie Brown; Rep. Gregory Porter; Rep. Robin Shackleford.**

Members Absent: **Sen. Rodric Bray; Sen. Jean Breaux; Sen. Frank Mrvan; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Eric Turner; Rep. B. Patrick Bauer.**

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[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.

Chairperson Patricia Miller called the meeting to order at 10:15 a.m.

Healthy Indiana Plan (HIP) Update

Secretary Debra Minott provided HIP statistics and an update concerning negotiations with the federal government that resulted in a one year renewal of HIP through December 31, 2014. See Exhibit 1. Secretary Minott discussed the two key changes that were negotiated and will take effect in the program beginning January 1, 2014: (1) eligibility for HIP will be reduced to 100% of the federal poverty level (FPL) and below to facilitate those that make more than 100% FPL to participate in the subsidies available in the federal Exchange; and (2) a new method for managing enrollment to ensure that enrollment does not exceed the allocated revenue from the cigarette tax. Secretary Minott stated that approximately 10,500 current HIP participants will no longer be eligible for HIP beginning January 1, 2014, because of income eligibility reduction. Secretary Minott stated that the current capitation on caregiver adults in HIP will be removed beginning January 1, 2014, but that if enrollment approaches 45,000, FSSA can submit an expedited amendment request to the Centers for Medicare and Medicaid Services (CMS) to lower HIP eligibility. When asked why HIP is limited to 45,000 when there is a surplus of cigarette tax dollars, Secretary Minott responded that the Budget Agency has told her that she can only use the cigarette funds currently being collected. Commission members asked the Chairperson and Secretary Minott to follow up with the Budget Agency about this limitation. In response to questions, Secretary Minott stated that FSSA is now in talks with CMS concerning extending Medicaid through the use of HIP. Commission members requested that Secretary Minott make the HIP quarterly reports to CMS available to the public.

Food Handling

Commission staff read the following language from SEA 457-2013:

> the State Department of Health shall present to the Health Finance Commission recommendations to clarify the existing laws and rules regarding nonprofit entities that participate in and serve or sell food at a fund raising event in situations where more than one (1)nonprofit entity is involved. The recommendation must include clarification concerning the limitations on the number of events that a nonprofit entity may participate in annually.

Representative Thompson spoke concerning his intent in having this language in the bill.

Mr. Scott Gilliam, Indiana State Department of Health, provided information concerning Indiana food handling statutes and rules. See Exhibit 2. Mr. Gilliam discussed retail food safety, wholesale food safety, the rapid response team that investigates foodborne illness outbreaks, and the produce safety initiative of registering farms that distribute wholesale fruits and vegetables. Mr. Gilliam provided information concerning entities that are statutorily exempt from regulation, including religious organizations and non-profit organizations. Mr. Gilliam stated that there is a 15-day limit for non-profit organizations to offer food for sale at an event for the benefit of the organization but that this limitation does not apply to an organization that is organized for religious purposes or nonpublic educational settings. See Exhibit 2. Mr. Gilliam commented on exemptions for food handling certification based on the foods being sold. Mr. Gilliam provided statistics on foodborne illnesses.

Mr. Eric Miller, Advance America, reminded the Commission of a bill that passed in the 2007 legislature that exempted churches and other religious entities from statutory requirements in order to allow potlucks, lunches after funerals, and other events. Mr.

Miller stated that there have not been sufficient complaints to warrant any changes to the current statutes. Ms. Connie Vickery, Indiana Restaurants and Lodging Association, stated that the Association is the largest food handling trainer in the state and that the current requirements are not onerous.

Telehealth and Telemedicine

Mr. Andy VanZee, FSSA, provided information concerning states that provide Medicaid reimbursement to home health agencies for various telehealth services. See Exhibit 3. Mr. VanZee stated that FSSA is working on the implementation of SEA 554-2013 which removed the 20-mile requirement for reimbursement of telemedicine services for certain healthcare providers, including drafting a Medicaid State Plan Amendment.

Dr. Jonathan Neufeld, Upper Midwest Telehealth Resource Center, explained that telemedicine refers to the billable interactive clinical service and is a subset of telehealth whereas telehealth is the broader field of distance health activities. See Exhibit 4. Dr. Neufeld stated that there are three basic types: (1) hospitals and specialities, where specialists see and manage patients remotely; (2) integrated care, where mental health and other specialists work in primary care settings; and (3) transition and monitoring, where patients access care where and when needed to avoid complications and higher levels of care. Dr. Neufeld testified that every telemedicine program is different and that not all medical treatments are effective. Dr. Neufeld said that Indiana offers a better telehealth climate now with the passage of SEA 554-2013.

Midwives

Ms. Mary Ann Griffin, Certified Professional Midwife (CPM), stated that she has been in contact with the Indiana Professional Licensing Agency which is currently working on establishing the Midwifery Committee, and that individuals who she knows that do not meet the education requirements to become a certified direct entry midwife have enrolled in education programs. Ms. Griffin testified that she has tried to get quotes for liability insurance but that so far, the lowest quote could result in driving a midwife out of business. Ms. Griffin stated that the requirement for a midwife to enter into a collaborative agreement with a physician is a big obstacle and physicians are reluctant to enter into a collaborative agreement.

Ms. Mary Helen Ayres, CPM, stated that she has worked with a physician for twelve years and her physician is reluctant or unwilling to enter into a collaborative agreement. Dr. Alan Wagoner stated that while he has worked with midwives most of his career, he is doubtful that his hospital employer will allow him to enter into a collaborative agreement.

Mr. Mike Rinebold, Indiana State Medical Association (ISMA), stated that ISMA did not support the portion of HEA 1135-2013 that allows for the certification of certified direct entry midwives but does support the collection of data on home births. Mr. Rinebold stated that since July 1, 2013, when the reporting requirements went into place, 24 home delivery births have been identified out of around 15,000 births. Mr. Rinebold said that he is waiting to see more information on home births as it is collected in the future.

The Commission took a short lunch break.

Methadone Report

Mr. Kevin Moore, FSSA, provided information concerning Indiana methadone clinic patients, including the fact that 14,426 patients were treated in Indiana methadone clinics in 2012. See Exhibit 5. Mr. Moore stated that Indiana has 13 methadone clinics, 3 of which are either associated with community mental health centers or not-for-profit entities. Mr.

Moore discussed the different medications used at these clinics, drug testing procedures, treatment timeframes, and the use of take home medication. Mr. Moore stated that one-third of Indiana's methadone clinic patients come from out of state.

Dr. Dick Huber, parent, discussed methadone and alternative treatments for addiction, and recommended that the use of methadone to treat addiction be banned. See Exhibit 6. Dr. Huber discussed his son who overdosed on methadone. See Exhibit 7. Mr. Jeff Kidd discussed multiple members of his family who died or overdosed on methadone. Mr. Kidd stated that take home doses of methadone should not be allowed.

Tanning Beds Follow-Up

Ms. Ashley Watson and Ms. Bethany Garling, Valparaiso University students, testified concerning television glorifying the use of tanning beds and the targeting of high school students to use the tanning beds. Statistics on cancer were provided and Ms. Watson and Ms. Garling recommended that individuals under 18 should be restricted from using tanning beds. See Exhibit 8.

Managed Care Issues

Mr. John Cardwell, Indiana Home Care Task Force, expressed concern that the Indiana Home Care Task Force was not asked to participate in FSSA's Aged Blind Disabled Task Force which was established through a bill last session to study whether the aged, blind, and disabled Medicaid population should receive services through managed care. See Exhibit 9. Ms. Nancy Griffin provided information concerning a pilot program that was implemented previously in Indiana that used nurse case managers and provided services, including mental health services, but was terminated after one year when only 200 individuals signed up for the program. Ms. Griffin talked about her experience in Arizona with her mother and the issues that arise for caregivers who would like to use home healthcare services. Mr. Dan Skinner provided his concerns with moving the aged, blind, and disabled population to managed care.

Ms. Susan Waschevski, FSSA, stated that FSSA's omission of the Indiana Home Care Task Force from the Aged Blind and Disabled Task Force was unintentional and that FSSA tried to reach out to as many advocates as possible to provide information to the Task Force. Ms. Waschevski stated that FSSA has since reached out to Mr. Cardwell to receive his input but has had no response.

Chairperson Miller adjourned the Commission meeting at 3:00 p.m.

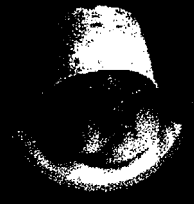
9/16/13 HFC Exhibit 1

Update on Healthy Indiana Plan

Health Finance Commission

September 16, 2013

Debra Minott, Secretary FSSA



Healthy Indiana Plan—Key Statistics

- Enrollment update (as of 8/31/2013):
  - Current Enrolled members: 35,058 individuals
  - Caretaker Adults: 24,377 (69.5%)
  - Non-Caretaker Adults: 10,681 (30.5%)
  - Current members under 100% FPL: 24,593 (70%)

- Waitlist update (as of 8/31/2013):
  - 56,278 applicants on waitlist
  - Waitlist is for non-caretaker adults

Survey of HIP Members

- Mathematica Policy Research Survey—March 2013

- Interviewed 847 current members and 627 members who left program in 2012
  - Strong endorsement for design of program
  - >80% of members receiving preventive check-ups
  - >70% of members report NOT using the ER
  - 95% of members satisfied with their experience in HIP

HIP Waiver

- One year waiver renewal approved on September 3, 2013, extending the plan to December 31, 2014.

- Two key changes:
  - Eligibility reduced to 100% of FPL to facilitate those above the threshold to participate in the subsidies available on the Federal Exchange
    - Tax credits to support premiums
    - Cost sharing reductions related to deductibles and co-pays
    - About 10,500 current members will transition to the Exchange.
    - Transition plan under development—will entail multiple forms of outreach to impacted individuals.

HIP Waiver

- Two key changes (continued):
  - New method for managing enrollment to ensure enrollment does not exceed allocated revenue from the cigarette tax.
    - Existing cap on non-caretaker adults remains, but no cap on parents
    - As enrollment approaches 45,000, can submit amendment to CMS to lower eligibility below 100% FPL for new entrants to the plan and CMS will adjudicate amendment on an expedited basis.

Questions

9/16/13 HFC Exhibit 2

Food Protection Program

Health Finance Summer Study Committee
September 16, 2013

Purpose of Authority

- Protect consumers from:
  - Disease transmission and illness
  - Injury from foreign material and objects
  - Illness from intoxications, i.e. – botulism
  - Incorrect or deceptive advertising
  - Intentional misuse of ingredients
  - Economic adulteration

Statutory Authority

- IC 16-19-3 – Powers and Duties ISDH
- IC 16-42-1-4 - Food, Drug and Cosmetic Act
- IC 16-42- 5 – Food Establishment – Sanitary Requirements
- IC 16-42-5.2 – Certified Food Handlers

Administrative Authority

- 410 IAC 7-5, Misbranding of Food
- 410 IAC 7-6, Labeling Requirements
- 410 IAC 7-13, Cold Storage Locker Plants
- 410 IAC 7-15.5, Bed & Breakfast Rule
- 410 IAC 7-21, Wholesale Food Rule
- 410 IAC 7-22, Food Handler Certification
- 410 IAC 7-23, Schedule of Civil Penalties
- 410 IAC 7-24, Retail Food Rule

Program Areas

- Retail and Wholesale Food Safety
- Rapid Response Team
- Produce Safety Initiative
- Indiana Food Transportation Assessment Project (hot trucks)
- Food Defense
- Variance and Plan Review

Retail Food Safety

- Extensive training and technical assistance to local health depts. (LHD), food industry and consumers
- Regulate retail food operations on state property, such as state parks, state fair, state cafeterias and toll road
- Promulgate rules that LHDs adopt into local food ordinances

Wholesale Food Safety

- Regulate warehouses, distributors and manufacturers other than dairy, meat, poultry and raw shell egg producers
- Approximately 750 with wide variety, such as large bakeries, bottling plants, corn starch, honey, snack foods, etc.

Rapid Response Team

- Foodborne illness outbreak investigation
- Complaint investigation
- Product sampling
- Laboratory analysis
- Recall notifications and audit checks
- Work closely with ISDH epidemiology and laboratory programs

Produce Safety Initiative

- Registration of farms distributing wholesale ready-to-eat fruits and vegetables
- Based on new FDA Produce Safety Rules
- Result of large *Salmonella* outbreak related to Indiana cantaloupe
- Approximately 90 farms registered

Indiana Food Transportation Assessment Project

- Started in 2006 with MI, OH and IL
- Evaluate level of food safety in distribution segment of industry
- Work with Indiana State Police and others – DNR, FDA, USDA, LHD
- Most progressive in nation
- Received national award for efforts

Food Defense

- Assessment of preparedness measures by all food industry against an intentional act of contamination
- Formed a Food Safety and Defense Task Force
- Developed a Food Emergency Response Plan (FERP) for Indiana
- Food defense mitigation efforts to be required under FDA soon

Variance and Plan Review

- Process and review all variance requests from ISDH food rules – LHDs are not allowed to approve variances
- Process and review all plans for construction and remodeling of retail food establishments under ISDH inspection

Enforcement

- Embargo and destruction authority
- Civil monetary penalties
- Administrative actions, i.e. – Compliance Order, Cease and Desist Order and a Complaint and Request for Hearing with ALJ
- Attorney General actions

Federal Influence

- Food programs codes are based in federal code of federal regulations
- Based in model codes
- Based in program standards
- Work closely with FDA and USDA
- Food Safety Modernization Act of 2011 driving sweeping changes nationally with at least 7 new regulations

Local Health Authority

- IC 16-20-1 – Powers and Duties of Local Health Departments
- All previously stated authorities except for IC 16-19-3 designated for ISDH
- Local food ordinances
- Cannot be more or less restrictive concerning food safety requirements as specified in IC 16-42-5.

Local Health Authority

- Subordinate to the state ISDH Board
- Must enforce the rules of the state
- Delegation by state to regulate retail food establishments other than those licensed or otherwise regulated by the state, but with similar programmatic responsibilities as ISDH
- Over 40K retail food establishments under the 93 LHDs

Statutorily Exempt Entities

- Private home
- Gathering of persons at a venue of an organization organized for educational purposes in a nonpublic educational setting or for religious purposes; if the individuals prepare the food, free of charge and consume it; and the gathering is for the purposes of the organization

Statutorily Exempt Entities

- Those gatherings include wedding receptions, christenings, bar and bat mitzvahs, baptisms, communions, etc.
- Vehicle used to transport food solely for distribution to the needy
- A private gathering of persons who prepare and consume their own food whether or private or public property

Statutorily Exempt Entities

- Sale of food prepared for an organization that is organized for religious purposes or nonpublic educational settings; is exempt from taxation under IRS 501 code; and offers the food for sale to the final consumer at an event held for the benefit of the organization; unless the food is being provided in a cafeteria or restaurant with an extensive menu

Statutorily Exempt Entities

- An Indiana non-profit organization organized for civic, fraternal, veterans, or charitable purposes; exempt from the IRS 501 code; and offers food for sale at an event for the benefit of the organization and only for 15 days or less per calendar year

Statutorily Exempt Entities

- Farmers market and roadside stand food vendors if:
  - Food is made, grown or raised on own property
  - Is not a potentially hazardous food
  - Proper sanitary procedures are practiced
  - Product is labeled
  - Poultry and rabbit processing without inspection with limited sales

Statutorily Exempt Entities from Food Handler Certification

- Hospitals and health facilities (licensed)
- Assisted living
- Continuing care retirement communities
- Community mental health centers
- Licensed private mental health institutions
- Area agency on aging, except for prep sites
- Food pantry (501 exempt) to final consumer

Statutorily Exempt Entities from Food Handler Certification

- Establishments are exempt based on menu – heating or serving precooked food; continental breakfast; alcoholic or nonalcoholic beverages or ice; packaged or unpackaged foods that are not potentially hazardous
- Providing prepackaged foods in its original packaging

Statutorily Exempt Entities from Food Handler Certification

- Does not apply to a pharmacy that is a food establishment that provides only prepackaged food products for sale unless it exceeds 10,000 square feet of retails sales space

Statutorily Exempt Entities from Food Handler Certification

- An organization exempt from the state gross retail tax under IC 6-2.5-5-21(b)(1)(B) through (D)
  - Includes public schools
  - Exempted organizations are allowed to waive their right of exemption

Outbreak Data

- CDC estimates that 48 million cases of foodborne illness, 128,000 hospitalizations and 3,000 death occur annually in the US
- 2012 *Salmonella* Typhimurium and Newport associated with cantaloupe in Indiana – 260 in 24 states and 3 deaths (30 were in Indiana alone)
- Norovirus most prevalent of all

Outbreak Data

- Although most outbreaks are associated with main stream food industry there are documented cases from non-profits
- Recent situation at a IN county festival with ice cream contaminated *Staphylococcus* Aureus toxin with a stand operated by a youth educational organization – bad things can happen to well intentioned people

Cooperative Relations

- Associations with a variety of groups
  - Indiana Restaurant & Hospitality Assn.
  - Indiana Grocers Assn.
  - Indiana Convenience Store Assn.
  - Indiana Licensed Beverage Assn.
  - Testing Groups
  - Conference for Food Protection
  - AFDO and NCAFDO
  - Indiana Environmental Health Assn.

Final Comments

- Food safety is neutral and benefits everyone
- ISDH would like to establish a workgroup with stakeholders in an effort to agree on recommendations to this committee for more clear and concise language to clarify the existing code version

Questions?

www.in.gov/isdh/20640.htm

Scott Zarazee, Legislative Liaison
szarazee@isdh.in.gov 234-3808
Scott Gilliam, Director
Food Protection Program
sgilliam@isdh.in.gov 234-8570

9/16/13 HFC Exhibit 3

The Indiana Family and Social Services Administration

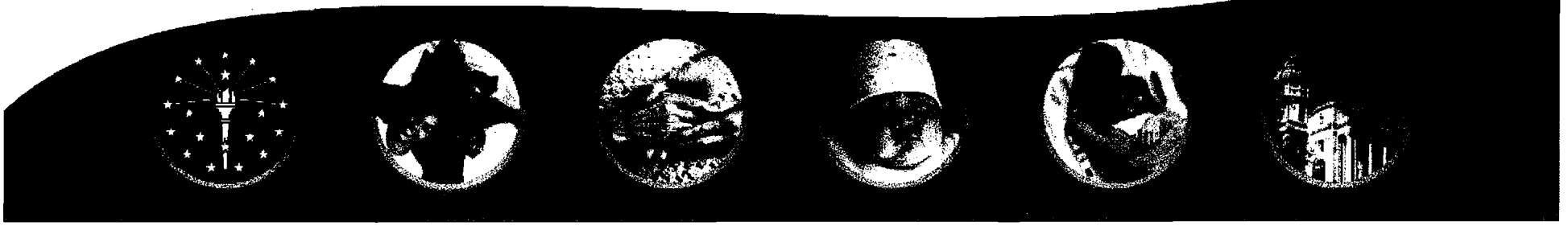
SEA 554 Update

(Telehealth and Telemedicine Services Under Medicaid)

Andy VanZee, Director of Healthcare Strategies and Technology

Health Finance Commission

September 16, 2013



Home Health Agency Reimbursement for Telehealth Services by State

State	Medicaid Reimbursement	Aging Waiver Reimbursement
Alaska	✓	
Colorado	✓	
Kansas	✓	
Minnesota	✓	
New York (demonstration)	✓	
Utah (pilot program)	✓	
Washington	✓	
Pennsylvania		✓
South Carolina		✓
South Dakota		✓
Texas (rule pending approval)		

Current Telehealth Climate

- States primarily limit services to individuals with chronic conditions such as:
  - Chronic Heart Failure
  - Chronic Obstructive Pulmonary Disease
  - Diabetes
  - Hypertension

  AND
  - a high ER/inpatient stay utilization.

Next Steps for Implementation

- Telehealth
  - Review/ Finalize policy recommendations.
  - Work with Myers and Stauffer to develop reimbursement methodology.
  - Develop fiscal impact.
  - Draft State Plan Amendment (to be submitted to CMS December 1, 2013).
  - Draft/ Submit rule.
  - Identify/ Implement claim system updates.

Next Steps for Implementation

- Removal of 20-mile (one-way) requirement for telemedicine services for Federally Qualified Health Center, Rural Health Clinics, Community Mental Health Centers and Critical Access Hospitals.
  - Update policy
  - Draft State Plan Amendment
  - Draft/ Submit rule (to be submitted to CMS December 1, 2013).
  - Identify/ Implement claim system updates

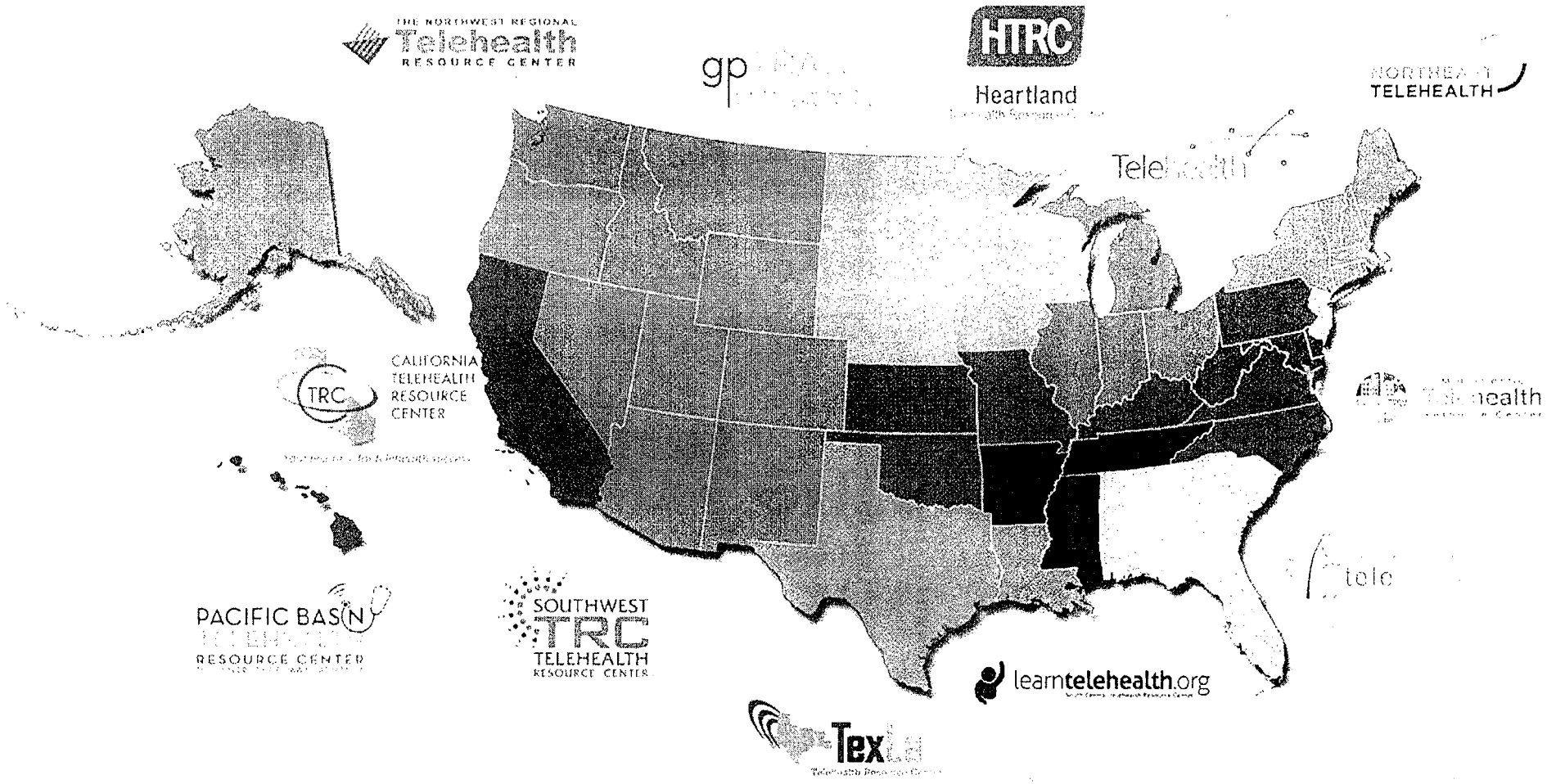
Questions?

9/16/13 HFC Exhibit 4

Telemedicine and Telehealth in Context

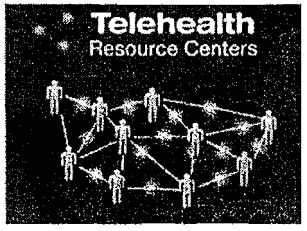
Jonathan Neufeld, PhD
Clinical Director
Upper Midwest Telehealth Resource Center

TelehealthResourceCenters.org



TTAC
TelehealthTechnology.org

Center for
Connected
Health Policy



NRTRC	[illegible]	[illegible]
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	

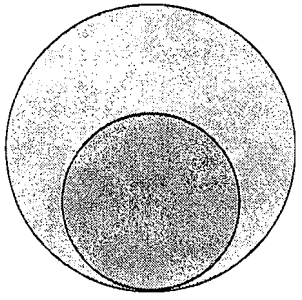
2 National Resource Centers

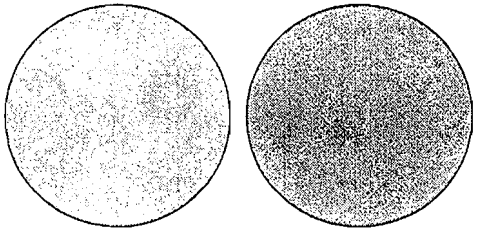
12 Regional Resource Centers

Definitions and Concepts

Telehealth and Telemedicine

- Sometimes used interchangeably
- Two types of distinctions -
  - Telemedicine = billable interactive clinical services
  - Telehealth =
    - Broader field of distance health activities (CME, etc.)
    - Clinical remote monitoring (usually at home)





Three Basic "Types" or Models

Hospital & Specialties

- Specialists see and manage patients remotely

Integrated Care

- Mental health and other specialists work in primary care settings (e.g., PCMH's, ACO's)

Transitions & Monitoring

- Patients access care (or care accesses patients) where and when needed to avoid complications and higher levels of care

****<u>Value proposition differs</u> among these types****

Historical Context

- Used at Nebraska Psychiatric Institute in 1955
- Developed extensively by NASA in 1960's
- VA started in 1990's – CCHT Program
  - Pilot in VISN 8 in 2003 – 63% reduction in ER visits, 88% reduction in SNF days
  - 2012 Utilization: 0.5 M patients; 1.5 M episodes
- Added by Medicare in 1996 (multiple updates)
- Regulations requiring Medicaid and commercial coverage in states began about the same time
  - Wave of equipment and program grants, projects

Research Context – Good medicine

- 20+ years of rigorous research
- 11 current standards/guidelines documents

<u>Summary of Findings</u>:

When used appropriately, medical care delivered via telemedicine is

- as effective
- as satisfactory (to patients and providers)
- as efficient (and often more efficient)

as the same services delivered via traditional in-person medical care.

Research Context – Good medicine

Caveats:

1. Every telemedicine program is different
2. Some telemedicine services are novel (most are not)
3. Some services may offset other services
4. Not all medical treatments are effective (but we still provide them)
5. Improving access for the underserved will lead to increased utilization

Economic Context: Inexpensive and Underutilized

- Medicare: spent ~$6 M in services in 2012
- Medicaid (44 states cover at least some):
  - Indiana – 2012: $160,000 ($0.14 per enrollee)
  - Virginia – 2012: $257,800 ($0.31 per enrollee)
  - Texas – 2009: $506,137 ($0.13 per enrollee)
- VHA saved $1,999 per enrolled pt in 2012
- Many instances of cost savings; many examples of no savings
  - Paying for equipment/tech drives "efficiency"

Federal Telemedicine Law & Policy

Professionals are regulated at the state level (doctors, nurses, counselors, etc.)

Medicare: Pays for certain outpatient professional services (CPT codes) for patients accessing care in rural counties and HPSAs in rural census tracts.

*No regs; only conditions of payment.

Medicaid: Telemedicine is "a cost-effective alternative to the more traditional face-to-face way of providing medical care…that states can choose to cover."

Current Telemedicine in Indiana

Hospital and Specialty Care

- Tele-stroke, inpatient specialties & e-ICU
- Pediatric specialty programs, neonatal care

Primary Care and Integrated Care

- Telepsychiatry, therapy, and outreach services at CMHCs

Transitions

- Post-acute home monitoring, chronic care

Critical Needs for Going Forward

- Recognition of multiple sources of value
- Practical methods for measuring effectiveness and efficiency (rather than volume) and connecting with payment
- Principles and practices to minimize potential for fraud and abuse
- Reimbursement that supports current programs and drives innovation

Better Care - Better Health - Lower Cost

Jonathan Neufeld, PhD, HSPP

Clinical Director

Upper Midwest Telehealth Resource Center

574-606-5038 jneufeld@umtrc.org

9/16/13 HFC Exhibit 5

The Indiana Family and Social Services Administration

IN Opioid Treatment Programs

Kevin Moore, Director of the Division of Mental Health and Addiction

Indiana Health Finance Commission

September 16, 2013

Number of Patients Treated

- 14,426 total patients treated in CY 2012.
- 13 Methadone Clinics throughout the state.

Breakdown by age (years)						
	<18	18-24	25-34	35-49	50-59	>60
% of Patients	.17%	11.71%	48.9%	28.57%	8.78%	1.87%

Breakdown by sex		
	Male	Female
% of Patients	56.62%	43.38

Medications Used

- Methadone
  - Typical beginning dosage of 30 mg.
- Buprenorphine
  - Typical beginning dosage of 8 mg.

Drug Testing

- Current rule requires a minimum of 8 drug tests during each 12 months following admission.
- Of the 14,426 patients served in 2012, there were 5196 total positive drug screens including initial screens. This represents a 5% positive drug screen rate.

Continuing Treatment

- 56.04% of patients continue to receive treatment.
  - 8,098 patients
- 2.15% of patients were deemed to have successfully completed treatment.
  - 311 patients
- The remaining 41.81% of patients dropped out during the course of treatment.

Length of treatment							
	< 90 d	90-1y	1-2y	2-3y	3-6y	6-10y	>10y
% of Patients	17.93%	27.04%	18.27%	11.10%	15.02%	6.64%	4.01%

Questions?

G. DISADVANTAGES OF METHADONE

- long and unpredictable half-life; pain relief may be gone but methadone still in body
- risks of accumulating toxic levels, especially respiratory depression
- multiple interactions with other drugs; often a problem because addicts are often on many drugs
- causes major disturbances of cardiac rhythm
- majority (73 – 80 %) of overdoses are unintentional
- patients often need to reduce dosage if they are off methadone for a few days
- prescribed inappropriately. FDA found most common diagnoses associated with methadone use was for back pain and arthritis (46 %), headaches (17 %), cancer (11%), trauma (5 %); most methadone prescriptions are written by primary care doctors and nurse practitioners.
- often abused or diverted to illegal market
- contributes disproportionately to overdosing
- probably can not successfully be regulated; too much state and federal involvement.

H. ALTERNATE TREATMENT FOR ADDICTION

- buprenorphine becoming more the acceptable medication; much safer

I. INDIANA STATE MEDICAL ASSOCIATION

- no opposition voiced at hearing to eliminate methadone
- squeaky wheels
- ban methadone clinics in Indiana
- physician assistance program – no physician in the program if taking methadone

J. **MUST** WEIGH BENEFITS VS. RISKS

K. SUGGESTIONS

- no methadone, period
- no stand-alone methadone treatment clinics
- required training to prescribe
- limit supply through single dispensing agent
- limit number of opioid prescriptions covered by insurers
- change prescribing practices – using patient agreements, drug monitoring programs, education for patients, recognizing overdoses, etc

WISE PEOPLE GET INVOLVED

or

WE LIVE WITH THE DECISIONS/CONSEQUENCES MADE BY THE UNWISE/GREEDY

Dick Huber, M.D.
31 N. Restin Rd.
Greenwood, IN 46142
317-885-9078
hubermd@comcast.net

9/16/13 HFC Exhibit 6

METHADONE

A. OPIOIDS (chemicals that resemble morphine)
- Synthetic opioids – methadone, hydrocodone, oxycodone, fentanyl, buprenorphine (Suboxone, Subutex, Buprenex, Butrans), etc.
- Estimated 980,000 people in U.S. currently addicted to opioids

B. PAINKILLERS – of all painkiller prescriptions in U.S., 2 % are for methadone, yet methadone accounts for more than 30 % of prescription painkiller deaths. CDC, 7-3-2012, Methadone remains a drug that contributes disproportionately to the excessive number of opioid pain reliever overdoses and associated medical and societal costs.

C. METHADONE –
- used for pain and addictions
- deaths in Indiana increased 10 fold from 1999 – 2005
- 5000 die every year in U.S. from methadone overdoses; probably much higher
- 73 – 80 % of methadone overdoses are unintentional
- About one-half of patients served by methadone clinics in Indiana come from out-of-state.
- epidemic of opioid abuse
- considered a dangerous drug by many physicians

D. METHADONE USERS –
- often get methadone from friends and family, not physicians
- more than 40 % also have mental health disorders
- often don't tell their complete story; making for a difficult situation
- often sell/trade their methadone

E. PHYSICIANS
- criticized for inadequate pain treatment
- want to keep our patients happy
- in denial about any of their prescription medicine ending up in wrong hands
- guesstimate that 99 % of physicians would be happy if methadone not available

F. ADVANTAGES OF METHADONE
- treatment of pain
- treatment of opioid dependency, especially heroin (relieves the craving of opiods, relieves the symptoms associated with the withdrawal from opioids, allows person to work and participate in society, etc.)
- relative low cost
- available in liquid form
- long duration of action (half-life of 8 – 59 hours)

9/16/13 HFC Exh. 7

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000122 EDR No 000000250258 State No 013587

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Y
KYLE DAVID HUBER		MALE	02:00 AM	03/11/2012

5. Social Security Number	6a. Age - Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date of Birth (Month/Day/Year)	8. Birthplace (City and State or Foreign Country)
[redacted]	35	Months	Days	Hours	Minutes	06/04/1976	INDIANAPOLIS, IN

9. Ever in U.S. Armed Forces? ☐ Yes ☒ No ☐ Unknown

10. If Death Occurred In A Hospital: ☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number): 219 SYCAMORE DRIVE

12. City Or Town, State, And Zip Code: BEDFORD, IN, 47421

13. County Of Death: LAWRENCE

14. Marital Status At Time Of Death: ☐ Married ☐ Married, But Separated ☒ Divo ☐ Widowed ☐ Never Married ☐ Unkno

15. Surviving Spouse's Name:

15a. (If Wife)Give Maiden Last Name:

16. Decedent's Usual Occupation: IRON WORKER

17. Kind Of Business/Industry: CONSTRUCTION

18. Residence - State: INDIANA

18a. County: LAWRENCE

18b. City Or Town: BEDFORD

18c. Street And Number: 219 SYCAMORE DRIVE

18d. Apt. No.:

18e. Zip Code: 47421

18f. Inside City Limi ☒ Yes ☐ No

19. Decedent's Education: HIGH SCHOOL GRADUATE OR GED COMPLETED

20. Decedent Of Hispanic Origin: NOT HISPANIC

21. Decedent's Race: White

22. Father's Name (First, Middle, Last): RICHARD HUBER

23. Mother's Name (First, Middle, Last): JANET HUBER

23a. Mother's Maiden Last Name: PIPER

24. Informant's Name: JANET HUBER

24a. Relationship To Decedent: MOTHER

24b. Mailing Address (Street And Number, City, State, Zip Code): 219 SYCAMORE DRIVE, BEDFORD, IN 47421

25. Place Of Disposition

25a. Method Of Disposition: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):

25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place): SOUTH CENTRAL CREMATORY

25c. Location - City, Town, And State: NORTH VERNON, IN

26. Was Coroner Contacted? ☒ Yes ☐ No

27. Name And Complete Address Of Funeral Facility: FERGUSON-LEE FUNERAL HOME, 818 18TH STREET P.O. BOX 63, BEDFORD, IN 47421

27a. Funeral Home License Num: FH10300005

27b. Signature Of Indiana Funeral Service Licensee: ROBERT EDWARD LEE , BY ELECTRONIC SIGNATURE

27c. License Number (Of Licensee): FD01013337

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

Approximate Interval: Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death) A. CORONARY ARTERY DISEASE

Due to (Or As A Consequence Of):

Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last

B. METHADONE TOXICITY

Due to (Or As A Consequence Of):

C. DIABETES

Due to (Or As A Consequence Of):

D.

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Givin In Part I

29. Was An Autopsy Performed? ☒ Yes ☐ No

30. Were Autopsy Finding Available To Complete The Cause Of Death? ☒ Yes ☐ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☒ No ☐ Unknown

32. If Famale: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 D ☐ Not Pregnant, But Pregnant 43 Days To 1 year Before Death ☐ Unknown If Pregnant Within The Past Y

33. Manner Of Death:

34. Date Of Injury (Month/Day/Year)

35. Time Of Injury

36. Place Of Injury (E.G., Decedent's Hor

38. Location Of Injury - State

38a. City Or Town

38b. Street & Number

39. Describe How Injury Occurred

41. Signature, Of Person Certifying Cause Of Death: JOHN SHERRILL , BY ELECTRONIC SIGNATURE

43. Name, Address And Zip Code Of Person Certifying Cause Of Death: JOHN SHERRILL , 3522 DIXIE HIGHWAY, BEDFORD, IN 47421

46. Additional Funeral Service Provider:

48. Signature of Local Health Officer: ALAN F SMITH, VIA ELECTRONIC SIGNATURE

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR O

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.

9/16/13 HFC Exhibit 8

Testimony to State Legislature: Tanning Bed Restrictions for Minors

Presented by Bethany Garling and Ashley Watson

Prepared by Senior Social Work Students

Under the Supervision of Kendre Israel

Valparaiso University Social Work Department

Valparaiso, Indiana

With high school students being increasingly exposed to popular television shows like "*The Jersey Shore*" that glorify having tan, bronzed skin, a dangerous new trend of using artificial or "sunless" tanning devices has developed among minors. Despite extensive research revealing the negative side effects of tanning (specifically in tanning beds), Indiana's current legislation allows minors between the ages of sixteen and seventeen to use tanning devices in tanning facilities if accompanied by a parent or guardian. Senate Bill 0269 has proposed that the current legislation should be altered to prohibit minors younger than the age of eighteen from using a tanning device in a tanning facility.

It is important to weigh current research to evaluate the consequences of excessive exposure to ultraviolet (UV) light when making a decision of whether or not to pursue a similar bill in this session. Research shows that skin cancer is the most common form of cancer in the U.S. (IBJNews, 2013). Seventy-five percent of all skin cancer related deaths are caused by melanoma (2013), and 65% of melanoma developments are believed to have been contributed to by exposure to UV rays (2013). In more digestible terms, one in fifty people are afflicted by melanoma (2013). Woman ages forty-five and younger make up 60% of tanning bed users (2013), so although this is an issue that impacts all citizens, it is a significantly "youth oriented" issue. Melanoma is currently the second most common cancer in women between the ages of 20-29 (2013), an age that should be characterized by health and youthfulness. As these statistics suggest, this is a serious and growing issue, making this issue extremely pertinent.

Other states are taking action against the harmful effects that the UV (ultraviolet) rays emitted by indoor tanning beds have on our nation's youth. For example, the State of Illinois bans any indoor tanning for children under the age of eighteen, recognizing the correlation between rates of melanoma and the availability of indoor UV tanning salons to minors ("Indoor tanning restrictions," 2013). Like Indiana, the Illinois law once only required the presence and consent of a parent for a child under eighteen to receive tanning services; but as noted, the current law has made a movement to protect youth from skin cancer through indoor UV tanning.

Across the country, legislation is showing that our nation wants to protect its youth from the harmful effects of indoor UV tanning. Twenty out of the 31 states seeking to change indoor UV tanning policies propose a ban on tanning under the age of eighteen, some of which only allow exceptions with a doctor's consent ("Indoor tanning restrictions," 2013). In supporting a similar piece of legislation this coming session, Indiana would be catching up with the reform efforts of other states.

This bill holds several important implications, both for Indiana families, and for indoor tanning salons. First, by restricting access of indoor UV tanning to legal adults, youth will be safer and will have more time to become informed on the consequences surrounding indoor UV tanning. Second, the tanning salons who do provide tanning services to customers under the age of eighteen, can be charged with a Class C misdemeanor and be given up to $500 in fines ("Information maintained by"), a potentially expensive mistake. Additionally, they could spend up to sixty days in jail ("Information maintained by"). These potential consequences should go a long way in generating accountability for observing tanning legislation. Though many tanning salons rightfully worry about what a ban on tanning bed use by minors will mean for their business, in order to offset the consequence of decreased tanning bed use, tanning salons can expand their spray tan business, offering these services to clients under age eighteen, making up for the revenue they may have lost from UV tanning.

Therefore, because the literature strongly supports the conclusion that there is a strong correlation between the development of melanoma and tanning bed exposure, resulting in higher instances of skin cancer related death, we urge you to earnestly consider the consequences of failing to restrict tanning bed exposure to children under the age of eighteen. In addition to the already apparent increase in instances of melanoma being seen in individuals under the age of twenty-five, we must also look ahead to the implications of tanning bed exposure the upcoming generations will face as they age. The reality of increased skin cancer will have serious financial consequences as melanoma related healthcare costs increase, and it will have devastating effects on the individuals and families who will be affected by skin cancer. We ask you to thoughtfully consider the implications your decision will have, both now and in the future, and that you take decisive action to stop Indiana youths' reckless exposure to dangerous, artificial ultraviolet rays. Ultimately, it is the responsibility of our government to protect the health and well-being of our minor children. We support the legislation prohibiting children under the age of eighteen to use tanning devices in tanning facilities that was proposed last year, and believe that this is an issue that should remain at the forefront of your minds in coming session. Thank you for your time and attention.

References

IBJNews. (2013, August 21). *Dermatologists seek ban on minors using tanning beds*. Retrieved from http://www.ibj.com/dermatologists-seek-ban-on-minors-using-tanning-beds/PARAMS/article/43117

Indoor tanning restrictions for minors - a state-by-state comparison. (2013, August). Retrieved from http://www.ncsl.org/issues-research/health/indoor-tanning-restrictions.aspx

(n.d.). *Information maintained by the office of code revision indiana legislative services agency*. Retrieved from website: http://www.in.gov/legislative/ic/code/title25/ar8/ch15.4.html

9/16/13 HFC Exhibit 9

Indiana Home Care Task Force
One North Capitol Avenue, Suite 1025
Indianapolis, IN 46204

September 16, 2013

Hon. Patricia Miller, Chairwoman, and
Members of the Health Finance Commission
State House
Indianapolis, IN 46204

Dear Senator Miller and Members of the Commission:

The Indiana Home Care Task Force is honored to have this opportunity to communicate with the members of the Health Finance Commission of the Indiana General Assembly. On behalf of the IHCTF, I must thank Senator Miller for this opportunity.

First, the IHCTF is here today because we were excluded from the ABD Task Force established by the Indiana Family and Social Services Administration (FSSA). The FSSA ABD Task Force was created this summer with a charge that included examining the merits of risk-based managed care directed by private for-profit companies for individuals that need publicly funded home and community based services (HCBS).*

The Indiana Home Care Task Force was founded in April 1986. The IHCTF is a voluntary alliance of individuals and organizations that represent citizens of all ages that need home and community based services. The IHCTF has long been the state's leading consumer consortium. Some sixty plus organizations are members. They represent an enormous number of Hoosiers.

The IHCTF has been highly vocal on the issue of managed care for persons that use HCBS. The IHCTF has testified on the issue multiple times at the State House at hearings attended by FSSA senior staff and has communicated directly with FSSA on these issues many, many times since 2005. The IHCTF should have been invited to participate the moment the ABD Task Force was conceived.

It is the mission of the IHCTF to represent the interests of all citizens of all ages that need HCBS. Every member of the General Assembly should know that advocates for citizens that must use HCBS have substantial reservations regarding the merits of managed care that is controlled by for-profit corporations. Experience has taught us that managed care that is driven and defined

by a profit motive can place in jeopardy the dignity, independence, health, safety, and prerogatives of human beings.

The academic and research literature is replete with ill findings regarding risk-based managed care controlled by for-profit corporations. It is clear that people who need HCBS and their family caregivers do best when they maintain control over the care they use and the decisions that affect their quality of life and rights.

Regarding FSSA, that agency should exist first and foremost for the citizens of Indiana. FSSA was not created in 1991 to serve as an agent for for-profit providers and their trade associations in the managed care industry. FSSA is a public agency with the mission to serve and protect the interests of Indiana's most vulnerable citizens. When FSSA does that all Hoosiers are well served and all taxpayers benefit from programs that fulfill a clear public need.

Today, you will hear from citizens who have had many years of experience as volunteer advocates for people that need HCBS. These citizens continue to volunteer for the Indiana Home Care Task Force and many of its member organizations.

Listen to what these advocates have to say. Then listen to the people in your districts that need HCBS. Listen to the people in your districts that have been harmed by welfare privatization. Listen to the people and their high praise for the non-profit area agencies on aging that have a highly successful record in working the with ABD population that needs HCBS. Do not throw away what the area agencies on aging do so well.

Listen to the people in your districts that want to stay at home with independence and dignity among their families and friends. Truly listen and then implement their wise counsel.

Thank you and take care.

Sincerely yours,

John Cardwell, Chairperson
Indiana Home Care Task Force

*Home and community based services (HCBS) is often identified in professional literature as long term services and supports (LTSS). LTSS is sometimes used to include a wider array of services than those traditionally identified as HCBS.