Southwest Michigan

BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting
KVCC – The Grove Campus: 7107 Elm Valley Dr. Kalamazoo, MI, 49009
Dial: 855-528-6413 Room: 1 Pwd: 1234
Monday, August 28, 2017
4:00-5:30
Draft 08/04/17

1. **Welcome and Introductions (Randall Hazelbaker)**
2. **Public Comment**
3. **Agenda Review and Adoption (Randall Hazelbaker)** (d) (pg.1)
4. **Consent Agenda (Randall Hazelbaker)**

   Approval of July 17, 2017 Meeting Minutes (d) (pg.2)
5. **Board Education**
   a. Fiscal Year 16/17 YTD Financials – (Tracy Dawson) (d) (pg.7)
   b. Michigan Automated Prescription System (MAPS) report (Achiles Malta) (d) (pg.8)
6. **Board Actions to be Considered (Randall Hazelbaker)**
   None scheduled
7. **Recess SUDOPB for FY 17/18 Budget Hearing (Randall Hazelbaker)**
8. **Public Budget Hearing on Public Act 2 Dollars (Randall Hazelbaker)**
   a. Budget Assumptions (Tracy Dawson) (d) (pg.10)
   b. Fiscal Year 2017 Projections (Tracy Dawson) (d) (pg.14)
   c. Fiscal Year 2018 PA2 Budget (Tracy Dawson) (attachments)
   d. Board questions and answers
   e. Public Comment
9. **Reconvene SUDOPB Meeting (Randall Hazelbaker)**
10. **Board Action**

    Resolution for Fiscal Year 2018 PA2 Budget (Randall Hazelbaker) (attachment)
11. **Communication and Counsel**
    a. FY 2018 Rate Setting Meeting Update (Brad Casemore)
    b. Legislative and Policy Updates (Brad Casemore) (d) (pg.21)
12. **Adjourn**

The meeting will be held in compliance with the Open Meetings Act, 1976 PA 267, MCL 15.261 to 15.275

Southwest Michigan
BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting Minutes

SWMBH: 5250 Lovers Lane, Suite 200, Portage, MI, 49002
Dial: 855-528-6413 Room: 1 Pwd: 1234
July 17, 2017
4:00 – 5:30 pm
Draft: 07/18/17

Members Present: Randall Hazelbaker (Branch County), Robert Wagel (Cass County), Richard Godfrey (Van Buren County), Debra Panozzo (Berrien County) Steve Frisbie (Calhoun County) Daniel Doerhman (Kalamazoo County)

Members Participating via Phone: Allen Balog (St. Joseph County), Michael Majerek (Berrien County), Ben Geiger (Barry County), Lisa White (Kalamazoo County)

Guests Participating via Phone: Michele Johnson, Calhoun County Finance

Members Absent: Kathy-Sue Dunn (Calhoun County), Kathy Pangle (St. Joseph County) Tara Smith (Cass County), Paul Schincariol (Van Buren County)

Staff Present: Joel Smith, SUD Services Manager, SWMBH; Mila Todd, Chief Compliance and Privacy Officer; SWMBH; Kim Rychener, Director of Utilization Management and Member Engagement; Tracy Dawson, Chief Financial Officer, SWMBH; Michelle Jorgboyan, Senior Operations Specialist, SWMBH

Guests: Susan Meinke, Todd Brodie

Welcome and Introductions – Randall Hazelbaker called the meeting to order at 4:00 pm.

Agenda review and adoption

Motion	Robert Wagel moved to approve the agenda.
Second	Richard Godfrey
Motion carried	

Consent Agenda

Motion	Debra Panozzo moved to accept the May 15, 2017

meeting minutes.

Second Richard Godfrey

Motion carried

Board Education

Valley Psychological Center: SUD Application

Susan Meinke gave a presentation on Valley Psychological Center services. Federal Grant funds would be used for CBT for individuals in the Kalamazoo area who are referred by KPEP for services. Susan distributed handouts regarding additional services that Valley Psychological Center provides and answered questions from the Board Members.

FY 16/17 YTD Financials

Tracy Dawson reviewed the year to date financials as presented, highlighting numbers for Medicaid, Healthy Michigan, MI Child, Block Grant, PA2, and PA2 carryforward. Tracy stated SWMBH is upside down in Block Grant and asked the State for a 1.7 million dollar increase which the State approved. Tracy reviewed new information that was added to the financials to provide additional clarity. Board Members discussed financials.

SWMBH SUDOPB Member Orientation/Training

Joel Smith reviewed the SUD Treatment orientation materials as presented.

PA2 Reports

Joel Smith reviewed the PA2 reports as presented.

PA2 Budget Planning

Joel Smith stated that SWMBH is in the process of collecting Provider work plans, renewing contracts and developing budgets for FY2018. Joel included budget calendars in the packet for the Board Members information.

CY2017 SUDOPB Attendance

Randall Hazelbaker reviewed the CY2017 SUDOPB attendance as presented and reminded Board Members that the attendance report is sent to each County Commissioners' Board Chair periodically during the year so that the County Commissioners are aware of their Commissioners attendance.

Board Actions to Consider

Approve Intergovernmental Contract

Joel Smith reviewed the Intergovernmental Contract as presented.

Members discussed.

Motioned to approve the Intergovernmental Contract Robert Wagel

Second Richard Godfrey

Chairperson Randall Hazelbaker initiated a roll call vote. The following Board Members voted in favor of the Intergovernmental Contract:

Randall Hazelbaker
Robert Wagel
Richard Godfrey
Deb Panozzo
Ben Geiger

Lisa White
Steve Frisbie
Michael Majerek
Alan Balog

The following Board Member voted to oppose the Intergovernmental Contract:

Daniel Doehrman

Conflict of Interest (COI) consideration – Daniel Doehrman and Lisa White
Mila Todd indicated that Financial Interest Disclosure statements had not yet been secured from Lisa White or Dan Doehrman and posed the following question prior to consideration of item 6(b) PA2 Budget Amendments – Berrien, Kalamazoo and St. Joseph: Are you or any of your immediate family members a member of any other Boards, employed by any agency or provider, or have any other financial interest or serve in any other capacity that would create a conflict for you in voting on these PA2 budget amendments? An example would be if you or a family member were employed by one of the agencies seeking an amendment to its budget.

Both Ms. White and Mr. Doehrman answered "No".

FY16/17 PA2 Budget Amendments – Berrien, Kalamazoo, and St. Joseph
Berrien
Joel Smith reviewed the budget amendment for the Berrien PA2 budget. Members discussed.
Motion to approve the Berrien PA2 Budget Amendment Robert Wagel
Second Richard Godfrey
Chairperson Randall Hazelbaker initiated a roll call vote. The following Board Members voted in favor of the Berrien PA2 budget amendment:

Randall Hazelbaker
Robert Wagel
Richard Godfrey
Ben Geiger
Steve Frisbie
Lisa White
Daniel Doehrman
Allen Balog

No Board Member voted against the Berrien PA2 budget amendment.
The Berrien PA2 budget amendment was approved. The resolution reflected the roll call vote and was signed by the Board Chair, Randall Hazelbaker.

Kalamazoo
Joel Smith reviewed the budget amendment for the Kalamazoo PA2 budget. Members discussed.
Motion to approve the Kalamazoo PA2 Budget Amendment Robert Wagel
Second Richard Godfrey
Chairperson Randall Hazelbaker initiated a roll call vote. The following Board Members voted in favor of the Kalamazoo PA2 budget amendment:

Randall Hazelbaker
Robert Wagel

Richard Godfrey
Ben Geiger
Steve Frisbie
Debra Panozzo
Michael Majerek
Allen Balog

No Board Member voted against the Kalamazoo PA2 budget amendment.
The Kalamazoo PA2 budget amendment was approved. The resolution reflected the roll call vote and was signed by the Board Chair, Randall Hazelbaker.

St. Joseph
Joel Smith reviewed the budget amendment for the St. Joseph PA2 budget. Members discussed.
Motion to approve the St. Joseph PA2 Budget Amendment — Robert Wagel
Second — Richard Godfrey
Chairperson Randall Hazelbaker initiated a roll call vote. The following Board Members voted in favor of the St. Joseph PA2 budget amendment:

Randall Hazelbaker
Robert Wagel
Richard Godfrey
Ben Geiger
Steve Frisbie
Debra Panozzo
Michael Majerek
Lisa White
Daniel Doehrman

No Board Member voted against the St. Joseph PA2 budget amendment.
The St. Joseph PA2 budget amendment was approved. The resolution reflected the roll call vote and was signed by the Board Chair, Randall Hazelbaker.

Conflict of Interest (COI) consideration – Tara Smith
Mila Todd stated that COI forms were sent to Tara Smith and had not been returned. Because Tara Smith was not present, this consideration will be tabled until the August 28, 2017 meeting.

Communication and Counsel

Grant(s) Status/Updates
Joel Smith shared that SWMBH was awarded a two year grant totaling $730,000. The Federal Grant money will be used to address the current Opioid crisis. These funds will used in both Prevention programs and Treatment programs.

SUDOPB August 28th Meeting/Budget Public Hearing
Joel Smith shared that the August 28, 2017 SUDOPB Meeting/Budget Public Hearing will be held at KVCC – The Groves Center in order to accommodate the expected attendance. Michelle Jorgboyan will send an email invitation to the Members reflecting the location, directions, and call in information.

Legislative Updates

Joel Smith and Kim Rychener highlighted the FY2018 Budget in regards to the 298 update/status as presented.

Michigan Consortium for Healthcare Excellence (MCHE) written report
Joel Smith noted the MCHE written report as presented.

Articles of Interest
Joel Smith noted articles of interest and highlighted a recent meeting involving SWMBH, Senator Mike Shirkey, and Pines Behavioral Health.

SUDOPB Pictures and Bios
Michelle Jorgboyan reminded the Board Members to forward any pictures and bios to her attention for inclusion in the new SWMBH website and stated that she would send an email reminder to the Board Members.

Board Member Comments
Robert Wagel stated that Kathy Emans, Woodlands CEO, accepted a position with the University of Arkansas. The interim CEO for Woodlands is Kathy Sheffield.

Adjourn

Motion	Robert Wagel moved to adjourn meeting.
Second	Richard Godfrey
Motion Carried	

Meeting adjourned at 5:45 pm.

Southwest Michigan Behavioral Health

Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2017
October 1, 2016 - June 30, 2017

	MEDICAID	MEDICAID				Healthy MI	Healthy MI			
	Budgeted Annual Rev	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted Annual Rev	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)
Barry	210,971	158,228	101,240	83,062	18,178	335,074	251,305	182,838	156,295	26,543
Berrien	559,096	419,322	426,988	209,464	217,524	887,982	665,986	709,993	423,945	286,048
Branch	161,311	120,984	111,505	92,376	19,129	256,202	192,151	174,944	121,732	53,212
Calhoun	485,398	364,048	440,697	288,929	151,768	770,931	578,198	681,672	427,909	253,763
Cass	186,455	139,841	120,571	75,619	44,952	296,136	222,102	203,033	199,829	3,205
Kazoo	892,499	669,374	583,323	192,966	390,357	1,417,508	1,063,131	1,080,657	323,752	756,905
St. Joe	218,526	163,895	160,112	42,275	117,837	347,073	260,305	267,423	120,034	147,389
Van Buren	271,888	203,916	215,441	81,213	134,228	431,825	323,869	357,970	226,542	131,427
DRM	1,313,856	985,392	990,592	1,978,208	(987,616)	2,348,467	1,761,350	1,894,105	2,595,481	(701,376)
Admin/Acces	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL	4,300,000	3,225,000	3,150,468	3,044,111	106,357	7,091,197	5,318,398	5,552,634	4,595,519	957,115

	BLOCK GRANT	BLOCK GRANT				Current Year PA	Current Year PA2				PA2 Carryforward	PA2 Carryforward
	Budgeted Annual Rev	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Budgeted Annual Rev	Budgeted YTD Revenue	Actual YTD Revenue	YTD Expense	Fav (Unfav)	Utilization	Prior Year Balance
Barry	323,023	242,268	242,268	170,239	72,028	85,020	63,765	34,474	24,176	10,298	0	332,275
Berrien	856,045	642,034	642,034	469,346	172,688	497,840	373,380	269,215	269,215	(0)	88,694	342,931
Branch	246,988	185,241	185,241	119,997	65,245	70,000	52,500	136,860	27,251	109,610	0	313,450
Calhoun	743,205	557,403	557,403	354,126	203,277	458,931	344,198	294,904	294,904	0	56,336	672,293
Cass	285,486	214,114	214,114	89,252	124,863	67,980	50,985	66,910	19,968	46,942	0	253,181
Kazoo	1,366,525	1,024,894	1,024,894	871,373	153,521	1,009,712	757,284	640,406	632,050	8,356	161,369	2,152,872
St. Joe	334,591	250,943	250,943	299,314	(48,371)	138,945	104,208	73,700	69,326	4,374	4,913	284,069
Van Buren	416,295	312,221	312,221	119,683	192,539	120,473	90,355	102,058	7,904	94,154	0	98,956
DRM	600,101	491,966	491,966	2,051,026	(1,559,060)	0	0	0	0	0	0	0
PFS	133,991	100,493	100,493	59,697	40,796	0	0	0	0	0	0	0
SDA	128,219	96,164	96,164	128,196	(32,032)	0	0	0	0	0	0	0
Admin/Acces	93,984	70,488	70,488	252,506	(182,018)	0	0	0	0	0	0	0
GRAND TOTAL	5,528,453	4,188,230	4,188,230	4,984,754	(796,524)	2,448,901	1,836,676	1,618,528	1,344,795	273,733	311,312	4,450,026

Legend
DRM - Detox, Residential, and Methadone
PFS - Partnerships for Success
SDA - State Disability Assistance

Van Buren's encounters are not being accounted for in the correct funding source. Please see below for the allocation to the correct funding sources.

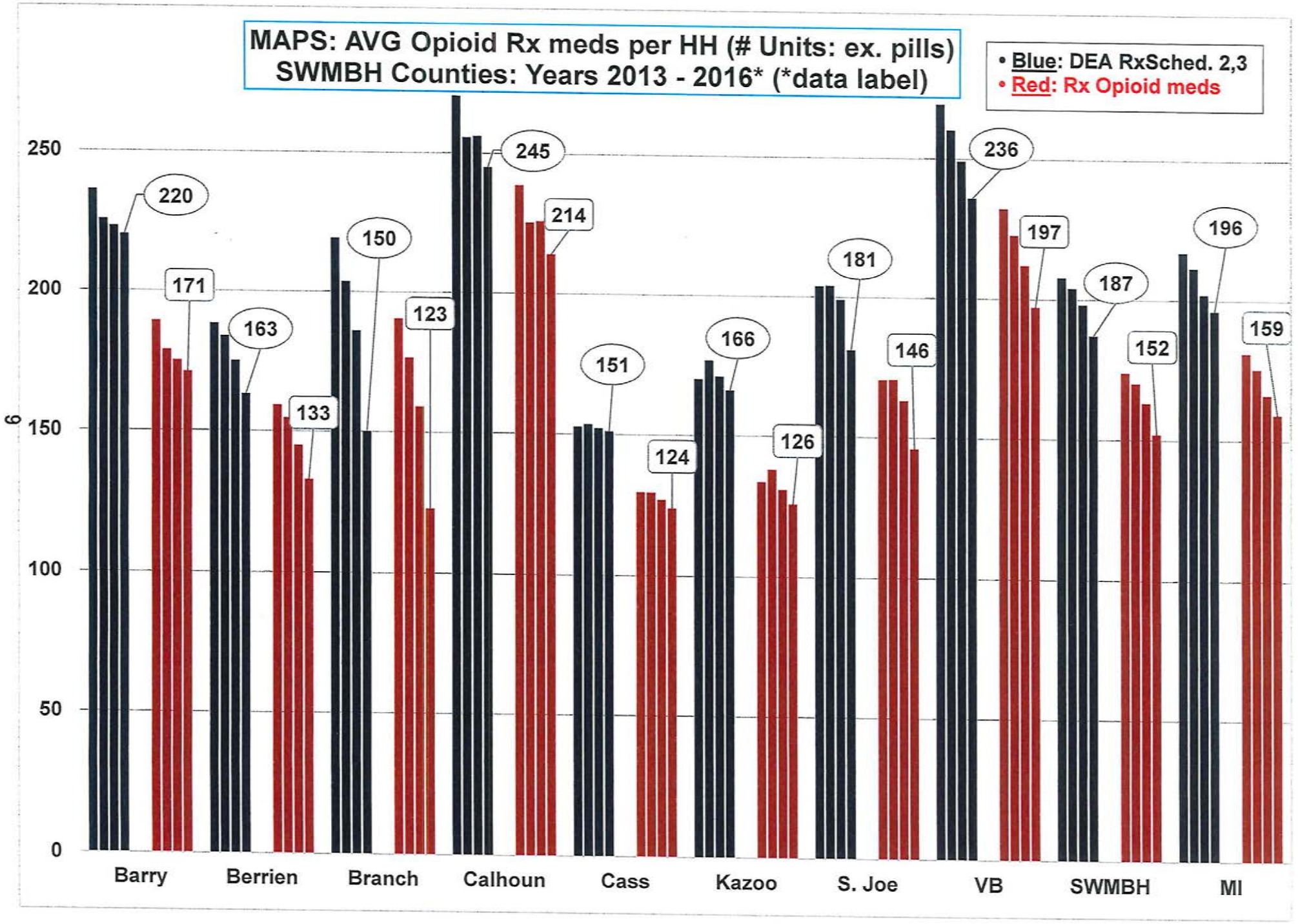
Van Buren

427,438	0.28	119,682.64	Block Grant
	0.19	81,213.22	McdSA
	0.53	226,542.14	HMPSA

Confidential

2016 Michigan Automated Prescription System (MAPS) Data
(Volume of Prescribed Opioid pain meds in each SWMBH County)

County	Year(s)	# Opioid Scripts	2016 / '15 % Scripts	# Opioid Units (ex. pills)	2016 / '15 % diff. Opioid Units
Barry	2016	47,428	-1.7%	3,420,269	-2.2%
	2015	48,245		3,496,383	
Berrien	2016	136,627	-7.9%	9,011,669	-8.7%
	2015	148,354		9,865,203	
Branch	2015	32,158	-4.0%	2,052,643	-22.2%
	2016	33,509		2,638,539	
Calhoun	2016	158,947	0.2%	11,599,488	-5.0%
	2015	158,671		12,214,750	
Cass	2015	30,358	-3.2%	2,072,884	-2.7%
	2016	31,369		2,130,152	
Kalamazoo	2016	183,762	-4.2%	12,543,279	-4.0%
	2015	191,755		13,069,806	
Saint Joseph	2015	50,516	-7.5%	3,419,840	-10.6%
	2016	54,618		3,823,358	
Van Buren	2016	84,273	-4.0%	5,974,642	-6.8%
	2015	87,783		6,412,923	
SWMBH	2015	724,069	-4.0%	50,094,714	-6.6%
	2016	754,304		53,651,114	
State of Michigan	2016	8,756,533	-3.7%	610,578,467	-4.9%
	2015	9,094,115		642,281,881	


MAPS: AVG Opioid Rx meds per HH (# Units: ex. pills)
SWMBH Counties: Years 2013 - 2016* (*data label)
• Blue: DEA RxSched. 2,3
• Red: Rx Opioid meds
250
200
150
100
50
0
220
171
163
133
150
123
245
214
151
124
166
126
181
146
236
197
187
152
196
159
Barry
Berrien
Branch
Calhoun
Cass
Kazoo
S. Joe
VB
SWMBH
MI

Southwest Michigan
BEHAVIORAL HEALTH

Fiscal Year 2018 Budget

October 1, 2017 – September 30, 2018
Assumptions and Targets

Board Material

July 14, 2017

Additional fiscal year 2018 strategic planning and budget assumptions

- No PIHP Consolidation
- No Imminent Behavioral Health Carve-In to Medicaid Health Plans
- "Pilots" – Yes
  - Threat? – Under Consideration
  - Opportunity? – Under Consideration
  - Pilot in SWMBH Region? Assume NO for the time being
- MI Health Link (Medicare-Medicaid "Duals") Continues in SWMBH Region
- Higher MLR than FY 2017 in Specialty Services – Percentage Under Development
- Higher MLR than FY 2017 in Healthy Michigan Plan – Percentage Under Development

Additional fiscal year 2018 strategic planning and budget assumptions

- Lower ALR than FY 2017 in Specialty Services – Percentage Under Development
- Lower ALR than FY 2017 in Healthy Michigan Plan – Percentage Under Development
- Enhanced Regional Collaboration on Programs/Services
- Enhanced Regional Collaboration on Administrative Expense Reductions
- Improvements in Depth and Breadth of Uses of Assessment Tools and Analytics
- Improvements in Uses of Level of Care Guidelines
- Improved Healthcare Data Analytics
- Proof of Value & Outcomes Initiatives

Additional fiscal year 2018 strategic planning and budget assumptions

- Fully Funded Internal Service Funds (Medicaid & Healthy Michigan Plan) at 10/1/17
- FY 2017 Medicaid Savings into FY 2018 at $8,400,000
- FY 2017 Health Michigan Plan Savings into FY 2018 at $1,982,000
- Full earning of fiscal year 2017 Performance Bonus Incentive Program in March 2018 (avoids a $1,400,000 return to MDHHS)

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*	*Mos in FYTD*								
2	For the Fiscal YTD Period Ended 9/30/2017			12	7								
3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
6	***Medicaid Specialty Services***			*HCC%*	81.7%	73.7%	80.2%	79.5%	80.5%	83.4%	83.8%	86.0%	81.6%
7	Subcontract Revenue		196,169,351	17,401,916	178,767,435	6,900,265	35,183,062	9,310,557	33,102,018	8,961,476	56,071,390	12,060,933	17,177,735
8	Incentive Payment Revenue		1,177,960	162,438	1,015,522	-	-	39,269	214,784	49,352	653,834	-	58,285
9	Contract Revenue		197,347,312	17,564,354	179,782,957	6,900,265	35,183,062	9,349,826	33,316,801	9,010,827	56,725,224	12,060,933	17,236,019
10													
11	External Provider Cost		127,348,323	2,567,257	124,781,066	3,852,445	22,528,685	6,266,420	23,250,155	5,608,672	46,476,311	7,633,577	9,164,800
12	Internal Program Cost		48,481,521	-	48,481,521	3,266,068	9,257,555	2,568,618	10,136,961	3,235,283	8,347,536	4,390,329	7,279,170
13	SSI Reimb, 1st/3rd Party Cost Offset		(706,319)	-	(706,319)	(86,127)	(106,996)	(82,518)	-	(57,019)	(179,878)	(19,740)	(174,041)
14	HICA & Use Tax, HRA		10,674,465	10,674,465	-	-	-	-	-	-	-	-	-
15	MHL Cost in Excess of Medicare FFS		2,171,488	2,171,488	-	-	-	-	-	-	-	-	-
16	**Total Healthcare Cost**		187,969,477	15,413,210	172,556,267	7,032,386	31,679,245	8,752,520	33,387,116	8,786,937	54,643,969	12,004,165	16,269,929
17	Medical Loss Ratio (HCC % of Revenue)		95.2%	87.8%	96.0%	101.9%	90.0%	93.6%	100.2%	97.5%	96.3%	99.5%	94.4%
18													
19	Managed Care Administration		19,747,314	5,769,709	13,977,605	570,917	3,019,099	687,747	2,752,642	535,375	4,544,630	730,628	1,136,567
20	Admin Cost Ratio (MCA % of Total Cost)		9.5%	2.8%	6.7%	7.5%	8.7%	7.3%	7.6%	5.7%	7.7%	5.7%	6.5%
21													
22	Contract Cost		207,716,791	21,182,918	186,533,873	7,603,303	34,698,345	9,440,267	36,139,757	9,322,312	59,188,599	12,734,793	17,406,496
23	Net before Settlement		(10,369,480)	(3,618,564)	(6,750,915)	(703,039)	484,718	(90,441)	(2,822,956)	(311,484)	(2,463,375)	(673,860)	(170,477)
24													
25	Prior Year Savings		16,467,632	16,467,632	-	-	-	-	-	-	-	-	-
26	Internal Service Fund Risk Reserve		1,717,890	1,717,890	-	-	-	-	-	-	-	-	-
27	Contract Settlement combined w/ MIChild		595,251	(6,155,664)	6,750,915	703,039	(484,718)	90,441	2,822,956	311,484	2,463,375	673,860	170,477
28	Net after Settlement		8,411,293	8,411,293	0	-	(0)	0	-	-	0	-	(0)
29													
30	Eligibles and PMPM												
31	Average Eligibles		147,959	147,959	147,959	7,406	29,274	8,300	27,920	8,428	38,992	12,143	15,496
32	Revenue PMPM		$ 111.15	$ 9.89	$ 101.26	$ 77.64	$ 100.15	$ 93.87	$ 99.44	$ 89.10	$ 121.23	$ 82.77	$ 92.69
33	Expense PMPM		$ 116.99	$ 11.93	$ 105.06	$ 85.55	$ 98.77	$ 94.78	$ 107.87	$ 92.18	$ 126.50	$ 87.39	$ 93.61
34	Margin PMPM		$ (5.84)	$ (2.04)	$ (3.80)	$ (7.91)	$ 1.38	$ (0.91)	$ (8.43)	$ (3.08)	$ (5.26)	$ (4.62)	$ (0.92)
35													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
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3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
36	***Medicaid Specialty Services***												
37	Budget v Actual												
38													
39	Eligible Lives (Average Eligibles)												
40	Actual		147,959	147,959	147,959	7,406	29,274	8,300	27,920	8,428	38,992	12,143	15,496
41	Budget		145,435	145,435	145,435	7,318	28,942	7,988	27,941	8,368	37,844	11,859	15,175
42	Variance - Favorable / (Unfavorable)		2,524	2,524	2,524	88	332	312	(21)	60	1,148	284	321
43	% Variance - Fav / (Unfav)		1.7%	1.7%	1.7%	1.2%	1.1%	3.9%	-0.1%	0.7%	3.0%	2.4%	2.1%
44													
45	Contract Revenue before settlement												
46	Actual		197,347,312	17,564,354	179,782,957	6,900,265	35,183,062	9,349,826	33,316,801	9,010,827	56,725,224	12,060,933	17,236,019
47	Budget		197,841,400	15,719,424	182,121,976	7,011,525	37,600,606	9,782,142	35,503,516	9,289,751	56,186,066	11,432,342	15,316,028
48	Variance - Favorable / (Unfavorable)		(494,088)	1,844,930	(2,339,018)	(111,260)	(2,417,544)	(432,316)	(2,186,714)	(278,924)	539,158	628,591	1,919,991
49	% Variance - Fav / (Unfav)		-0.2%	11.7%	-1.3%	-1.6%	-6.4%	-4.4%	-6.2%	-3.0%	1.0%	5.5%	12.5%
50													
51	Healthcare Cost												
52	Actual		187,969,477	15,413,210	172,556,267	7,032,386	31,679,245	8,752,520	33,387,116	8,786,937	54,643,969	12,004,165	16,269,929
53	Budget		176,450,171	9,979,865	166,470,306	7,100,845	32,007,113	8,384,253	28,696,602	9,289,611	54,765,836	12,173,368	14,052,677
54	Variance - Favorable / (Unfavorable)		(11,519,306)	(5,433,345)	(6,085,961)	68,459	327,868	(368,267)	(4,690,513)	502,674	121,867	169,203	(2,217,252)
55	% Variance - Fav / (Unfav)		-6.5%	-54.4%	-3.7%	1.0%	1.0%	-4.4%	-16.3%	5.4%	0.2%	1.4%	-15.8%
56													
57	Managed Care Administration												
58	Actual		19,747,314	5,769,709	13,977,605	570,917	3,019,099	687,747	2,752,642	535,375	4,544,630	730,628	1,136,567
59	Budget		22,229,019	7,667,934	14,561,085	418,684	3,235,024	708,476	2,478,447	571,232	5,265,325	790,626	1,093,271
60	Variance - Favorable / (Unfavorable)		2,481,705	1,898,225	583,480	(152,233)	215,924	20,729	(274,194)	35,857	720,695	59,998	(43,296)
61	% Variance - Fav / (Unfav)		11.2%	24.8%	4.0%	-36.4%	6.7%	2.9%	-11.1%	6.3%	13.7%	7.6%	-4.0%
62													
63	Total Contract Cost												
64	Actual		207,716,791	21,182,918	186,533,873	7,603,303	34,698,345	9,440,267	36,139,757	9,322,312	59,188,599	12,734,793	17,406,496
65	Budget		198,679,190	17,647,799	181,031,391	7,519,529	35,242,137	9,092,729	31,175,050	9,860,843	60,031,161	12,963,994	15,145,948
66	Variance - Favorable / (Unfavorable)		(9,037,601)	(3,535,120)	(5,502,482)	(83,774)	543,792	(347,538)	(4,964,708)	538,531	842,562	229,201	(2,260,548)
67	% Variance - Fav / (Unfav)		-4.5%	-20.0%	-3.0%	-1.1%	1.5%	-3.8%	-15.9%	5.5%	1.4%	1.8%	-14.9%
68													
69	Net before Settlement												
70	Actual		(10,369,480)	(3,618,564)	(6,750,915)	(703,039)	484,718	(90,441)	(2,822,956)	(311,484)	(2,463,375)	(673,860)	(170,477)
71	Budget		(837,790)	(1,928,375)	1,090,585	(508,004)	2,358,469	689,413	4,328,466	(571,092)	(3,845,096)	(1,531,652)	170,080
72	Variance - Favorable / (Unfavorable)		(9,531,690)	(1,690,190)	(7,841,500)	(195,035)	(1,873,752)	(779,854)	(7,151,422)	259,607	1,381,721	857,791	(340,556)
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*	*Mos in FYTD*								
2	For the Fiscal YTD Period Ended 9/30/2017			12	7								
3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
75	***Healthy Michigan Plan***			*HCC%*	8.3%	13.8%	7.1%	8.8%	9.4%	9.2%	8.2%	5.9%	7.4%
76	Contract Revenue		26,427,292	5,728,710	20,698,582	1,125,473	4,313,141	1,067,841	4,074,270	1,249,033	5,064,413	1,621,248	2,183,163
77													
78	External Provider Cost		12,547,601	3,493,383	9,054,218	552,896	1,070,718	230,324	1,491,740	356,759	4,372,529	299,628	679,625
79	Internal Program Cost		8,523,640	-	8,523,640	767,505	1,732,247	736,106	2,400,706	608,281	961,063	530,190	787,541
80	HICA & Use Tax		915,187	915,187	-	-	-	-	-	-	-	-	-
81	Total Healthcare Cost		21,986,428	4,408,570	17,577,858	1,320,402	2,802,965	966,429	3,892,446	965,040	5,333,592	829,818	1,467,165
82	Medical Loss Ratio (HCC % of Revenue)		83.2%	77.0%	84.9%	117.3%	65.0%	90.5%	95.5%	77.3%	105.3%	51.2%	67.2%
83													
84	Managed Care Administration		2,128,112	701,550	1,426,562	107,196	267,129	75,939	320,918	58,798	443,584	50,507	102,492
85	Admin Cost Ratio (MCA % of Total Cost)		8.8%	2.9%	5.9%	7.5%	8.7%	7.3%	7.6%	5.7%	7.7%	5.7%	6.5%
86													
87	Contract Cost		24,114,540	5,110,120	19,004,420	1,427,597	3,070,094	1,042,369	4,213,364	1,023,838	5,777,176	880,325	1,569,657
88	Net before Settlement		2,312,752	618,590	1,694,162	(302,124)	1,243,047	25,473	(139,094)	225,195	(712,763)	740,923	613,506
89													
90	Prior Year Savings		1,678,141	1,678,141	-	-	-	-	-	-	-	-	-
91	Internal Service Fund Risk Reserve		(298,677)	(298,677)	-	-	-	-	-	-	-	-	-
92	Contract Settlement		(1,710,169)	(16,007)	(1,694,162)	302,124	(1,243,047)	(25,473)	139,094	(225,195)	712,763	(740,923)	(613,506)
93	Net after Settlement		1,982,047	1,982,047	-	-	-	(0)	0	-	(0)	-	-
94													
95	Eligibles and PMPM												
96	Average Eligibles		49,394	49,394	49,394	2,533	9,634	2,399	9,009	2,819	14,473	3,634	4,895
97	Revenue PMPM		$ 44.59	$ 9.66	$ 34.92	$ 37.03	$ 37.31	$ 37.10	$ 37.69	$ 36.93	$ 29.16	$ 37.18	$ 37.17
98	Expense PMPM		40.68	8.62	32.06	46.97	26.56	36.21	38.97	30.27	33.26	20.19	26.72
99	Margin PMPM		$ 3.90	$ 1.04	$ 2.86	$ (9.94)	$ 10.75	$ 0.88	$ (1.29)	$ 6.66	$ (4.10)	$ 16.99	$ 10.45
100													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*	*Mos in FYTD*								
2	For the Fiscal YTD Period Ended 9/30/2017			12	7								
3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
101	***Healthy Michigan Plan***												
102	Budget v Actual												
103													
104	Eligible Lives (Average Eligibles)												
105	Actual		49,394	49,394	49,394	2,533	9,634	2,399	9,009	2,819	14,473	3,634	4,895
106	Budget		46,868	46,868	46,868	2,481	9,240	2,253	8,677	2,624	13,547	3,378	4,668
107	Variance - Favorable / (Unfavorable)		2,526	2,526	2,526	52	394	146	332	195	926	256	227
108	% Variance - Fav / (Unfav)		5.4%	5.4%	5.4%	2.1%	4.3%	6.5%	3.8%	7.4%	6.8%	7.6%	4.9%
109													
110	Contract Revenue before settlement												
111	Actual		26,427,292	5,728,710	20,698,582	1,125,473	4,313,141	1,067,841	4,074,270	1,249,033	5,064,413	1,621,248	2,183,163
112	Budget		25,000,000	9,589,403	15,410,597	860,521	3,236,556	781,175	3,053,073	983,096	4,090,663	1,003,260	1,402,252
113	Variance - Favorable / (Unfavorable)		1,427,292	(3,860,694)	5,287,985	264,952	1,076,585	286,666	1,021,196	265,937	973,750	617,988	780,911
114	% Variance - Fav / (Unfav)		5.7%	-40.3%	34.3%	30.8%	33.3%	36.7%	33.4%	27.1%	23.8%	61.6%	55.7%
115													
116	Healthcare Cost												
117	Actual		21,986,428	4,408,570	17,577,858	1,320,402	2,802,965	966,429	3,892,446	965,040	5,333,592	829,818	1,467,165
118	Budget		18,353,512	3,908,617	14,444,895	1,203,582	2,463,539	1,163,209	3,081,861	728,665	3,884,618	843,470	1,075,952
119	Variance - Favorable / (Unfavorable)		(3,632,916)	(499,953)	(3,132,963)	(116,820)	(339,427)	196,780	(810,586)	(236,375)	(1,448,974)	13,652	(391,213)
120	% Variance - Fav / (Unfav)		-19.8%	-12.8%	-21.7%	-9.7%	-13.8%	16.9%	-26.3%	-32.4%	-37.3%	1.6%	-36.4%
121													
122	Managed Care Administration												
123	Actual		2,128,112	701,550	1,426,562	107,196	267,129	75,939	320,918	58,798	443,584	50,507	102,492
124	Budget		2,058,689	817,493	1,241,197	70,966	248,995	98,292	266,172	44,807	373,477	54,781	83,707
125	Variance - Favorable / (Unfavorable)		(69,422)	115,943	(185,365)	(36,229)	(18,134)	22,353	(54,746)	(13,992)	(70,107)	4,274	(18,785)
126	% Variance - Fav / (Unfav)		-3.4%	14.2%	-14.9%	-51.1%	-7.3%	22.7%	-20.6%	-31.2%	-18.8%	7.8%	-22.4%
127													
128	Total Contract Cost												
129	Actual		24,114,540	5,110,120	19,004,420	1,427,597	3,070,094	1,042,369	4,213,364	1,023,838	5,777,176	880,325	1,569,657
130	Budget		20,412,201	4,726,109	15,686,092	1,274,548	2,712,533	1,261,501	3,348,033	773,472	4,258,095	898,251	1,159,659
131	Variance - Favorable / (Unfavorable)		(3,702,338)	(384,010)	(3,318,328)	(153,049)	(357,560)	219,133	(865,331)	(250,367)	(1,519,082)	17,927	(409,998)
132	% Variance - Fav / (Unfav)		-18.1%	-8.1%	-21.2%	-12.0%	-13.2%	17.4%	-25.8%	-32.4%	-35.7%	2.0%	-35.4%
133													
134	Net before Settlement												
135	Actual		2,312,752	618,590	1,694,162	(302,124)	1,243,047	25,473	(139,094)	225,195	(712,763)	740,923	613,506
136	Budget		4,587,799	4,863,294	(275,495)	(414,027)	524,023	(480,326)	(294,959)	209,625	(167,432)	105,008	242,593
137	Variance - Favorable / (Unfavorable)		(2,275,047)	(4,244,704)	1,969,657	111,903	719,024	505,799	155,865	15,570	(545,332)	635,915	370,913
138													
139		x											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*	*Mos in FYTD*								
2	For the Fiscal YTD Period Ended 9/30/2017			12	7								
3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
140	***Autism Specialty Services***			*HCC%*	3.7%	4.4%	6.0%	7.3%	2.6%	1.3%	3.1%	2.5%	3.4%
141	Contract Revenue		3,308,921	197,911	3,111,010	336,381	807,696	402,607	269,891	76,877	809,424	93,333	314,802
142													
143	External Provider Cost		6,175,075	-	6,175,075	-	2,386,345	798,619	14,792	134,758	1,992,807	351,845	495,908
144	Internal Program Cost		1,650,528	-	1,650,528	415,912	1,080	-	1,052,781	1,306	-	230	179,217
145	HICA & Use Tax		108,046	108,046	-	-	-	-	-	-	-	-	-
146	Total Healthcare Cost		7,933,648	108,046	7,825,603	415,912	2,387,426	798,619	1,067,574	136,065	1,992,807	352,076	675,125
147	Medical Loss Ratio (HCC % of Revenue)		239.8%	54.6%	251.5%	123.6%	295.6%	198.4%	395.6%	177.0%	246.2%	377.2%	214.5%
148													
149	Managed Care Administration		915,229	260,547	654,682	33,765	227,527	62,753	88,017	8,290	165,738	21,429	47,162
150	Admin Cost Ratio (MCA % of Total Cost)		10.3%	2.9%	7.4%	7.5%	8.7%	7.3%	7.6%	5.7%	7.7%	5.7%	6.5%
151													
152	Contract Cost		8,848,877	368,593	8,480,284	449,678	2,614,952	861,372	1,155,591	144,355	2,158,545	373,505	722,287
153	Net before Settlement		(5,539,956)	(170,681)	(5,369,274)	(113,297)	(1,807,257)	(458,765)	(885,700)	(67,478)	(1,349,121)	(280,172)	(407,485)
154	Contract Settlement		5,539,956	170,682	5,369,274	113,297	1,807,257	458,765	885,700	67,478	1,349,121	280,172	407,485
155	Net after Settlement		0	0	-	-	-	-	-	-	-	-	-
156													
157		x											
158	***SUD Block Grant Treatment***			*HCC%*	0.5%	0.8%	0.5%	0.4%	0.0%	0.3%	0.0%	1.4%	2.7%
159	Contract Revenue		5,648,124	4,157,704	1,490,420	169,855	636,290	80,588	-	200,374	-	257,093	146,219
160													
161	External Provider Cost		5,128,205	5,127,547	658	658	-	-	-	-	-	-	-
162	Internal Program Cost		1,076,455	-	1,076,455	79,672	187,432	44,524	-	31,748	-	193,468	539,611
163	HICA & Use Tax		-	-	-	-	-	-	-	-	-	-	-
164	Total Healthcare Cost		6,204,659	5,127,547	1,077,113	80,330	187,432	44,524	-	31,748	-	193,468	539,611
165	Medical Loss Ratio (HCC % of Revenue)		109.9%	123.3%	72.3%	47.3%	29.5%	55.2%	0.0%	15.8%	0.0%	75.3%	369.0%
166													
167	Managed Care Administration		209,490	209,490	-	-	-	-	-	-	-	-	-
168	Admin Cost Ratio (MCA % of Total Cost)		3.3%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
169													
170	Contract Cost		6,414,150	5,337,037	1,077,113	80,330	187,432	44,524	-	31,748	-	193,468	539,611
171	Net before Settlement		(766,026)	(1,179,333)	413,307	89,525	448,858	36,064	-	168,626	-	63,626	(393,392)
172	Contract Settlement		-	413,307	(413,307)	(89,525)	(448,858)	(36,064)	-	(168,626)	-	(63,626)	393,392
173	Net after Settlement		(766,026)	(766,026)	-	-	-	-	-	-	-	-	-
174													
175		x											

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	***Southwest Michigan Behavioral Health***			*Mos in Period*	*Mos in FYTD*								
2	For the Fiscal YTD Period Ended 9/30/2017			12	7								
3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	***INCOME STATEMENT***		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
176	***SWMBH CMHP Subcontracts***												
177	Subcontract Revenue		231,553,688	27,486,241	204,067,447	8,531,974	40,940,189	10,861,594	37,446,179	10,487,760	61,945,227	14,032,607	19,821,918
178	Incentive Payment Revenue		1,177,960	162,438	1,015,522	-	-	39,269	214,784	49,352	653,834	-	58,285
179	Contract Revenue		232,731,649	27,648,679	205,082,969	8,531,974	40,940,189	10,900,862	37,660,962	10,537,111	62,599,060	14,032,607	19,880,203
180													
181	External Provider Cost		151,199,204	11,188,187	140,011,017	4,406,000	25,985,748	7,295,363	24,756,687	6,100,189	52,841,647	8,285,050	10,340,333
182	Internal Program Cost		59,732,143	-	59,732,143	4,529,158	11,178,315	3,349,248	13,590,449	3,876,619	9,308,599	5,114,217	8,785,539
183	SSI Reimb, 1st/3rd Party Cost Offset		(706,319)	-	(706,319)	(86,127)	(106,996)	(82,518)	-	(57,019)	(179,878)	(19,740)	(174,041)
184	HICA & Use Tax, HRA		11,697,698	11,697,698	-	-	-	-	-	-	-	-	-
185	Total Healthcare Cost		221,922,725	22,885,884	199,036,841	8,849,030	37,057,068	10,562,093	38,347,136	9,919,789	61,970,368	13,379,527	18,951,830
186	Medical Loss Ratio (HCC % of Revenue)		95.4%	82.8%	97.1%	103.7%	90.5%	96.9%	101.8%	94.1%	99.0%	95.3%	95.3%
187													
188	Managed Care Administration		23,000,144	6,941,296	16,058,849	711,878	3,513,755	826,439	3,161,577	602,463	5,153,952	802,564	1,286,221
189	Admin Cost Ratio (MCA % of Total Cost)		9.4%	2.8%	6.6%	7.4%	8.7%	7.3%	7.6%	5.7%	7.7%	5.7%	6.4%
190													
191	Contract Cost		244,922,870	29,827,180	215,095,690	9,560,908	40,570,822	11,388,532	41,508,712	10,522,253	67,124,320	14,182,090	20,238,051
192	Net before Settlement		(12,191,221)	(2,178,501)	(10,012,720)	(1,028,934)	369,367	(487,670)	(3,847,750)	14,859	(4,525,260)	(149,483)	(357,849)
193													
194	Prior Year Savings		18,145,773	18,145,773	-	-	-	-	-	-	-	-	-
195	Internal Service Fund Risk Reserve		1,419,213	1,419,213	-	-	-	-	-	-	-	-	-
196	Contract Settlement		4,425,038	(5,587,683)	10,012,720	1,028,934	(369,367)	487,670	3,847,750	(14,859)	4,525,260	149,483	357,849
197	Net after Settlement		11,798,803	11,798,803	-	-	(0)	0	0	(0)	-	0	(0)
198													
199													

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Southwest Michigan Behavioral Health**			*Mos in Period*	*Mos in FYTD*								
2	For the Fiscal YTD Period Ended 9/30/2017			12	7								
3	*(For Internal Management Purposes Only)*		FY17 Projection										
4	**INCOME STATEMENT**		Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Kalamazoo CCMHSAS	St Joseph CMHA	Van Buren MHA
5													
200	***State General Fund Services***			*HCC%*	5.8%	7.1%	6.2%	4.1%	7.5%	5.6%	5.0%	4.1%	5.0%
201	Contract Revenue				10,238,762	597,286	1,752,773	575,078	2,096,719	586,183	3,547,838	295,920	786,965
202													
203	External Provider Cost				4,402,282	109,278	425,062	70,586	668,389	286,620	2,399,264	339,810	103,273
204	Internal Program Cost				7,810,634	567,274	2,036,461	375,406	2,437,627	306,989	961,486	239,263	886,130
205	SSI Reimb, 1st/3rd Party Cost Offset				(124,505)	-	-	-	-	-	(124,505)	-	-
206	Total Healthcare Cost				12,088,411	676,552	2,461,522	445,991	3,106,016	593,610	3,236,245	579,073	989,403
207	Medical Loss Ratio (HCC % of Revenue)				118.1%	113.3%	140.4%	77.6%	148.1%	101.3%	91.2%	195.7%	125.7%
208													
209	Managed Care Administration				1,103,290	61,155	260,502	39,167	285,233	38,905	301,847	39,428	77,053
210	Admin Cost Ratio (MCA % of Total Cost)				8.4%	8.3%	9.6%	8.1%	8.4%	6.2%	8.5%	6.4%	7.2%
211													
212	Contract Cost				13,191,701	737,706	2,722,024	485,159	3,391,249	632,514	3,538,092	618,501	1,066,456
213	Net before Settlement				(2,952,940)	(140,420)	(969,251)	89,919	(1,294,530)	(46,332)	9,746	(322,581)	(279,491)
214													
215	Other Redistributions of State GF				(205,503)	(6,502)	(89,716)	(4,479)	(52,266)	(6,477)	(64,918)	-	18,855
216	Contract Settlement				(56,687)	-	-	(56,687)	-	-	-	-	-
217	Net after Settlement				(3,215,129)	(146,922)	(1,058,967)	28,754	(1,346,796)	(52,809)	(55,173)	(322,581)	(260,636)
218													

Dear Mr. President:

I am proud to present to you today the interim report prepared by your Commission on Combating Drug Addiction and the Opioid Crisis. This interim report is just a start; our work is ongoing and we will have more to share with you and the nation later in the Fall of 2017. We now recommend several actions for you to take as our nation's Chief Executive and someone who spoke passionately on this issue in the 2016 campaign.

Our nation is in a crisis. Your Executive Order recognized that fact. The work of your Commission so far acknowledges the severity of this national problem.

According to the Centers for Disease Control (CDC), the most recent data estimates that 142 Americans die every day from a drug overdose. Our citizens are dying. We must act boldly to stop it. The opioid epidemic we are facing is unparalleled. The average American would likely be shocked to know that drug overdoses now kill more people than gun homicides and car crashes combined. In fact, between 1999 and 2015, more than 560,000 people in this country died due to drug overdoses – this is a death toll larger than the entire population of Atlanta. As we have all seen, opioids are a prime contributor to our addiction and overdose crisis. In 2015, nearly two-thirds of drug overdoses were linked to opioids like Percocet, OxyContin, heroin, and fentanyl. This is an epidemic that all Americans face because here is the grim reality: Americans consume more opioids than any other country in the world. In fact, in 2015, the amount of opioids prescribed in the U.S. was enough for every American to be medicated around the clock for three weeks.

Since 1999, the number of opioid overdoses in America have quadrupled according to the CDC. Not coincidentally, in that same period, the amount of prescription opioids in America have quadrupled as well. This massive increase in prescribing has occurred despite the fact that there has not been an overall change in the amount of pain Americans have reported in that time period. We have an enormous problem that is often not beginning on street corners; it is starting in doctor's offices and hospitals in every state in our nation.

But, the challenge of reducing opioid supplies has evolved. As access to prescription opioids tightens, consumers increasingly are turning to dangerous street opioids, heroin, fentanyl alone or combined, and mingled with cocaine or other drugs. In 2016, specific states witnessed an escalating number of overdose deaths due to heroin and/or fentanyl(s), in some states vastly exceeding deaths due to prescription opioids.

In 2015, 27 million people reported current use of illegal drugs or abuse of prescription drugs. Despite this self-reporting, only 10 percent of the nearly 21 million citizens with a substance use disorder (SUD) receive any type of specialty treatment according to the most recent National Survey on Drug Use and Health. This is contributing greatly to the increase of deaths from overdose.

Over forty percent of people with a substance use disorder also have a mental health problem, but less than half of these people receive treatment for either issue. The reasons for these

treatment gaps are many, including lack of access to care, fear of shame and discrimination, and lack of motivation to seek treatment.

This Commission has been hard at work to meet the goals set for us in the Executive Order on March 29th, 2017. As a Commission, we have already met with leading national organizations in the addiction space, and we have received information and recommendations from countless individuals and groups, all of whom share in our commitment to beating this epidemic. The Commission thanks all the individuals and organizations, including Governors and representatives from Governors Offices from around the country, that have reached out to offer their experiences, expertise, and input.

In addition to conducting phone calls with Governors and their teams in all 50 states, we also held a listening session with bi-partisan members of Congress, and key cabinet members of your Administration. Individual Commission members have organized "listening sessions" and solicited recommendations from treatment providers, addiction psychiatrists and other physicians, data analysts, professional medical and treatment societies, medical educators, healthcare organizations, pharmacoepidemiologists, and insurance providers. Outreach also has been made to scientists with broad expertise in pain, addiction biology and treatment.

The first public meeting of the Commission was held on June 16th at the White House, and was a great success. The Commission members heard comprehensive public testimony by nine leading nonprofits, and have received more than 8,000 comments from the public, including comments from at least 50 organizations.

This information was reviewed by the Commission members and helped inform this interim report.

The first and most urgent recommendation of this Commission is direct and completely within your control. Declare a national emergency under either the Public Health Service Act or the Stafford Act. With approximately 142 Americans dying every day, America is enduring a death toll equal to September 11th every three weeks. After September 11th, our President and our nation banded together to use every tool at our disposal to prevent any further American deaths. Your declaration would empower your cabinet to take bold steps and would force Congress to focus on funding and empowering the Executive Branch even further to deal with this loss of life. It would also awaken every American to this simple fact: if this scourge has not found you or your family yet, without bold action by everyone, it soon will. You, Mr. President, are the only person who can bring this type of intensity to the emergency and we believe you have the will to do so and to do so immediately.

The Commission is additionally proposing the following recommendations for action:

- **Rapidly increase treatment capacity. Grant waiver approvals for all 50 states to quickly eliminate barriers to treatment resulting from the federal Institutes for Mental Diseases**

(IMD) exclusion within the Medicaid program. This will immediately open treatment to thousands of Americans in existing facilities in all 50 states.

The Commission has been urged by every Governor, numerous treatment providers, parents, and non-profit advocacy organizations to eliminate the IMD exclusion within the Medicaid program. This component of the Social Security Act prohibits federal Medicaid funds from reimbursing services provided in an inpatient facility treating "mental diseases" (including SUDs) that have more than 16 beds. This exclusion makes states entirely responsible for Medicaid-eligible patients in inpatient treatment facilities, including patients undergoing withdrawal management in addiction treatment facilities rather than hospitals. The Commission members that serve as Governors, as well as individuals and organizations that treat Medicaid patients, are intimately aware of how the IMD exclusion impacts the ability to serve patients with severe SUDs that are best served in an inpatient setting. The Commission recognizes that legislation would be necessary to repeal the exclusion in its entirety. However, certainly after an emergency declaration by the President (and arguably even without it) the Department of Health and Human Services (HHS) Secretary would be empowered to immediately grant waivers to each state that requests one. This is the single fastest way to increase treatment availability across the nation.

- **Mandate prescriber education initiatives with the assistance of medical and dental schools across the country to enhance prevention efforts. Mandate medical education training in opioid prescribing and risks of developing an SUD by amending the Controlled Substance Act to require all Drug Enforcement Administration (DEA) registrants to take a course in proper treatment of pain. HHS should work with partners to ensure additional training opportunities, including continuing education courses for professionals.**

  According to a Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health and Statistics Quality (CBHSQ) report, four out of every five new heroin users begin with nonmedical use of prescription opioids.

  In other words, Mr. President, this crisis began in our nation's health care system. While we acknowledge that some of this inappropriate overprescribing is done illegally and for profit, we believe the overwhelming percentage is due to a lack of education on these issues in our nation's medical and dental schools and a dearth of continuing medical education for practicing clinicians. This can and must be solved by using Presidential moral and legal authority to change this lack of education leading to addiction and death.

  There are several initiatives around the country aimed at ensuring that providers are aware of the potential for misuse and abuse of prescription opioids.

  Governor Baker's administration in Massachusetts has worked with the medical and dental schools in that state and the Medical Society to develop core competencies related to opioids and SUDs that all graduating students are expected to learn and put into practice. Other states such as Arizona, Connecticut, Pennsylvania, New York, and Utah have expanded continuing medical education requirements for opioid prescribers and

dispensers. Alternatively, the American Society of Addiction Medicine (ASAM) has recommended implementing a requirement that clinicians who apply for a registration with the DEA to prescribe controlled substances demonstrate competency in safe prescribing, pain management, and substance use identification. In New Jersey, Governor Christie recently signed a law that requires providers themselves to take continuing education related to opioids, and requires prescribers to discuss the risks of opioid dependence with their patients prior to the first prescription. We urge national implementation of these initiatives.

In our first Commission meeting, we heard from several nonprofits about the need to promote expanded implementation of the CDC *Guideline for Prescribing Opioids for Chronic Pain* through increased prescriber education initiatives. The Office of National Drug Control Policy (ONDCP) estimates that, apart from federal prescribers who are required to be trained, fewer than 20% of the over one million prescribers licensed to prescribe controlled substances to patients have training on how to prescribe opioids safely. Similarly, it seems that many medical providers are not well-versed on how to screen for addiction, and what to do if a patient has become dependent on substances or presents with an SUD. We urge you to instruct the Department of Justice (DOJ) and the DEA to require continuing medical education for every physician requesting an initial DEA license or the renewal of such a license.

The CDC and the U.S. Food and Drug Administration (FDA) should finalize, review and recommend national training standards working with the Accreditation Council for Continuing Medical Education (ACCME) to ensure training courses are coordinated with other federal agencies, professional societies, medical schools, and residency programs to avoid discrepancies.

The FDA should also work with the ACCME to develop data analytics to determine whether courses change practices, increase patient referrals to treatment, and methods to improve compliance consistent with opioid prescribing education.

Clinicians need more detailed and specific guidance on drug choice, dose, and quantity to be dispensed in treating specific pain conditions. We also recommend a detailed analysis of, and solutions to clinical problems encountered in applying recommended guidelines.

- **Immediately establish and fund a federal incentive to enhance access to Medication-Assisted Treatment (MAT). Require that all modes of MAT are offered at every licensed MAT facility and that those decisions are based on what is best for the patient. Partner with the National Institutes of Health (NIH) and the industry to facilitate testing and development of new MAT treatments.**

MAT has proven to reduce overdose deaths, retain persons in treatment, decrease use of heroin, reduce relapse, and prevent spread of infectious disease. Expansion of MAT availability for qualified individuals and for short- or long-term treatment is an essential

component of treatment services. Yet approximately 10 percent of conventional drug treatment facilities in the United States provide MAT for opioid use disorder.

Individuals seeking SUD treatment, and even those currently enrolled in a treatment system, often find barriers to using MAT as a component of their treatment. Particularly for populations with opioid use disorders (OUDs) involved in the criminal justice system, there is often inadequate access to FDA-approved medications that are proven to improve outcomes as part of a full continuum of care. Multiple studies have shown that individuals receiving MAT during and after incarceration have lower mortality risk, remain in treatment longer, have fewer positive drug screens, and have lower rates of recidivism than other individuals with OUDs that do not receive MAT. The DOJ, in consultation with HHS and ONDCP, should be directed to increase the use of MAT for OUDs in these correctional settings.

In addition, the Centers for Medicare & Medicaid Services (CMS) should require all federally-qualified health centers (FQHCs) to mandate that their staff physicians, physician assistants, and nurse practitioners possess waivers to prescribe buprenorphine.

There are several barriers to the use of MAT, including a prevalent belief that use of MAT does not constitute true recovery or sobriety. The Federal Government, as a major purchaser of health care services, has a tremendous opportunity to increase the availability of MAT for individuals with OUDs. For example, across the Veterans Administration (VA) and Indian Health Services, there is a lack of providers able to prescribe/administer MAT. For Medicare patients, the Part B physician benefit does not cover methadone treatment and the Part D pharmaceutical benefit does not cover it either, as it is administered by a medical professional. CMS should send a letter to state health officials requesting that state Medicaid programs cover all FDA-approved MAT drugs for OUD.

Additionally, all FDA-approved MAT should be offered by authorized providers, not just one or two of these approved options. These decisions of which (if any) MAT to be used must be based upon what is best for the patient, not what is best for the provider. This can be mandated by the Executive Branch.

Finally, we urge you to instruct the NIH to begin to immediately work with the pharmaceutical industry in two areas; the development of additional MAT options and the development of new, non-opioid pain relievers based on research to clarify the biology of pain. The nation needs more options to treat those already addicted and can help to prevent addiction in the first place by avoiding the prescription of opioids. The NIH is best positioned, in our opinion, to lead this effort with industry partners.

- **Provide model legislation for states to allow naloxone dispensing via standing orders, as well as requiring the prescribing of naloxone with high-risk opioid prescriptions; we must equip all law enforcement in the United States with naloxone to save lives.**

Naloxone is a lifesaver that rapidly reverses opioid overdose. It is the first line of defense in many parts of our country; if we lose someone to overdose we obviously have no chance to

treat them and return them to a productive life. We urge you to mandate, with federal assistance, that naloxone be in the hands of every law enforcement officer in the United States. By declaring a national emergency, you can empower the HHS Secretary to negotiate reduced pricing for all governmental units. Forty-seven states have expanded access to naloxone in some form. The Federal Government should ensure that naloxone is made available when there is the greatest chance for an overdose. Accordingly, model legislation should include a requirement that naloxone is prescribed in combination with any CDC-defined high-risk opioid being prescribed.

An impediment to naloxone usage and people seeking help in the event of an overdose is the perceived threat of law enforcement involvement. Overly restrictive or punitive laws may prevent the uptake of naloxone or the seeking of aid in an emergency. In response, most state legislatures and some law enforcement agencies have created a variety of immunity and 'Good Samaritan' laws to ensure bystanders and those experiencing an overdose are not deterred from seeking immediate help. States vary widely in the content of 'Good Samaritan' laws, but they generally offer protection to people assisting at the scene of an overdose, or seeking care for their own or another's overdose, from civil or criminal prosecution. As of July 2017, 40 states and the District of Columbia have enacted some form of a 'Good Samaritan' or 911 drug immunity law. In addition to enacting legislation, it is crucial that states ensure the public fully understands the protections provided by the 'Good Samaritan' law and how it empowers them to call 911 in the case of an overdose.

HHS and other federal agencies should be directed by you or your cabinet to make recommendations on ways to identify persons who have overdosed and been revived with naloxone and the feasibility of notification of their primary care and other physicians caring for them. These primary care providers may be prescribing medications that increase future risks of another overdose.

- **Prioritize funding and manpower to the Department of Homeland Security's (DHS) Customs and Border Protection, the DOJ Federal Bureau of Investigation (FBI), and the DEA to quickly develop fentanyl detection sensors and disseminate them to federal, state, local, and tribal law enforcement agencies. Support federal legislation to staunch the flow of deadly synthetic opioids through the U.S. Postal Service (USPS).**

Illicit fentanyl and fentanyl analogs are the next grave challenge on the opioid front and the awful news is that it is much, much more deadly than hydrocodone, oxycodone or even heroin. Since 2012, the nation has seen an alarming increase in the number of drug overdose deaths that involve fentanyl, a synthetic opioid many times more powerful than heroin, as well as heroin and cocaine laced with non-pharmaceutical fentanyl. Fentanyl defies detection at our borders, as the small quantities involved for psychoactivity of fentanyl and fentanyl analogs challenge Customs and Border Protection, USPS, and express consignment carriers' ability to detect and interdict. We are miserably losing this fight to prevent fentanyl from entering our country and killing our citizens. We are losing this fight predominately through China. This must become a top tier diplomatic issue with the

Chinese; American lives are at stake and it threatens our national security. Our inability to reliably detect fentanyl at our land borders and at our international mail handling facilities creates untenable vulnerabilities. Key federal agencies, including the DEA, DHS, FBI, and DOJ, should coordinate pursuant to the Controlled Substances Act to intercept fentanyl (and other synthetic opioids) in envelopes and packages at mail processing distribution centers, and increase detection efforts using enhanced technology, more manpower, and expanded canine deployment. Only a presidential directive will give this issue the top level attention it deserves from DOJ, DHS, and USPS.

- **Provide federal funding and technical support to states to enhance interstate data sharing among state-based prescription drug monitoring programs (PDMPs) to better track patient-specific prescription data and support regional law enforcement in cases of controlled substance diversion. Ensure federal health care systems, including Veteran's Hospitals, participate in state-based data sharing.**

  PDMPs are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs. They are designed to give providers access to critical information regarding a patient's controlled substance prescription history, and can help health professionals identify patients who may be or are at risk of misusing prescription opioids or other prescription drugs. PDMPs are also used by professional licensing boards to identify clinicians with patterns of inappropriate prescribing and dispensing, and to assist law enforcement in cases of controlled substance diversion. Multiple published best practices for utilizing PDMPs, including guidelines from the Heller School for Social Policy and Management at Brandeis University, have identified interstate data sharing among PDMPs as a top priority to ensure that healthcare professionals and law enforcement have a complete picture of prescribing practices and controlled substances diversion. Numerous professional health organizations, including the American Medical Association (AMA) and the Association of State and Territorial Health Officials (ASTHO), agree that PDMPs are an effective and important clinical tool to combat the addiction crisis; however, they are being significantly underutilized in the vast majority of our states. Forty-nine states now have PDMPs but not nearly a majority of those are sharing their information. This is unacceptable. We urge you to direct the VA and HHS to lead an effort to have all state and federal PDMP systems to share information and to set a deadline of July 1, 2018 to achieve this data sharing.

  In addition to sharing data between states and the federal government, the PDMP needs to be improved with regard to its ease of use, and inclusion of other data to assist prescribing doctors. Ideally, clinicians should check their state PDMP before making the decision to prescribe either an opioid or benzodiazepine (several states already have this requirement in place), determine whether their patient has had an overdose, and other relevant information that can be summarized into categories of high to low risk.

- **Better align, through regulation, patient privacy laws specific to addiction with the Health Insurance Portability and Accountability Act (HIPAA) to ensure that information about SUDs be made available to medical professionals treating and prescribing medication to a**

patient. This could be done through the bipartisan Overdose Prevention and Patient Safety Act/Jessie's Law.

Providers and other advocates have found that certain privacy regulations, while well-intentioned patient protections, act as a barrier to communication between providers, can make it difficult for family members to be involved in a loved one's treatment, and limits the ability to use electronic health records to their full potential. 42 CFR Part 2, which requires addiction treatment professionals to acquire written patient consent before sharing any information with a patient's other health care providers, including when the addiction treatment facility is part of a larger health care system, is a particular hindrance to comprehensive health care. Making it administratively difficult for providers to share information has ill-effects on patients in both physical and behavioral health settings, by restraining physicians' ability to make informed healthcare decisions.

We urge you to direct that regulation be changed to permit the sharing of this type of information among health care providers and the loved ones of those suffering from SUDs. Otherwise, drugs with high abuse liability may be prescribed to people with OUD. That will lead to even more unnecessary and preventable deaths.

- **Enforce the Mental Health Parity and Addiction Equity Act (MHPAEA) with a standardized parity compliance tool to ensure health plans cannot impose less favorable benefits for mental health and substance use diagnoses verses physical health diagnoses.**

As Congressman Kennedy spoke eloquently about at the first Commission meeting, there has long been a difference in how individuals with health insurance receive treatment and medication for physical health diagnoses versus mental health and SUD diagnoses. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits health insurance plans that cover behavioral health from imposing benefit limitations on mental health or SUD treatment that are less favorable than limitations imposed on medical or surgical benefits. Benefit limitations can be quantitative, such as visit limits, or non-quantitative, such as pre-authorization requirements. But not providing real parity is already illegal. The Commission urges you to direct the Secretary of Labor to enforce this law aggressively and to penalize the violators.

The Commission heard from numerous organizations, including ASAM and the American Academy of Addiction Psychiatry, about the need to systematically monitor and enforce MHPAEA with a standardized tool, and actual penalties for non-compliance, to ensure parity in the coverage of mental health and addiction treatment services. The Labor Secretary, with appropriate direction from you, is the person to do this.

At this point, the largest outstanding issue is treatment limits. Patients seeking addiction treatment, including MAT, are often subjected to dangerous fail-first protocols, a limited provider network, frequent prior authorization requirements, and claim denials without a transparent process. The Commission applauds SAMHSA's work with multidisciplinary teams from states to improve parity enforcement and public education. However, we need

robust enforcement of the parity law by the state and federal agencies responsible for implementing the law. Regulators should be required to levy penalties against health plans that violate MHPAEA, and information about parity violations should be made available to the public.

It is not only critical that the Federal Government provide sufficient resources to prevent and combat this disease; it must also provide the easiest pathway for private providers and local and state governments to achieve success.

That is why the Commission, as a primary focus of the final report, is undertaking a full-scale review of federal programs, regulations, laws, and funding mechanisms targeted toward addressing addiction.

In addition to a full review of federal funding and programs and obstacles and opportunities for treatment, the final report will include, but not be limited to, a more thorough examination of the following issues:

- Development of a national prevention strategy using "big data analytics" to devise targeted prevention messages that employ cutting-edge methods of marketing and communications.
- Evidence-based prevention programs for schools, and tools for teachers and parents to enhance youth knowledge of the dangers of drug use, as well as early intervention strategies for children with environmental and individual risk factors (trauma, foster care, adverse childhood experiences (ACEs), and developmental disorders).
- The need for satisfaction with pain level as a satisfaction criteria through which health care providers are evaluated by HHS.
- Workforce access and training needs within the treatment community nationally, with a particular focus on the regions of the country with the highest overdose deaths.
- Improvements in treatment programs, based on adherence to principles of evidence-based treatment, continuum of care, outcome measures, and patient education on quality treatment.
- Research initiatives and opportunities to combat the epidemic and enhance treatment options, including alternative pain management strategies, and treatment for vulnerable populations such as pregnant women, and substance-exposed infants through work by the NIH, HHS, CDC, FDA, SAMHSA, and pharmaceutical partners.
- Opportunities to further the practice of substance use screenings and referrals through CMS quality measures.
- Opportunities for patient protections providing better information about the risks and benefits of taking prescription opioids.
- Supply reduction of heroin, fentanyl analogs and counterfeit pills through coordinated federal and state law enforcement initiatives.
- Targeted data collection and analytics needed to identify most effective prevention and treatment strategies, quality treatment access programs, reimbursements, and aid to law enforcement activities. The possibility of a behavioral health surveillance system run

through CDC that tracks prevalence rates, treatment modalities, and comorbidities with other illnesses in real-time.

- Regulatory or statutory changes to reduce commercial insurance barriers to MAT, such as dangerous fail-first protocols and onerous and frequent prior authorization requirements.

In our final report, we will provide an additional set of detailed recommendations that, if implemented, will ensure that the Federal Government operates as a strong partner in the fight against addiction and the opioid crisis.

Finally, our country needs you, Mr. President. We know you care deeply about this issue. We also know that you will use the authority of your office to deal with our nation's problems. The Commission looks forward to submitting its final report.

Sincerely,

Commission members

The House C.A.R.E.S. Task Force

Michigan is at a unique crossroad to change public policy that will support its citizens to live happier, healthier, independent lives, thereby building vibrant communities and a productive workforce. Over the years, perception and opinion about the proper approach to successfully treating our vulnerable populations has changed, especially with respect to those who suffer from illnesses and conditions that mentally, emotionally, and socially inhibit their ability to thrive. Whether it is the child who suffers from autism, the veteran returning home from service with PTSD, the prisoner with underlying mental disorders, or the victim whose life is forever altered by a traumatic crime, each individual's success is severely limited by inadequate access to care and confusing regulations. Consistent care, smart rehabilitation, and vocational training can be the difference between productive, happy individuals, and those who perpetually cycle through the medical or prison system. Accordingly, the Legislature now has an opportunity to weave together a comprehensive system-wide package of reforms that will support our vulnerable citizens and create safe, vibrant communities.

Reforms to consider include consistent mental health services across the State, better support for our veterans, additional attention to substance and opioid abuse, improving our mental health courts, enhanced training for law enforcement, and reducing prison waste, among others. Each of these will meet the needs of our vulnerable populations, make our communities safer, and prevent the vicious cycle of criminality. Breaking administrative barriers between State departments and local governments will be similarly instrumental in finding ways to bridge the gap of services a person receives from one silo to the next.

While working across multiple issue areas, such as mental health, veteran support, criminal justice, and workforce development, is no small endeavor, a comprehensive approach is the only way to achieve substantive and meaningful reform. To that end, a bipartisan task force has been created to allow members to deeply explore a wide breadth of issues and hear from interested stakeholders before reporting recommendations to the Legislature.

The task force, entitled the House C.A.R.E.S., encompasses the main elements to reaching the goal of supporting vulnerable citizens in secure and vibrant communities: Community, Access, Resources, Education, and Safety. The plan for the task force is to conduct hearings, facility tours, and collect input from stakeholders over July and August, with a report issued this fall.

Goals of the House C.A.R.E.S. Task Force

The goal for the Task Force is crafting solutions that cross issue areas to address the concerns described above. The Task Force's priorities would center on improving mental health services, ensuring public safety, smarter expenditure of resources, satisfying the needs of crime victims and other vulnerable populations, preparing those who are incarcerated to safely and productively re-enter society, breaking the cycle of crime, building our workforce, and encouraging coordination of State services. Furthermore, the Task Force would focus on where coordination between community programs and other State governmental programs can be improved to enhance overall care to residents while reducing duplication of services. In other

words, the Task Force would explore ways to tap into our existing infrastructure and encourage coordination of efforts and services to assist in breaking down barriers to consistent care.

Key points of discussion for the Task Force are outlined below. When possible, the task force's recommendations should lead to legislative proposals, but they could also result in revised regulations and departmental policies, new pilot programs, and/or workgroups to continue developing policy proposals.

- Improving the Delivery of Mental Health Services - Currently, community mental health centers (CMHs) are not required to offer a set of baseline services across the state. Through the state budget process, the Legislature worked with the Department of Health and Human Services (DHHS) and stakeholders to explore how mental health services could be delivered more efficiently and effectively. The Task Force could continue this discussion, even as DHHS embarks on setting up pilot projects to implement "Section 298" changes, and explore ways to ensure that individuals receive the same standard of care and consistency of services regardless of their location.
- Better Utilizing Substance Abuse Disorder (SUD) Treatments – The Task Force could consider increasing access to SUD treatments to improve individuals' long-term success when CMH services are utilized. This could include considering ways to ensure treatment programs are available, and whether additional programming is needed.
- Using Social Workers More Effectively – The Task Force could consider whether social worker placement and whether additional social workers in emergency rooms, schools, jails, prison, and courts might increase efficiency and help connect individuals with existing programs.
- Attracting and Retaining More Mental Health Professionals - Evidence suggests that the State has a shortage of psychiatrists, psychotherapists, and psychologists. The most recent budget sends additional resources to DHHS to attract and retain talent in these fields, but a more comprehensive look at the issue is warranted. To this point, the task force could assess ways to attract and retain highly qualified individuals to ensure that our state's residents have access to the care they need to be successful.
- Enhancing Coordination of Veteran Services - While there are multiple levels of programs to support veterans, anecdotal reports suggest a lack of coordinated services among the various entities. This lack of coordination can threaten access and utilization of services for and by our veterans. Such services can be particularly important for veterans because they are particularly vulnerable to incarceration for behavior driven by post-service mental health disorders. The Task Force could consider ways to enhance service coordination accordingly.
- Bridging the Information Gap Between State Agencies - The Task Force could consider, for example, requiring DHHS and the Michigan Department of Corrections (MDOC) to identify whether an individual in their custody is a veteran and, if so, to send that information to the Department of Military & Veterans Affairs (DMVA) to determine if he or she is eligible for veteran benefits. Another issue to consider is how to better utilize the housing first

concept so that veterans have access to stable housing, regardless of their current situations.

- Expanding Mental Health Intervention Training - Law enforcement, school, and emergency department personnel are frequently on the front lines of initial intervention and identification. Early identification of mental health needs before an individual enters the criminal justice system and connecting him or her to the services needed accordingly is critical meaningful reform. While some personnel are trained to identify a crisis situation and de-escalate it, not everyone has access to or receives such training. Additional crisis intervention training, de-escalation technique training, and early childhood intervention training could benefit residents by decreasing emergency costs, connecting people with needed services, and reducing the amount of individuals flowing into our prison system.

- Allowing More Discretion in the Criminal Justice System - Too often, inflexible policies prevent common sense interventions by professionals who are in the best position to make such decisions—whether that is a police officer on patrol, a prosecutor filing charges, a judge, or a corrections officer. Expanding discretion for these actors in the appropriate circumstances can allow responses to a crime to be tailored to the individual circumstances of both the victim and the perpetrator, which ensures better public safety outcomes.

- Incentivizing Offender Rehabilitation - To best protect victims and our communities, the criminal justice system should incentivize inmates to rehabilitate and prepare for release. The Task Force could consider whether to offer earlier release incentives to inmates who complete job training, receive mental health treatment, and complete substance abuse, anger management and other evidence-based programs that have been demonstrated to reduce recidivism. Providing an earned credit contingent on a risk/needs assessment, for example, can be used to incentivize inmates to rehabilitate and prepare for reentry.

- Expanding Options for Alternative Sentencing - Too often, people leave prison less prepared to live safely in their communities than when they entered. Substantial evidence demonstrates that recidivism rates are lower when individuals are sentenced to supervised probation instead of jail. However, this option is not always available at the time of sentencing. The task force could consider expanding access to supervised probation and provide alternative sentencing options accordingly.

- Extending Services to More Crime Victims - Because most crimes are not reported, many victims do not receive the services they need. Crime victims who do not receive trauma recovery services are far more likely to be victimized again and, in some cases, commit crimes themselves. The Task Force could thus consider how to expand access to recovery services for *all* crime victims.

Members of the House C.A.R.E.S. Task Force

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Representative Edward Canfield
Representative David Pagel
Representative Daire Rendon
Representative Fred Durhall, III
Representative Vanessa Guerra
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