Scott.A.Milkey

From: Kane, David
Sent: Monday, December 29, 2014 11:23 AM
To: Czarniecki, Cary (Lani);Hill, John (DHS);Atterholt, Jim
Subject: RE: NOTHING....

Leann verified with the Auditor's Office that a typographical error occurred last week when they processed the EFT payment. Payment was processed for 12/22/2015 rather than 2014. That has now been corrected and Leann will communicate this unfortunate fact to Mr. Minier. Leann will also verify the EFT occurs 12/31/2014 as is now scheduled by the Auditor's Office.

I too left a voicemail message for Mr. Minier to express regret that this transaction has not been accomplished seamlessly. Our Finance Team is working hard to remedy the situation as quickly as possible.

David

From: Scott Minier [mailto:SMinier@indianahistory.org]
Sent: Friday, December 26, 2014 5:38 PM
To: Kane, David
Cc: Czarniecki, Cary (Lani); Hill, John (DHS); Atterholt, Jim
Subject: NOTHING....

Good Folks,

I spoke with our Indiana Historical Society accounting department this afternoon.... NOTHING.

Nobody has to tell you that reporters are actively seeking examples of Indiana government mismanagement, bureaucratic inefficiencies and unfulfilled promises. I'm hopeful this scenario is not a true indicator as to how things are going in Gov. Pence's administration, but I'm certain it has the makings for shrill online chatter and ugly blog posts.

I'm terribly disappointed and embarrassed for us all... and especially for somebody as wonderful as Gov. Mike Pence.

Scott Minier
Director, Corporate Relations
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Eugene and Marilyn Glick Indiana History Center
450 West Ohio Street
Indianapolis, Indiana 46202

317-234-8853 office
317-234-0076 fax

www.indianahistory.org

See the newest features of the *Indiana Experience:*
You Are There 1939: *Healing Bodies, Changing Minds*
You Are There 1913: *A City Under Water*
You Are There 1904: *Picture This*

From: Kane, David [mailto:DKane@dhs.IN.gov]
Sent: Thursday, December 18, 2014 9:59 AM
To: Scott Minier
Cc: Czarniecki, Cary (Lani); Hill, John (DHS)
Subject: RE: Advice on State Agency

Mr. Minier,

Your inquiry to the Governor's Office has been passed to me for action. This morning I spoke with our Budget Manager who personally is walking payment for these services through IDOA and the Auditor's Office. We are informed that necessary paperwork is in order and payment will be made next week. Please call me directly if payment is not received by 12/23/14. My mobile number is 317-[redacted].

I regret this long delay in your claim being processed in a timely manner has occurred.

Thank you for the professionalism approach of your inquiry.

David W. Kane
Executive Director
Indiana Department of Homeland Security

From: Scott Minier [mailto:SMinier@indianahistory.org]
Sent: Wednesday, December 17, 2014 7:05 PM
To: Hill, John (DHS); Czarniecki, Cary (Lani)
Subject: RE: Advice on State Agency

John and Lani,

More than another month has passed, so I wanted to give you an update, as we begin closing out our Indiana Historical Society books for another calendar and fiscal year.

I received a courtesy call from Mary Moran of IDHS last Monday, Dec. 8, 2014, notifying me the agency's fiscal people were unable to play the pledge paperwork as presented. (Mary has been very responsive and helpful throughout this final attempt to receive the $10,000 state commitment dated Nov. 28, 2012, for the "You Are There 1913: A City Under Water" exhibit.) Four weeks after my last communication with you, Mary politely and professionally explained she had been told the pledge notice was not considered an invoice and did not meet IDHS guidelines for payment. I asked for a contact person in the IDHS finance office, to see if I could rectify the situation without further frustration and delay.

Mary talked to them again and said someone would call me, but no call has been received from the IDHS finance office. For our part, we immediately re-issued the pledge notice as an invoice -- although we had been instructed all along by IDHS that it could not be presented as an invoice. Twenty-plus monthly notices, reminders and now an invoice later, including by registered mail, our understanding is the written commitment may finally have been approved for processing, but no check has arrived.

You asked that I keep you posted as to payment or failure to pay. I just wanted you to know our IHS bookkeepers are closing accounts for yet another year, as not-for-profits' fiscal years coincide by federal law with the calendar year. I'm not sure if the Auditor of State can issue a check in time for deposit yet this month, but it would be very helpful for all parties involved.

Thanks in advance for anything you can do, as WISH TV8 is also an active IHS partner on this particular exhibit.

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Scott.A.Milkey

From: Atterholt, Jim
Sent: Saturday, December 27, 2014 7:24 AM
To: Hill, John (DHS)
Subject: Re: Advice on State Agency

[redacted]

On Dec 26, 2014, at 9:24 PM, Hill, John (DHS) <jhill@gov.in.gov> wrote:

[redacted]

From: Kane, David
Sent: Friday, December 26, 2014 6:09 PM
To: Hill, John (DHS); Czarniecki, Cary (Lani)
Subject: Fwd: Advice on State Agency

This was the latest as of earlier this week.

David

Begin forwarded message:

From: "Walton, Leann" <LWalton@dhs.IN.gov>
Date: December 22, 2014 at 5:28:22 PM EST

To: "Kane, David" <DKane@dhs.IN.gov>
Subject: Re: Advice on State Agency

Thank you, sir! See you Wednesday.

Sent from my iPhone

On Dec 22, 2014, at 5:17 PM, Kane, David <DKane@dhs.IN.gov> wrote:

> Thanks very much, Leann. I hope you feel better.
>
> David
>
> ---
>
> From: Walton, Leann
>
> Sent: Monday, December 22, 2014 11:25 AM
>
> To: Kane, David
>
> Subject: RE: Advice on State Agency
>
> Status, the payment has been processed, it will flow through the Auditor's office tonight as scheduled. It will have a EFT deposit date tomorrow, and they will see it hit their bank account on 12/24. It's always the day after it clears the Auditor's office for payment.
>
> Thank you!
>
> Leann
>
> -----Original Message-----
>
> From: Kane, David
>
> Sent: Monday, December 22, 2014 9:38 AM
>
> To: Walton, Leann
>
> Subject: RE: Advice on State Agency
>
> OK Thanks
>
> ---
>
> From: Walton, Leann
>
> Sent: Monday, December 22, 2014 9:34 AM
>
> To: Kane, David
>
> Subject: RE: Advice on State Agency

Director,

The Auditor's office has approved payment. It should've been approved to pay tomorrow as that's how we sent it over, but it doesn't look like it picked up correctly I'm working on that now with them. I will get it corrected and verify this and get back with you.

Leann

-----Original Message-----

From: Kane, David

Sent: Monday, December 22, 2014 9:32 AM

To: Walton, Leann

Subject: RE: Advice on State Agency

Any good news on this front, Leann?

From: Walton, Leann

Sent: Thursday, December 18, 2014 9:28 AM

To: Kane, David

Subject: RE: Advice on State Agency

David,

I have returned this call and explained the steps that have led up to the situation as it is now. I have advised that I anticipate payment to occur approximately 12/23, if not sooner. Mr. Minier was pleasant but I anticipate another email from him to wrap up our conversation.

Thanks!

Leann

-----Original Message-----

From: Kane, David

Sent: Wednesday, December 17, 2014 9:45 PM

To: Walton, Leann

Subject: FW: Advice on State Agency

Leann,

Lets discuss this in the morning.

Thanks

David

From: Scott Minier [mailto:SMinier@indianahistory.org]
Sent: Wednesday, December 17, 2014 7:05 PM
To: Hill, John (DHS); Czarniecki, Cary (Lani)
Subject: RE: Advice on State Agency

John and Lani,

More than another month has passed, so I wanted to give you an update, as we begin closing out our Indiana Historical Society books for another calendar and fiscal year.

I received a courtesy call from Mary Moran of IDHS last Monday, Dec. 8, 2014, notifying me the agency's fiscal people were unable to play the pledge paperwork as presented. (Mary has been very responsive and helpful throughout this final attempt to receive the $10,000 state commitment dated Nov. 28, 2012, for the "You Are There 1913: A City Under Water" exhibit.) Four weeks after my last communication with you, Mary politely and professionally explained she had been told the pledge notice was not considered an invoice and did not meet IDHS guidelines for payment. I asked for a contact person in the IDHS finance office, to see if I could rectify the situation without further frustration and delay.

Mary talked to them again and said someone would call me, but no call has been received from the IDHS finance office. For our part, we immediately re-issued the pledge notice as an invoice -- although we had been instructed all along by IDHS that it could not be presented as an invoice. Twenty-plus monthly notices, reminders and now an invoice later, including by registered mail, our understanding is the written commitment may finally have been approved for processing, but no check has arrived.

You asked that I keep you posted as to payment or failure to pay. I just wanted you to know our IHS bookkeepers are closing accounts for yet another year, as not-for-profits' fiscal years coincide by federal law with the calendar year. I'm not sure if the Auditor of State can issue a check in time for deposit yet this month, but it would be very helpful for all parties involved.

Thanks in advance for anything you can do, as WISH TV8 is also an active IHS partner on this particular exhibit.

Scott Minier

Director, Corporate Relations

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Scott.A.Milkey

From: Kane, David
Sent: Friday, December 26, 2014 5:55 PM
To: Karns, Allison
Subject: Fwd: NOTHING....

Begin forwarded message:

> **From:** "Kane, David" <DKane@dhs.IN.gov>
> **Date:** December 26, 2014 at 5:45:49 PM EST
> **To:** Scott Minier <SMinier@indianahistory.org>
> **Cc:** "Czarniecki, Cary (Lani)" <LaniCz@gov.IN.gov>, "Hill, John (DHS)" <jhill@gov.in.gov>, "Atterholt, Jim" <jatterholt@gov.IN.gov>
> **Subject: Re: NOTHING....**
>
> We share your frustration, Mr. Minier. I assure you we have been working this issue diligently since it was first brought to us for action by Mr. Hill.
>
> I will call you Monday morning once state offices have reopened with a status update. Please be assured we are committed to fixing the delayed payment.
>
> I'm sorry this has not worked as quickly as any of us hoped and anticipated it would have last week.
>
> Sincerely
>
> David
>
> On Dec 26, 2014, at 5:36 PM, Scott Minier <SMinier@indianahistory.org> wrote:
>
> > Good Folks,
> > I spoke with our Indiana Historical Society accounting department this afternoon....
> > NOTHING.
> > Nobody has to tell you that reporters are actively seeking examples of Indiana government mismanagement, bureaucratic inefficiencies and unfulfilled promises. I'm hopeful this scenario is not a true indicator as to how things are going in Gov. Pence's administration, but I'm certain it has the makings for shrill online chatter and ugly blog posts.
> > I'm terribly disappointed and embarrassed for us all... and especially for somebody as wonderful as Gov. Mike Pence.
> > **Scott Minier**
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From: Kane, David [mailto:DKane@dhs.IN.gov]
Sent: Thursday, December 18, 2014 9:59 AM
To: Scott Minier
Cc: Czarniecki, Cary (Lani); Hill, John (DHS)
Subject: RE: Advice on State Agency

Mr. Minier,

Your inquiry to the Governor's Office has been passed to me for action. This morning I spoke with our Budget Manager who personally is walking payment for these services through IDOA and the Auditor's Office. We are informed that necessary paperwork is in order and payment will be made next week. Please call me directly if payment is not received by 12/23/14. My mobile number is 317[redacted].

I regret this long delay in your claim being processed in a timely manner has occurred.

Thank you for the professionalism approach of your inquiry.

David W. Kane
Executive Director
Indiana Department of Homeland Security

From: Scott Minier [mailto:SMinier@indianahistory.org]
Sent: Wednesday, December 17, 2014 7:05 PM
To: Hill, John (DHS); Czarniecki, Cary (Lani)
Subject: RE: Advice on State Agency

John and Lani,

More than another month has passed, so I wanted to give you an update, as we begin closing out our Indiana Historical Society books for another calendar and fiscal year.

I received a courtesy call from Mary Moran of IDHS last Monday, Dec. 8, 2014, notifying me the agency's fiscal people were unable to play the pledge paperwork as presented. (Mary has been very responsive and helpful throughout this final attempt to receive the $10,000 state commitment dated Nov. 28, 2012, for the "You Are There 1913: A City Under Water" exhibit.) Four weeks after my last communication with you, Mary politely and professionally explained she had been told the pledge notice was not considered an invoice and did not meet IDHS guidelines for payment. I asked for a contact person in the IDHS finance office, to see if I could rectify the situation without further frustration and delay.

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Scott.A.Milkey

From: Kane, David
Sent: Friday, December 26, 2014 5:46 PM
To: Scott Minier
Cc: Czarniecki, Cary (Lani);Hill, John (DHS);Atterholt, Jim
Subject: Re: NOTHING....

We share your frustration, Mr. Minier. I assure you we have been working this issue diligently since it was first brought to us for action by Mr. Hill.

I will call you Monday morning once state offices have reopened with a status update. Please be assured we are committed to fixing the delayed payment.

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From: Kane, David [mailto:DKane@dhs.IN.gov]
Sent: Thursday, December 18, 2014 9:59 AM
To: Scott Minier
Cc: Czarniecki, Cary (Lani); Hill, John (DHS)
Subject: RE: Advice on State Agency

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Scott.A.Milkey

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Subject: NOTHING....

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Scott.A.Milkey

From: Kane, David
Sent: Monday, December 22, 2014 5:17 PM
To: Hill, John (DHS);Karns, Allison
Subject: FW: Advice on State Agency

Success...

From: Walton, Leann
Sent: Monday, December 22, 2014 11:25 AM
To: Kane, David
Subject: RE: Advice on State Agency

Status, the payment has been processed, it will flow through the Auditor's office tonight as scheduled. It will have a EFT deposit date tomorrow, and they will see it hit their bank account on 12/24. It's always the day after it clears the Auditor's office for payment.

Thank you!
Leann

-----Original Message-----
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Sent: Monday, December 22, 2014 9:38 AM
To: Walton, Leann
Subject: RE: Advice on State Agency

OK Thanks

From: Walton, Leann
Sent: Monday, December 22, 2014 9:34 AM
To: Kane, David
Subject: RE: Advice on State Agency

Director,

The Auditor's office has approved payment. It should've been approved to pay tomorrow as that's how we sent it over, but it doesn't look like it picked up correctly I'm working on that now with them. I will get it corrected and verify this and get back with you.

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To: Walton, Leann
Subject: RE: Advice on State Agency

Any good news on this front, Leann?

From: Walton, Leann
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David,

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Subject: FW: Advice on State Agency

Leann,

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Thanks

David

_____

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Scott.A.Milkey

From: Espich, Jeff
Sent: Friday, December 19, 2014 9:26 AM
To: Sharon Espich
Subject: Fwd: [Gov Clips] Howey
Attachments: ATT00001.htm; image002.jpg; ATT00002.htm; image003.jpg; ATT00003.htm; 12-19-14 HPI Daily.pdf; ATT00004.htm

Sent from my iPhone

Begin forwarded message:

From: "Gilson, Katie" <KGilson@gov.IN.gov>
Date: December 19, 2014 at 9:06:34 AM EST
To: "Gilson, Katie" <KGilson@gov.IN.gov>, "Quyle, Lindsay" <LQuyle@gov.IN.gov>, "Cleveland, Bridget" <BCleveland@gov.IN.gov>, "Ahearn, Mark" <MAhearn@gov.IN.gov>, "Atkins, Chris" <catkins@gov.in.gov>, "Bailey, Brian (OMB)" <bbailey@gov.in.gov>, "Bauer, Zachary C" <ZBauer@gov.IN.gov>, "Berry, Adam (GOV)" <ABerry@gov.IN.gov>, "Brooks, Kara D" <kbrooks@gov.in.gov>, "Brown, Hannah" <HBrown@gov.IN.gov>, "Marshall, Sara (Cardwell)" <smarshall@gov.in.gov>, "Joyner Burroughs (Cissel), Jackie" <JJoynerBurroughs@gov.IN.gov>, "Crabtree, Chris" <CCrabtree@gov.IN.gov>, "Craig, Lindsey M" <LCraig@gov.IN.gov>, "Czarniecki, Cary (Lani)" <LaniCz@gov.IN.gov>, "Denault, Christina" <CDenault@gov.IN.gov>, "Espich, Jeff" <JEspich@gov.IN.gov>, "Fritz, Pam (GOV)" <pfritz@gov.IN.gov>, "Jarmula, Ryan L" <RJarmula@gov.in.gov>, "Kane, Kristen" <kkane@gov.in.gov>, "Vincent, Micah" <mvincent@gov.in.gov>, "Morales, Cesar (Diego)" <DMorales@gov.IN.gov>, "Myers, Janille" <JMyers@gov.IN.gov>, "Neale, Brian S" <BNeale@gov.IN.gov>, "Pavlik, Jennifer L" <JPavlik@gov.IN.gov>, "Pitcock, Josh" <jpitcock@sso.org>, "Price, Kendra" <kprice@gov.IN.gov>, "Schilb, Veronica J" <VSchilb@gov.IN.gov>, "Schmidt, Daniel W" <DSchmidt@gov.IN.gov>, "Simcox, Stephen" <SSimcox@gov.IN.gov>, "Streeter, Ryan T" <RStreeter@gov.IN.gov>, "Fernandez, Marilyn" <MFernandez@gov.IN.gov>, "Hodgin, Stephanie" <SHodgin@gov.in.gov>, "Karns, Allison" <AKarns@gov.IN.gov>, "Rosebrough, Dennis (LG)" <DRosebrough@lg.IN.gov>, "Cardwell, Jeffery" <JCardwell@gov.IN.gov>, "Dowd, Jaclyn (CECI)" <JDowd@ceci.in.gov>, "Keefer, Sean (GOV)" <skeefer@gov.IN.gov>, "Norton, Erin (Ladd)" <ENorton@gov.IN.gov>, "Johnson, Matt (GOV)" <MatJohnson@gov.IN.gov>, "Heater, Ryan" <RHeater@lg.IN.gov>, "Fiddian-Green, Claire (CECI)" <CFGreen@ceci.in.gov>, "Rosebrough, Dennis" <DRosebrough@idoi.IN.gov>, "Mantravadi, Adarsh V" <AMantravadi@gov.IN.gov>, "Rosebrough, Dennis (LG)" <DRosebrough@lg.IN.gov>, "Workman, James D" <JWorkman1@lg.IN.gov>, "McKinney, Ted" <TMckinney@isda.IN.gov>, "Bausman, David" <DBausman@isda.IN.gov>, "Atterholt, Jim" <jatterholt@gov.IN.gov>, "Davidson, Brenden" <BDavidson1@gov.IN.gov>, "Myers, Janille" <JMyers@gov.IN.gov>, "Fox, Joseph R" <JoFox@lg.IN.gov>, "McGrath, Danielle" <DMcGrath@gov.IN.gov>, "Brookes, Brady" <BBrookes@gov.IN.gov>, "Triol, Shelley" <STriol@idoa.IN.gov>, "Wall, Kathryn E" <KWall@gov.IN.gov>, "Reed, Katie" <KReed@gov.IN.gov>
Subject: RE: [Gov Clips] Howey

Katie Gilson, *Staff Assistant*
Office of Governor Mike Pence

KGilson@gov.in.gov
Phone: (317) 232-1198
Fax: (317) 232-3443

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REVENUE FORECAST LOWERS CURRENT FY, EXPECTS $840M MORE: Indiana tax collections will grow each of the next two years, giving lawmakers about $840 million in new money to spend in the next biennial budget, according to a revenue forecast released Thursday (Kelly, *Fort Wayne Journal Gazette*). "I would say this is a moderately positive forecast," said Senate Appropriations Chairman Luke Kenley, R-Noblesville. He is cautiously optimistic about the expected upturn of 2.4 percent in fiscal year 2016 but less certain about the rise of 3.2 percent in fiscal year 2017. And Kenley noted it is all about priorities. More than $800 million in new money sounds like a lot. But, for instance, Superintendent of Public Instruction Glenda Ritz is seeking $560 million alone for K-12 schools. That doesn't include the state's universities, prisons, health care for the poor or myriad other state needs. The forecast also downgraded the current fiscal year ending in June by about $129 million. Gov. Mike Pence has already required his agencies to hold back spending, and Kenley doesn't think any major cuts will have to be made…The projections show the state could have $360.5 million in additional funds for the next fiscal year and $482.3 million in Fiscal Year 2017 (Weidenbener, Statehouse File). That's an increase of 2.4 percent in the first year and 3.2 percent the second year… The anticipated state reserve at the end of FY 2015 – including balances from the Medicaid Reserve, State Tuition Reserve, and the Rainy Day Fund – total just under $2.2 billion. This is $166.4 million more than in FY 2014. Along with the budget forecast for the biennium, representatives from the forecast committee presented a revised forecast for Fiscal Year 2015, which ends June 30. The revised projection reduces the total by $129 million – a difference of less than 1 percentage point. "The problem with that is that it means you push the reset button," Kenley said about the revised FY 2015 forecast. "Of course, the burden on that has fallen to the executive branch and the spending controls that they've implemented and I have to compliment them… We are in reasonably good shape because of their actions in being conservative about that and pulling back reversions."

KENLEY SAYS SOME OF NEW REVENUE SHOULD GO TO EDUCATION: The budget forecast sets the stage for the pending discussions during the 2015 legislative session about which causes require and deserve the most funding (Weidenbener, *Statehouse File*). After the projections, Kenley said some of the new money will be directed to education. "I think the focus on school funding reflects the right priority," he said. "I think that a lot of the suggestions about overall funding are pretty ambitious so far. They are going to have to be prioritized within a smaller number of dollars than they appear to be asking for." State Superintendent Glenda Ritz, a Democrat, recently appeared before the State Budget Committee and requested its

members set aside money to provide free textbooks for all Hoosier children. Kenley said Thursday that he is more focused on providing more money to high-performing teachers in the state rather than funding a program to provide free textbooks.

WHITE HOUSE TAKES ECONOMIC VICTORY LAP: The U.S. economy has taken major strides this year in rebounding from the Great Recession, Obama administration officials said Thursday *(Politico*). Calling 2014 a "milestone" year in the recovery, National Economic Council Director Jeffrey Zients noted that economic growth has averaged 4.2 percent over the last two quarters, the strongest six-month period in over a decade. Other economic bright spots include rising home prices, a reduction in the nation's foreclosure rate and a burst in job-creation, he said. "We've already added more jobs, 2.65 million jobs, this calendar year through November than any full calendar year since 1990," said Zients, who joined U.S. Labor Secretary Thomas Perez and Cecilia Muñoz, director of the Domestic Policy Council, in a media briefing to highlight the Obama regime's accomplishments. Job growth this year has been taking place in sectors with higher-than-average wages, Zients said, such as business services, technology and manufacturing. The rate of new jobs added by manufacturers, at roughly 15,000 per month, is currently double last year's pace. President Barack Obama declared 2014 to be a "year of action" on the economy, and his representatives were keen to point out their policy successes, such as increased federal investment in advanced manufacturing research. Implementing the president's economic vision, said Perez, will ensure that economic growth "results in shared prosperity, in an economy that works for everybody."

U.S. BLAMES N. KOREA FOR SONY HACK: With U.S. intelligence analysts quietly pointing to North Korea as having a hand in the destructive hack of Sony Pictures Entertainment computers, Obama administration officials scrambled Thursday to consider what, if anything, they should do in response (*Los Angeles Times*). Options are limited, partly because the United States already imposes strict sanctions on North Korea's economy and because the country's leader, Kim Jong Un, relishes confrontation with the West. White House officials are wary of playing into an effort by nuclear-armed North Korea to provoke the U.S. into a direct confrontation. "How do you sanction the world's most heavily sanctioned country?" asked John Park, a specialist on Northeast Asia at Harvard University's John F. Kennedy School of Government. Hackers caused tens of millions of dollars in damage last month to Sony Pictures' computers, destroyed valuable files, leaked five films, four of them unreleased, and exposed private employment information including 47,000 Social Security numbers. In response to the cyberattack and a threat against movie theaters, Sony canceled the Christmas Day release of "The Interview," a comedy starring Seth Rogen and James Franco that

depicts a fictional assassination of Kim. The Obama administration has stopped short of saying openly that North Korea was involved in the intrusion

U.S. TO RATE COLLEGES: In a report due out on Friday, the Obama administration will offer its first public glimpse of a planned system for rating how well colleges perform, saying it plans to group schools into just three broad categories — good, bad and somewhere between (*New York Times*). In detailing what elements the system is likely to contain, the Department of Education also revealed how dauntingly complex the project has been, and how it continues to be hampered by the limitations of the data available. The department labeled what the Friday release calls a "draft framework," much of it subject to change, with a lot of work still to be done before it produces a first version of an actual rating formula. Officials said that first system should become public before the start of the next school year, about eight months away, but even then, it will remain a work in progress, to be upgraded as problems arise and better data become available. One fairly firm conclusion, said Ted Mitchell, under secretary of education, is that the department will assign each college one of three ratings, with the great majority of schools falling into the middle category, between high-performing and low-performing. "We want to avoid the false precision that we believe plagues lots of ratings," he said. "We think the top and the bottom will be relatively small categories."

PUTIN DOWNPLAYS ECONOMIC WOES: President Vladimir V. Putin tried to play down Russia's dire economic straits in his annual news conference on Thursday, attributing the troubles to declining oil prices that, following a short period of economic turbulence, were bound to recover along with global demand (*New York Times).* "We are going through a trying period, difficult times at the moment," Mr. Putin said at the three-hour get together with 1,200 reporters from Russia and around the world. "I would not call the situation a crisis. You may call it whatever you want." Russia's oil and gas-dependent economy crashed this week, with the ruble testing historic lows of 80 to the dollar before rallying to closer to 60, still down about 40 percent on the year. Analysts said the panic reflected not just the oil price drop but investors' distrust of the government's ability to cope with the crisis or to promote economic growth through something other than the extraction of natural resources. "Economically, socially and politically, the country will have to go through severe economic tests in the years to come," said Dmitri Trenin, the head of the Carnegie Moscow Center. "Not having a working, realistic, credible model for economic development, not just muddling through, will become critical." Addressing these concerns, a relaxed, at times even jovial Mr. Putin repeated several times that he thought the Central Bank of Russia and the government overall were doing the right things to halt the ruble's nose-dive, if acting slightly late. "I believe that the central bank and the government are taking adequate

measures," he said. "They won't leave it alone, because they will always seek to chain it," he said. "Once they manage to chain it, they will rip out the teeth and claws." The teeth and claws in this case are nuclear deterrence, he said.

HPI DAILY ANALYSIS: Sony Pictures made a stupid movie, didn't protect itself, and then caved to North Korea. Newt Gingrich called it the losing battle in the first cyber war, which is also a dumb assessment (i.e. remember the U.S. turning off Syria's air defenses for Israel could take out a nuke plant; or the Iranian centrifuge operation). - *Brian A. Howey*

Revenue Forecast

GOV. PENCE WILL 'EXERCISE CAUTION': "This revenue forecast confirms the growth we are seeing across our state and should be an encouragement to every Hoosier," said Gov. Mike Pence Thursday (*Howey Politics Indiana*). "While the December revenue forecast projects economic growth for our state, Hoosiers may be assured that our Administration will continue to exercise caution as we finalize our recommended budget for the next two years." The state revenue forecast comes on the heels of the Indiana Economic Outlook 2015 Forecast, published by the Ball State University Center for Business and Economic Research, which predicts an increase in the state's gross domestic product of 3.4 percent and an increase in personal income of 3.3 percent. It also follows solid revenue growth year over year in the current fiscal year. The Governor sounded a note of caution following flat revenue in fiscal year 2014 and the downward revision of the fiscal year 2015 estimate by $129 million from the December 2013 estimate.

CHAIRMAN BROWN REACTS: House Ways & Means chair Tim Brown, R-Crawfordsville, issued the following statement about today's revenue forecast (Gherardi and Spehler, *WXIN-TV*): "When considering today's revenue forecast, first and foremost, our focus should be on how this projection impacts Hoosiers all across the state. The forecast indicates signs of an improving economy, which means a brighter future for Hoosier families. After all, state government benefits from additional tax dollars only when Hoosiers are employed and have extra dollars to spend in the local economy. The numbers we saw today made it clear that Indiana is economically outperforming all of its neighbors, which is a direct result of the hard-fought economic policies put into place over the past decade. Many of the policies were challenging to enact, but there should be no doubt that these policies have paid dividends for Hoosier

families. The existence of new, spendable revenues will create challenges as well as opportunities when it comes to crafting the next biennial budget. Therefore, we must remain vigilant, in holding to the principles of fiscal discipline, that created the favorable financial position we enjoy today; mainly the principle that government should always live within its means. The new revenue and economic forecasts give us many reasons to be optimistic about the future of Indiana's economy but most importantly, the continued economic prosperity of Hoosier families."

ZODY REACTS: Indiana Democratic Party Chairman John Zody released the following statement Thursday following the release of the state's revenue forecast (*Howey Politics Indiana*): "Today's revenue forecast will force Governor Pence to make some tough choices. The question is, will he make the right choices for Hoosiers, or for his Presidential primary campaign? The lack of dollars coming in shows our state is struggling to meet its most basic needs and has proven unable to fulfill many of the duties required by state law. Roads, education and child services – these are just a few of the crucial public services where state government fails Hoosiers the most due to the lack of funding, or due to mismanagement in agencies like the BMV. All the while, the Governor continues his crusade against public and early childhood education. Personal income in Indiana is still nearly $10,000 than it was 10 years ago, and a report released in October ranked us last in personal income growth. Indiana Republicans should join with Democrats to right these wrongs for middle class Hoosiers. More educational opportunities for our children, and more money in the pockets of our hard working men and women means money injected into the economy now and in the future. It's simple math and logic that the GOP does not seem to understand. As long as Governor Mike Pence continues to hoard money for his surplus and fight wage increases while telling Hoosiers to do more with less, it is hard for anyone to see the light at the end of the economic tunnel in Indiana."

TALLIAN REACTS: Sen. Karen Tallian, D-Portage, said despite the good news of a growing Indiana economy and revenue, most agencies came in with budget requests that reflected a 3 percent budget cut right off the bat (Kelly, *Fort Wayne Journal Gazette*). And the Indiana Commission for Higher Education left out what is expected to be $90 million in new costs to fund the 21st Century Scholars Fund, which is an entitlement. "The governor needs to re-evaluate what he is doing. We are cutting services, letting our roads disintegrate, and risking educational obligations in order to fund his savings account. When is enough, enough?" Tallian asked. The Indiana surplus is expected to be at $2.17 billion in June. "We hear the governor insisting on additional reversions and promising little or no new spending," she said. "The truth of the matter is that agencies providing services are hurting – even if they won't or can't admit it."… "Today's revenue forecast set the stage for yet another year where Hoosiers will be

shortchanged while the governor pads his surplus," Tallian said (Weidenbener, *Statehouse File*). "The governor needs to reevaluate what he is doing. We are cutting services, letting our roads disintegrate, and risking educational obligations in order to fund his savings account."

PORTER REACTS: State Rep. Gregory W. Porter (D-Indianapolis), ranking Democrat on the Indiana House Ways and Means Committee, issued the following statement Thursday on the revenue forecast offered today to the State Budget Committee (*Howey Politics Indiana*): "It would be great to be happy about the fact that there will be an overall increase in state revenues over the next biennium, but we cannot do that without admitting that we are giving the people of Indiana an incomplete picture about the way we fund state government. For all the talk today, there is only one number that means anything when it comes to the way this administration runs your government: $2 billion. That is their cherished figure because it represents a surplus amount that is supposed to show the world that Indiana is being run the right way. So it really doesn't matter how much additional revenue our state expects to get, until you try and figure out how the administration will game the numbers to keep $2 billion in the bank at whatever cost. Past practice will indicate that services will run a poor second to keeping the bottom line healthy. We are still relatively early in the process of writing a new biennial state budget, but plenty of warning flags have been raised. The state's Department of Child Services (DCS) needs at least 77 new case managers to provide adequate services to Hoosier children at risk. However, agency officials have said they won't seek the funding for these positions…positions that could have been easily funded if DCS hadn't been so intent on reverting hundreds of millions of dollars back to feed the surplus. While the state Department of Health might claim that reducing infant mortality and tobacco usage are its two top priorities, the agency's budget proposal contains no new money for tobacco cessation and no funding at all for preventing infant mortality. The state Board of Accounts has finally come clean about its inability to do its job as a fiscal watchdog for local units of government, thanks to inadequate funding."

GOODIN REACTS: "With the forecast, is there enough money to do everything the Governor wants to do? I don't know," said State Representative, Terry Goodin (D – Austin) (Gherardi and Spehler, *WXIN-TV*). Goodin sits on the budget committee. With modest revenue gains, he's not so sure spending in the Hoosier state will be what it once was. "We have to approach this next budget writing session very cautiously. I think Senator Kenley said it well and so did Representative Brown that we're cautiously optimistic and I think we've all got to take that position as we move forward," he said.

Campaigns

2016: PETE SEAT ADVISES PREZ HOPEFULS TO 'JUST RUN' - Former Florida Gov. Jeb Bush's announcement this week that he is actively exploring a presidential bid is causing ripple effects as the 2016 electoral picture begins taking shape (Smith, *Indiana Public Media*). Pete Seat is a former spokesman for the Indiana Republican Party, Sen. Dan Coats, R-Indiana, and the Bush administration. He says presidents can't defer decisions of international or national importance once they're in office, so he asks why presidential candidates should get to do so when deciding to run. "If an individual believes that he or she is the most capable of occupying the Oval Office and the role of President of the United States, they should just run for the job," Seat says. Seat says that includes Gov. Mike Pence, who's received lots of attention regarding a potential candidacy but says he won't decide until next year. Don Cogman is the author of "Run Mitch, Run" about former Gov. Mitch Daniels' near-candidacy for president. Cogman, who was part of the circle of advisors for Daniels' decision, says it's not just the candidate who has to make the choice. "It's a difficult decision and it just depends on the family situation and sort of where they are in that particular stage of their life," Cogman says. Seat acknowledges that the upcoming legislative session could delay Pence's decision but notes there's rarely a perfect time for candidates to announce they're running for president.

2016: LoBIANCO REVIEWS 'TAKES' ON POTENTIAL PENCE PREZ BID - Gov. Mike Pence's flirtations with a White House run are continuing to draw national media attention to the Crossroads of America and the Indiana Statehouse (LoBianco, I*ndyStar*). Inside the state, Pence is perceived as a humble governor, known as much for his affable demeanor as the grueling battles he's had with Democratic state schools chief: Superintendent of Public Instruction Glenda Ritz. But in Washington, he's weaving a message of being an effective governor with the right solutions for Washington. Here's a quick rundown of national perspectives on Pence which have come out in the past week. As The Star's new political reporter/analyst, I've included a few of my own thoughts at the end of each blurb.

2014: MADISON CO. ELECTION BOARD ALLEGES FAMILY VOTER FRAUD - The Madison County Election Board believes three members of the family of Anderson city councilman Ollie H. Dixon have violated state election laws (de la Bastide, *Anderson Herald Bulletin*). The Election Board on Wednesday sent three letters, including documents in support of allegations of illegal activity by Dorothy Dixon, Dixon's wife, and his two daughters, Tamie Dixon-Tatum and Delisha Dixon, to Madison County Prosecutor Rodney Cummings. All three letters state the Election Board has found substantial reason to believe election laws were violated. Cummings said he will review the documents and determine whether an investigation should be conducted. He said the Indiana State Police would be asked to conduct the investigation. The Election Board earlier this year conducted several meetings concerning allegations raised by Major Brian Bell of the Madison County Sheriff's Department. Bell lost the Democratic Party nomination for sheriff in the May primary to Scott Mellinger, who defeated Republican Bruce Dunham and Libertarian Tim Basey in the November election. "My family has done nothing wrong," Dixon said. "It shouldn't matter as long as you only vote one time."

General Assembly

CASINOS CITING FIGURE THAT 25K HOOSIER JOBS IN GAMING: With casino revenue in Indiana falling, the head of the Casino Association hopes a new study will show lawmakers how much the state's economy would lose if casinos began to fail (Steele, *WIBC)*. At Thursday's announcement of state revenue projections for the coming year, the State Budget Committee learned that gaming taxes were more than 16-percent lowering than the same period of the previous budge year and about the same amount lower than the budget forecast from December 2013. That's because casinos aren't making as much money due in part to increased competition from neighboring states, and that's why the American Gaming Association commissioned the study from Oxford Economics. "It's important for the public and policy makers to get an idea of where we really stand when it comes to gaming revenue and jobs," said Mike Smith, former state representative and the president of the Casino Association of Indiana. The study says casinos, even though they aren't making as much money, still have an economic impact of more than $4 billion statewide. More importantly, Smith says, they are responsible for more than 25,000 jobs either directly or indirectly. "That's a pretty significant number when you look at a state of 6.5 million people," Smith said. "We have an unemployment rate of 5.7-percent right now, and the study calculated that rate would be 6.9-percent without the jobs tied to casinos." Those jobs are also in areas that otherwise wouldn't have them, Smith said. "When you go back to the 1993

law that legalized gaming, it was all intended to put these casinos in areas that had a depressed economic environment." The casinos still generate more than $700 million in gaming taxes for the state each year, but Smith says that could dwindle if lawmakers don't provide some help in the coming session. "There are properties that want to be able to move their properties on land instead of the boat. The two racetrack casinos would like to have live dealers at the table games that are currently automated," Smith said

CASINOS HOPE REVENUE WILL PROMPT LEGISLATIVE REFORMS: Casinos though were dealt the hardest hand of the year. Competition from casinos in neighboring states led to lower casino revenues here in Indiana (Gherarid and Spehler,*WXIN-TV*). The industry is now hemorrhaging money, with revenue dropping 30% in November alone. "From our peak, we're down about 4,000 machines. That would be like eliminating four casinos the size of Tropicana in Evansville," said Indiana Casino Association President, Mike Smith. What once was a winning source of revenue for the state is down nearly 10% from last year. "As time goes on, hopefully we can get some of our issues resolved at the legislature," said Smith. Many lawmakers, in an attempt to get that source of revenue closer to where it once was, are looking to pass pro-casino legislation in the upcoming session.

PELATH SAYS JOB ANNOUNCEMENT 'HYPE' IGNORES INCOME GAP: Indiana House Democratic Leader Scott Pelath from Michigan City issued the following statement Thursday in response to Gov. Mike Pence's announcement the same day about job creation this year (*Howey Politics Indiana*): "By now, most people are deservedly skeptical about these Hollywood productions designed to trumpet Indiana's alleged economic successes. All this sound and blather is at the service of jobs that 'might' be created over the next few years. By the time those years pass, and few of these jobs become reality, the administration will have moved on to other grand announcements about more jobs that 'might' be created even more years down the road. I suppose it makes people feel good, but I don't know if it helps at a time when Marion General Hospital is cutting 69 jobs, or Rolls-Royce in Indianapolis is cutting 200 jobs, or Union Hospital in Terre Haute is losing 150 jobs by the end of this year, or IU Health is losing 120 jobs by shutting down its proton therapy center. I know those job losses are happening, but those aren't the kinds of things that cause governors to conduct grand press conferences in the rotunda of the Indiana Statehouse. Those are the dirty little realities that politicians hope people ignore, but are all too commonplace for the people whose lives are disrupted. And even if you choose to keep your rose-colored glasses firmly in place, even the governor cannot deny the fact that Indiana may be a place that works, but it isn't paying its workers as much. According to the U.S. Census Bureau, Indiana's average household income has dropped from $53,482 in

2002 to $46,974 in 2013. Hoosiers rank 39th in per capita income, earning just over 87 percent of the U.S. average."

SEN. ARNOLD SAYS SUNDAY SALES COULD HELP REVENUE: The state of Indiana has a long history of banning carry out alcohol sales on Sundays (*WNDU-TV).* Some suspect this could this be the year lawmakers make history by changing that policy. "Now it's time for us to start looking for new ways of bringing in revenue," says Indiana Senator Jim Arnold. "We're competing with Michigan and, of course, I represent the area that borders Michigan right here. I haven't had any strong empirical data back from the Licensed Beverage Association about their feelings of it, and I know that most of them are probably against it because they feel they have to be open on Sunday, but the fact remains, maybe we're losing a number of sales across the line to Michigan. It's time to for us to step into the modern day." Arnold sits on the senate committee that would hear a Sunday sales bill. His son-in-law, Representative Tom Dermody, chairs the house.

REP. WESCO FEELS HIGHER PERFORMING SCHOOLS UNDERFUNDED: Some Indiana lawmakers feel the state's highest performing school districts are being underfunded (Peterson, *WNDU-TV*). Ind. Rep. Timothy Wesco, (R) Osceola is among those who plan to fight for 'equity' in the school funding formula. "The top ten worst performing school corporations in the state get 30 percent more in funding than the top ten best performing school corporations in the state," said Rep. Wesco. In Indiana, the average per pupil expenditure is $11,015. Larger urban school districts like the South Bend Community Schools tend to exceed that average at $12,577 (Mishawaka's per pupil expenditure is $12,100), while suburban or rural districts like Penn Harris Madison and John Glenn tend to be below the state average: PHM's per pupil expenditure is $10,125 and John Glenn's is $9,151. "So we're kind of looking at that money and saying its, we're investing all this additional funding into these school corporations and we're not seeing a return," said Rep. Wesco. "It's not bringing them up to the level of being the best so how could we be smarter about this?"

REP. WESCO WANTS SALES TAX, NOT GAS TAX FIX FOR ROADS: A local state lawmaker will soon hit the road with road funding on his mind *(WNDU-TV).* When Indiana Representative Timothy Wesco drives to Indianapolis in January for the start of the 2015 session of the general assembly, he'll do so with the goal of raising more money for road repairs. Wesco doesn't want to increase the sales tax on gasoline, but he does want to increase the amount of tax that funds roadwork. "Currently about 20 percent of the 7 percent sales tax that's currently paid on gasoline goes to roads," says

Wesco. "I would like to double that in this coming session and make it 40 percent." Wesco is still awaiting the results of a fiscal impact study but suspects the proposal would raise "hundreds of thousands of dollars" for road repairs.

Congress

DONNELLY ANNOUNCES COMMITTEE ASSIGNMENTS: Thursday, U.S. Senator Joe Donnelly announced his committee assignments for the 114th Congress (*Howey Politics Indiana*). He will continue to serve on the Senate Armed Services Committee, Agriculture Committee, and Special Committee on Aging. Starting next year, he will also serve on the Senate Banking, Housing, and Urban Affairs Committee. "I look forward to continuing my work on behalf of servicemembers on the Armed Services Committee, especially in the area of mental health," said Donnelly. "Further, there is ongoing work in the Agriculture Committee to properly implement the five-year Farm Bill and meet the needs of our ag sector. We have more to do in the Aging Committee, also, in the area of the protecting seniors from scams and fraud. "Finally, I look forward to the new opportunity to represent Hoosiers on the Banking Committee. From this new committee, I will be able to address issues affecting Indiana financial institutions and their customers, economic development, housing, and export financing."

BROOKS ADDRESSES PARTY POLITICS IN Q & A WITH USA TODAY: U.S. Rep. Susan Brooks talked with *USA TODAY* about her first term and the advantages and responsibilities Republicans will have next year when they will take over the Senate and expand their majority in the House (Groppe, Gannett). Question: When you were sworn into office, Congress' approval rating was 14 percent. It's now 16 percent. Is that progress? Answer: Obviously it's not the progress that the American people are hoping for, but the fact that our approval rating is slightly up is a small victory. But it's certainly not satisfactory. Part of why I ran — and one of our themes during the campaign — was trying to restore some confidence in Congress. The fact that only 16 percent of the American people like the way we do our job isn't good enough for me. There were opportunities in my first term that I have tried to take to restore some of that confidence in Congress. One was accepting the appointment to the Ethics Committee. ... That is a type of assignment that actually I hope allows my constituents to realize that members of Congress are certainly not above the law, not above the rules, and that's what this committee is in place to do.

BROOKS ADDRESSES BENGHAZI WORK, FUTURE CMTE ASSIGNMENTS: Q: You were appointed to the House committee investigating the 2012 attack on the American consulate in Benghazi, Libya (Groppe, Gannett). The panel will continue its investigation next year, even though the GOP-led House Intelligence Committee concluded last month that the Obama administration responded appropriately to the attacks. Why should this probe continue? A: The House Intelligence Committee's report was actually only focused on the intelligence part of the administration's role. It did not address the State Department's role or the White House's role ... so that's why our work is continuing. It really will heat up again beginning with a hearing in January. I think you will begin to see more regular hearings than what we've had thus far because there still are many questions that remain. Q: Your biggest committee assignment next year will be the Energy and Commerce Committee. Have you already started hearing from businesses, particularly those in Indiana, about issues they want the committee to address? A: Absolutely. I have heard from the health care community. ... Repeal of the medical device tax (included in the Affordable Care Act) is significant for the state of Indiana. That is a top priority. I have also heard from the energy sector ... (which) is very excited about my placement on the committee as well. I'm also on the Commerce, Manufacturing and Trade Subcommittee. With Indiana being one of the top manufacturing states in the country, I'm anxious to talk to a lot of manufacturers ... (to find out) what are the regulatory issues, what are the tax issues, that are impeding their growth?

State

GOVERNOR: PENCE MAKES END-OF-YEAR JOBS ANNOUNCEMENT - Gov. Mike Pence and executives from 16 companies announced new investments Thursday that are expected to bring 2,153 jobs to Indiana within what state officials are calling "the next few years (TenBarge, *Statehouse File*)." But actually, some of those jobs won't be created until 2023. Still, Pence lauded the deals – which involve tax credits and other incentives – as key to the state's economic growth. "From tech developers to manufacturing powerhouses, the collective energy of these Hoosier businesses will help power our economy into 2015, creating jobs, promoting opportunities and investing in our future," Pence said. Overall in 2014, the Indiana Economic Development Corporation announced it had secured job commitments from 285 companies from across the country and around the world. The companies anticipate investing $4.38 billion in their operations and are expected to create 25,317 jobs over the next decade. The new positions are projected to pay an average of $21.75, which is higher than the state's current average hourly wage of $20.17. The companies received tax credits, training grants and other incentives to either move to or expand in Indiana. In response to Pence's announcement, House Minority Leader Scott Pelath, D-Michigan City, said he

doesn't think the state's economic problems are solved by the jobs announcements. "I suppose it makes people feel good, but I don't know if it helps at a time when Marion General Hospital is cutting 69 jobs, or Rolls-Royce in Indianapolis is cutting 200 jobs, or Union Hospital in Terre Haute is losing 150 jobs by the end of this year, or IU Health is losing 120 jobs by shutting down its proton therapy center," Pelath said.

EDUCATION: GIVEN 1,800 APPLICATIONS, PRE-K PILOT EXPANDED TO 450 - Indiana's Office of Early Childhood and Out-of-School Learning (OECOSL) has received more than 1,800 applications from families in Allen, Lake, Marion and Vanderburgh counties who would like to enroll their 4-year-old children in the first phase of the On My Way Pre-K program beginning in January of 2015 (Howey Politics Indiana). "I am truly grateful to the many community partners who helped us reach out to families and open doors of opportunity for quality pre-k education to 1,800 disadvantaged children in our state," said Governor Pence. "The initial response to our pilot program confirms the need for high-quality early education for our most disadvantaged kids, and our Administration will continue to faithfully implement this program and determine how we might best serve more Indiana children in the years ahead." The goal for the first phase of On My Way Pre-K, which starts in January 2015, was to enroll a total of 350 children; however, with the demand being so great, OECOSL is looking to enroll 100 additional children in January for a target enrollment of 450

EDUCATION: PRIVATE SCHOOLS TO RETURN $3.9M IN VOUCHER FUNDS - Eighty of the more than 300 schools involved in the state's voucher system announced Wednesday they will return $3.9 million in voucher scholarship funds to the Indiana Choice Scholarship Program (Morello, *State Impact Indiana*). A new study on tuition and financial aid practices, released by the Indiana Non-Public Education Association, found the group overpaid those schools over the course of three years due to unintentional errors in calculating voucher costs. John Elcesser, executive director of the INPEA, tells The Indianapolis Star that most of the errors happened because schools forgot to apply discounts for parishioners (at Catholic schools), families enrolling more than one child or employees. He adds that families were not overcharged… A spokesman for state superintendent Glenda Ritz says her office is reviewing the information, according to the Associated Press.

EDUCATION: SHELBY CO. SCHOOLS WANT E-LEARNING ON SNOW DAYS - Officials with the Northwestern Consolidated Schools of Shelby County say teachers should still teach their students online when traditional school days are canceled because of snow (*Network Indiana*). The district filled out an application for e-learning

with the Department of Education, and has spent the last few months preparing teachers and students for the possible program… Superintendent Shane Robbins says he thinks implementing e-learning on snow days will prove effective compared to other alternatives. "We feel like what we're going to be able to on those snow days is far better and greater in preparing our students than it will be to tack days on at the end of the school year, when most of our kids have already checked out and are ready for summer vacation," Robbins said. In order to make the virtual learning effective, each teacher has to have online office hours and is required to have a Google Drive website with lesson plans available.

COURTS: SUPREME COURT SUSPENDS MUNCIE JUDGE - The Indiana Supreme Court on Thursday afternoon suspended Dianna Bennington from her duties as Muncie City Court judge "until further notice of this court (Walker, *Muncie Star Press*)." The order suspending the 43-year-old Muncie judge with pay — "effective at 12 a.m. Friday" — was signed by Indiana Chief Justice Loretta H. Rush, and issued shortly before 5 p.m. The action came a week after the Indiana Commission on Judicial Qualifications, which oversees Hoosier judges, filed a complaint against Bennington, citing 13 counts of misconduct. The commission alleged Bennington had abused her judicial power, taken "certain judicial actions" without the "legal authority to do so," and "engaged in injudicious and prejudicial public conduct related to her personal life."

ECONOMY: STATE WILL SEE GROWTH, BUT DEMOGRAPHICS A DRAG - A top U.S. economist is weighing in on the state of Indiana's economy (Corbin, *WIBC*). IHS Global Insight Chief U.S. Economist Douglas Handler told a committee of state lawmakers that economic growth in Indiana remains higher than in neighboring states. Handler says employment, personal income and real gross state product will all show slight gains in 2015. He says unemployment should drop to 5.5 percent. However, he adds that employment growth will slow due to large numbers of aging workers leaving the workforce nationwide. Manufacturing, especially the resurgence of the auto sector, is cited as key in Indiana's economic health. Handler says continued low gas prices could save Americans $1000 a year or roughly $20 per week. He adds that wage gains, auto sales and housing starts should remain steady.

TRANSPORTATION: NEW STATE APP WILL PROVIDE HAZARD INFO - Hoosiers now have access to a free mobile app that provides county travel status updates and alerts (*Network Indiana*). In addition to weather, the app, called Travel Advisory, includes notifications about flooding, hazardous materials spills and other events that could affect travel. Last winter, the Indiana Department of Homeland Security County

Travel Status Map was the most visited page on IN.gov, generating nearly 5 million unique visitors between the beginning of December 2013 and March 2014. The app is meant to be used as part of a system to stay aware of changing travel conditions.

Nation

WHITE HOUSE: CASTRO VISIT POSSIBLE - The White House said Thursday it wouldn't rule out a visit by Cuban president Raúl Castro to Washington for a meeting with President Obama *(The Hill).* "The president has had the leaders of both Burma and China to the United States," White House press secretary Josh Earnest said. "And for that reason, I wouldn't rule out a visit from President Castro."

IRS: AGENCY WARNS OF SHUTDOWN - The IRS is considering its own temporary shutdown due to recent budget cuts enacted by Congress, its chief said Thursday*(Politico*). IRS Commissioner John Koskinen said furloughs — forced unpaid days off for employees as part of an IRS closure — is one idea reluctantly being tossed about to save money, though they are hoping they will not have to go there. "There is no way we can say right now that that won't happen," Koskinen told reporters at a press conference on the upcoming tax season. "Again, I would stress that would be the last option." He said a one-day closure would save an estimated $29 million. The news comes a day after Koskinen warned IRS employees that overtime would be suspended and a hiring freeze enacted.

SECRET SERVICE: CALLS FOR MAJOR CHANGE - An independent panel on Thursday recommended sweeping changes at the Secret Service, saying the elite protective agency is "starved for leadership" and calling for an outsider as director, hundreds of new agents and officers, and a higher fence around the White House (*Washington Post*). The panel, created in October after a series of highly publicized security failures, said the fence protecting the executive mansion should be raised at least four feet to make it less vulnerable to jumpers. Panel members were reacting to a Sept. 19 incident in which a man scaled the fence and ran far into the White House through an unlocked front door. The four-member body also urged expanded and intensified training for agents, saying the service should run crisis response scenarios that possibly use a mock White House. The report especially targeted the Secret Service's highly insular culture, calling for new leadership from outside to shake up the agency — a suggestion sure to rankle some in the service's old guard. "The problems exposed by recent events go deeper than a new fence can fix," said the report's

executive summary, the only portion publicly released. “We believe that at this time in the agency’s history, the need for Service experience is outweighed by what the Service needs today: dynamic leadership that can move the Service forward into a new era and drive change in the organization.”

CUBA: POWELL BACKS CHANGE - President Obama announced Wednesday that more than 50 years after the U.S. cut diplomatic ties with Cuba, he would begin normalizing relations between the two countries. While critics from both parties voiced their concerns, some officials are optimistic” (*CBS News*). “This is still a terrible regime. We don't support their form of government. We don't like what they're doing," former Secretary of State Colin Powell said Thursday on "CBS This Morning." "But I think having diplomatic relations, as we have had with the Soviet Union, with Vietnam and so many other places, we can produce positive change." President George W. Bush supported the economic embargo on Cuba as did Powell during Mr. Bush's first term. Eleven years ago, Powell opposed relaxing restrictions against Cuba because he believed Fidel Castro would use it to enhance his power.“"Over the last 50 years I have watched this policy unfold, and I have been a part of it," he said. "And as secretary of state ... I supported it and even strengthened the sanctions against Cuba. But I think it's time now to turn that page of history."

MEDIA: COLBERT LIVES ON! - Instead of Stephen Colbert killing off his ultra-conservative pundit alter-ego on the final episode of “The Colbert Report” (as many assumed), he went with something different: Immortality (*Washington Post)*. It’s true: In the end, Colbert’s famous character, champion of America and truthiness, will live forever. Although at first, it didn’t seem like we would get such a definitive ending to the long-running Comedy Central show. “I am an emotionless, igneous news rock,” Stephen Colbert informed the audience at the beginning. Technically, he said it at the very end of “The Daily Show,” when Jon Stewart briefly cut to Colbert’s set to see how his real-life pal was holding up on his last night on Comedy Central. Colbert stayed in character and acted entirely nonplussed as Stewart’s show led into his for the final time, and the crowd chanted its typical “Steph-en! Steph-en!” chant. Colbert stood up and soaked in the applause, but then sat down at his desk for business as usual. He got in some jokes and reflected on all of the things that he had given to the nation over nine years (truthiness, mostly). He reflected on his more famous moments, such as running for president; starting a Super PAC; and the Rally to Restore Sanity and/or Fear. Colbert also looked back at when his show started (2005) and how many things were still the same in 2014. And that was okay by him. “If all we achieved over the last nine years was to come into your home each night and help you make a difficult day a little better — man, what a waste,” Colbert said, but offered this: “Nation I want you to know, if i had to do it all again, if I could do it with you, I would do it the same.” And then things

got weird. During what seemed be a routine intro to his famous "Cheating Death With Dr. Stephen Colbert, D.F.A." bit, Colbert faced off with his usual friend, the Grim Reaper ("Grimmy"). Would Grimmy finally off Colbert's character, putting an end to it all before real-life Colbert takes over "The Late Show" next year? Nope — Colbert accidentally shot and killed Grimmy. "I just killed death, I am immortal!" Colbert roared.

THE EPIC CAMEO: Colbert bid farewell to his audience by singing 'We'll Meet Again,' with Jon Stewart joining him by a piano manned by Randy Newman. ... There was Willie Nelson, Doris Kearns Goodwin, James Franco, Arianna Huffington, Jeff Daniels, Keith Olbermann, Samantha Power, Shane Smith, Katie Couric ... And then there was Ken Burns, Cyndi Lauper, Mark Cuban, Patrick Stewart, Michael Stipe, and Matt Taibbi, Sam Waterston, Paul Krugman ... [and] Mike Huckabee, Grover Norquist, Bill Clinton, and Henry Kissinger.

EDUCATION: PUBLIC UNIVS DEPEND MORE ON TUITION, THAN STATE FUNDING - According to a new study by the U.S. Government Accountability Office, these schools now receive a greater portion of revenues from student tuition than from state funding (*The Atlantic*). The study looked at the total breakdown of college revenues between 2003 and 2012. In 2003 state funding accounted for 32 percent of total revenues, while student tuition supplied just 17 percent. By 2012, the tables had turned: Students paid for 25 percent of total revenue, while states funded 23 percent. The additional revenue comes from federal grants and other sources, including private gifts and grants and auxiliary revenue streams, like hospitals and football games. The increase in tuition revenue seems—logically—to have come from a hike in tuition. In 2012 dollars, the average net cost to students—a value that measures what students actually pay, after all expenses and financial aid—rose 19 percent, from $1,874 in 2003 to $2,226 in 2012.

SUNDAY TALK LINEUP: "Fox News Sunday": Sony and North Korea: House Intelligence Chair Mike Rogers ... Cuba: Sens. Ron Johnson and Ben Cardin ... Morrill Worcester, Wreaths Across America ... Panel: George Will, Judy Woodruff, Liz Cheney, Juan Williams; "Face the Nation": Sen. Marco Rubio, Sen. Lindsey Graham, Rep. Chris Van Hollen ... Jeffrey Goldberg ... Annual CBS News correspondent roundtable: State Department Correspondent Margaret Brennan, Congressional Correspondent Nancy Cordes, Chief Legal Correspondent Jan Crawford, Political Director John Dickerson, Chief White House Correspondent Major Garrett, National Security Correspondent David Martin; "Meet the Press": Sen. Rubio; CNN's "State of the Union": For her last show, Candy interviews President Obama and Sen. McCain.

Local

CITIES: EVANSVILLE CONVENTION HOTEL DEAL FALLS THROUGH - A deal to build a convention hotel in downtown Evansville has collapsed and taken down a $71.3 million plan that also included an apartment tower, parking garage and infrastructure upgrades (*Associated Press*). Mayor Lloyd Winnecke announced the development at a Thursday news conference with Old National Bank President Bob Jones. Jones says a consultant to the bank found the value of naming rights for the convention hall long known as The Centre isn't worth the money the bank was prepared to invest in the project. The Evansville Courier & Press reports the financing gap came to $6.5 million. The bank last year pledged to be an investor along with developer HCW after the City Council set a $20 million cap on public financing. Winnecke says he'll keep working on the project.

CITIES: EVANSVILLE IU MED CENTER NOT INLUDED IN HIGHER ED BUDGET REQUESTS - The Mayor's Office has confirmed that Indiana's Commission for Higher Education did not include the med center in its list of projects it wants the state to approve (Raatz, *WFIE-TV*). Both Mayor Winnecke and Pat Shoulders with IU say this is a hurdle they had planned for. Shoulders says the three public universities requesting public funding from the general assembly for their portion of the IU Med School are IU, USI, and Ivy Tech. The officials on the front lines of getting this IU Med School project through its final hurdles still say they believe this project will happen.

CITIES: ELKHART ANNEXATION PLAN FACES THREE LAWSUITS - After an initial court date was pushed back past the New Year, road blocks to the annexation of three key areas in the City of Elkhart's 2015 plan are mounting (Hickey, *WNDU-TV*). There are currently three pending lawsuits that dispute the annexation of areas six, seven and eight, which were scheduled to be annexed on January 1 along with the other areas included in the plan. Members of the Elkhart "Stop Forced Annexation" group say they appeared at the Elkhart Superior Court Thursday only to learn that their hearing had been postponed due to the "judge's availability." Terry Karre, a homeowner in annexation area number eight and leader of the group opposing annexation, said he was not given a revised court date. The setback comes just days after the city distributed trash containers to the areas on the cusp of annexation with a note dated Dec. 15, 2014 welcoming the residents to the City of Elkhart

CITIES: FORT WAYNE COMPLETES FLOOD CONTROL PROJECT - Following a flood in 2013, the City of Fort Wayne began taking the steps to alleviate the problem which included the purchase of six homes which were demolished in order to provide an area to absorb floodwaters (*WANE-TV*). A larger stormwater pipe was also installed and other measures were taken, including the construction of a berm to block water from the Fairfield Ditch from entering the neighborhood.

CITIES: IMPD OFFICER ARRESTED ON 3 FELONY CHARGES - An Indianapolis Metropolitan Police Department officer was arrested Thursday on three felony charges, including official misconduct (Adams, *IndyStar)*. Officer Christopher Dickerson, a five-year veteran of the North District's operations division, was arrested on a warrant for felony charges of theft, obstruction of justice and official misconduct. The charges resulted from allegations that came from a November run Dickerson responded to, and his failure to follow department rules regarding proper handling of evidence. Detectives with IMPD and a special investigation unit were handling the investigation, which is still active, according to police. When the initial inquiry was complete, charges were filed by the Marion County prosecutor's office.

CITIES: INDY DEMS RAISE RED FLAGS OVER JUSTICE SITE - The proposed future home of the Marion County Jail could be in jeopardy after Democratic city-county councilors raised a red flag Thursday (Glavan*, WXIN-TV*). Questions are being raised after the release of emails between former city officials who worked on the troubled Regional Operations Center, or ROC. The ROC opened in the former Eastgate Mall ahead of the Super Bowl, as a place to make residents safer. However, just a year later it was evacuated after the building was deemed unsafe. A City-County Council committee has been investigating the circumstances surrounding the ROC's site and lease. Democratic councilors even went so far as to take the city to court, resulting in the release of the emails. "It shows a pattern. It shows a disregard for the process," said Councilor Joe Simpson. The emails seem to reveal that it was Mayor Greg Ballard, not former Public Safety Director Frank Straub as previously thought, who pushed for the east side location. "Drove by Eastgate, I'm a visionary (but) I thought it was horrible. It will be a long time before they get (that) space to look good," Straub said in one email.

CITIES: AMI INDUSTRIES PLANS 450 JOBS FOR MICHIANA BY 2017 - Governor Mike Pence and executives from 16 companies around the state announced over 2,000 new jobs are coming to Indiana, and some of the jobs are coming to Michiana (*WNDU-TV).* "Indiana's strong economy, fiscal responsibility and pro-growth

policies make days like this possible," says Pence. "Today's announcement includes some of the nation's fastest growing companies, and they have all either launched in Indiana or are choosing to move here." Heavy equipment parts manufacturer AMI Industries will invest $4.2 million to equip and expand agricultural component production in Plymouth. It will help create 250 new jobs by 2015. The company also plans to invest $4.35 million to equip and renovate its automotive manufacturing lines, creating 225 jobs by 2017.

COUNTIES: VANDERBURGH JAIL TO ADDRESS OVERCROWDING - New 2015 laws may cause a concern of overcrowding at the Vanderburgh County Jail (Kayser, *WFIE-TV*). Sheriff Dave Wedding says they are meeting with judges and the prosecutor's office to determine if they can do alternative sentencing, such as work release, and find ways so that overcrowding doesn't happen. House bill 1,006 will change the sentencing guidelines in Indiana and goes into effect July of 2015. This means more violent offenders or repeat offenders will serve longer sentences in the department of corrections and lower level offenders then have to go back into the custody of the county that their crime was committed. The Vanderburgh County Jail has nearly 500 inmates and its capacity is around 530.

COUNTIES: MARION SHERIFF DEPUTY ARRESTED ON RAPE CHARGE - A Marion County sheriff's deputy was arrested Thursday on a rape charge in a warrant issued out of Hendricks County (Adams, *IndyStar*). According to Hendricks County Superior court documents, rape charges against Deputy Craig Ryland were filed Nov. 30, and a $75,000 warrant for Ryland's arrest was issued Dec. 17. On Thursday morning, around 10:30 a.m., Ryland turned himself in, then immediately bonded out, said Hendricks County Sheriff's Department spokesperson Lt. Kelly Caldwell. Ryland, a 7-year veteran of the Marion County sheriff's department, was placed on unpaid administrative leave pending an ongoing investigation, according to Marion County Sheriff's spokesperson, Katie Carlson. He is a sergeant in the Marion County Jail.

Scott.A.Milkey

From: Gilson, Katie
Sent: Friday, December 19, 2014 9:07 AM
To: Gilson, Katie;Quyle, Lindsay;Cleveland, Bridget;Ahearn, Mark;Atkins, Chris;Bailey, Brian (OMB);Bauer, Zachary C;Berry, Adam (GOV);Brooks, Kara D;Brown, Hannah;Marshall, Sara (Cardwell);Joyner Burroughs (Cissel), Jackie;Crabtree, Chris;Craig, Lindsey M;Czarniecki, Cary (Lani);Denault, Christina;Espich, Jeff;Fritz, Pam (GOV);Jarmula, Ryan L;Kane, Kristen;Vincent, Micah;Morales, Cesar (Diego);Myers, Janille;Neale, Brian S;Pavlik, Jennifer L;Pitcock, Josh;Price, Kendra;Schilb, Veronica J;Schmidt, Daniel W;Simcox, Stephen;Streeter, Ryan T;Fernandez, Marilyn;Hodgin, Stephanie;Karns, Allison;Rosebrough, Dennis (LG);Cardwell, Jeffery;Dowd, Jaclyn (CECI);Keefer, Sean (GOV);Norton, Erin (Ladd);Johnson, Matt (GOV);Heater, Ryan;Fiddian-Green, Claire (CECI);Rosebrough, Dennis;Mantravadi, Adarsh V;Rosebrough, Dennis (LG);Workman, James D;McKinney, Ted;Bausman, David;Atterholt, Jim;Davidson, Brenden;Myers, Janille;Fox, Joseph R;McGrath, Danielle;Brookes, Brady;Triol, Shelley;Wall, Kathryn E;Reed, Katie
Subject: RE: [Gov Clips] Howey
Attachments: 12-19-14 HPI Daily.pdf

Katie Gilson, *Staff Assistant*
Office of Governor Mike Pence
KGilson@gov.in.gov
Phone: (317) 232-1198
Fax: (317) 232-3443

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Katie Gilson, *Staff Assistant*
Office of Governor Mike Pence
KGilson@gov.in.gov
Phone: (317) 232-1198
Fax: (317) 232-3443

Dec. 19, 2014 HPI Daily Wire, sponsored by Associated Builders & Contractors

Friday, December 19, 2014 8:07 AM

REVENUE FORECAST LOWERS CURRENT FY, EXPECTS $840M MORE: Indiana tax collections will grow each of the next two years, giving lawmakers about $840 million in new money to spend in the next biennial budget, according to a revenue forecast released Thursday (Kelly, *Fort Wayne Journal Gazette*). "I would say this is a moderately positive forecast," said Senate Appropriations Chairman Luke Kenley, R-Noblesville. He is cautiously optimistic about the expected upturn of 2.4 percent in fiscal year 2016 but less certain about the rise of 3.2 percent in fiscal year 2017. And Kenley noted it is all about priorities. More than $800 million in new money sounds like a lot. But, for instance, Superintendent of Public Instruction Glenda Ritz is seeking $560 million alone for K-12 schools. That doesn't include the state's universities, prisons, health care for the poor or myriad other state needs. The forecast also downgraded the current fiscal year ending in June by about $129 million. Gov. Mike Pence has already required his agencies to hold back spending, and Kenley doesn't think any major cuts will have to be made…The projections show the state could have $360.5 million in additional funds for the next fiscal year and $482.3 million in Fiscal Year 2017 (Weidenbener, Statehouse File). That's an increase of 2.4 percent in the first year and 3.2 percent the second year… The anticipated state reserve at the end of FY 2015 – including balances from the Medicaid Reserve, State Tuition Reserve, and the Rainy Day Fund – total just under $2.2 billion. This is $166.4 million more than in FY 2014. Along with the budget forecast for the biennium, representatives from the forecast committee presented a revised forecast for Fiscal Year 2015, which ends June 30. The revised projection reduces the total by $129 million – a difference of less than 1 percentage point. "The problem with that is that it means you push the reset button," Kenley said about the revised FY 2015 forecast. "Of course, the burden on that has fallen to the executive branch and the spending controls that they've implemented and I have to compliment them… We are in reasonably good shape because of their actions in being conservative about that and pulling back reversions."

KENLEY SAYS SOME OF NEW REVENUE SHOULD GO TO EDUCATION: The budget forecast sets the stage for the pending discussions during the 2015 legislative session about which causes require and deserve the most funding (Weidenbener, *Statehouse File*). After the projections, Kenley said some of the new money will be directed to education. "I think the focus on school funding reflects the right priority," he said. "I think that a lot of the suggestions about overall funding are pretty ambitious so far. They are going to have to be prioritized within a smaller number of dollars than they appear to be asking for." State Superintendent Glenda Ritz, a Democrat, recently appeared before the State Budget Committee and requested its

members set aside money to provide free textbooks for all Hoosier children. Kenley said Thursday that he is more focused on providing more money to high-performing teachers in the state rather than funding a program to provide free textbooks.

WHITE HOUSE TAKES ECONOMIC VICTORY LAP: The U.S. economy has taken major strides this year in rebounding from the Great Recession, Obama administration officials said Thursday *(Politico*). Calling 2014 a "milestone" year in the recovery, National Economic Council Director Jeffrey Zients noted that economic growth has averaged 4.2 percent over the last two quarters, the strongest six-month period in over a decade. Other economic bright spots include rising home prices, a reduction in the nation's foreclosure rate and a burst in job-creation, he said. "We've already added more jobs, 2.65 million jobs, this calendar year through November than any full calendar year since 1990," said Zients, who joined U.S. Labor Secretary Thomas Perez and Cecilia Muñoz, director of the Domestic Policy Council, in a media briefing to highlight the Obama regime's accomplishments. Job growth this year has been taking place in sectors with higher-than-average wages, Zients said, such as business services, technology and manufacturing. The rate of new jobs added by manufacturers, at roughly 15,000 per month, is currently double last year's pace. President Barack Obama declared 2014 to be a "year of action" on the economy, and his representatives were keen to point out their policy successes, such as increased federal investment in advanced manufacturing research. Implementing the president's economic vision, said Perez, will ensure that economic growth "results in shared prosperity, in an economy that works for everybody."

U.S. BLAMES N. KOREA FOR SONY HACK: With U.S. intelligence analysts quietly pointing to North Korea as having a hand in the destructive hack of Sony Pictures Entertainment computers, Obama administration officials scrambled Thursday to consider what, if anything, they should do in response (*Los Angeles Times*). Options are limited, partly because the United States already imposes strict sanctions on North Korea's economy and because the country's leader, Kim Jong Un, relishes confrontation with the West. White House officials are wary of playing into an effort by nuclear-armed North Korea to provoke the U.S. into a direct confrontation. "How do you sanction the world's most heavily sanctioned country?" asked John Park, a specialist on Northeast Asia at Harvard University's John F. Kennedy School of Government. Hackers caused tens of millions of dollars in damage last month to Sony Pictures' computers, destroyed valuable files, leaked five films, four of them unreleased, and exposed private employment information including 47,000 Social Security numbers. In response to the cyberattack and a threat against movie theaters, Sony canceled the Christmas Day release of "The Interview," a comedy starring Seth Rogen and James Franco that

depicts a fictional assassination of Kim. The Obama administration has stopped short of saying openly that North Korea was involved in the intrusion

U.S. TO RATE COLLEGES: In a report due out on Friday, the Obama administration will offer its first public glimpse of a planned system for rating how well colleges perform, saying it plans to group schools into just three broad categories — good, bad and somewhere between (*New York Times*). In detailing what elements the system is likely to contain, the Department of Education also revealed how dauntingly complex the project has been, and how it continues to be hampered by the limitations of the data available. The department labeled what the Friday release calls a "draft framework," much of it subject to change, with a lot of work still to be done before it produces a first version of an actual rating formula. Officials said that first system should become public before the start of the next school year, about eight months away, but even then, it will remain a work in progress, to be upgraded as problems arise and better data become available. One fairly firm conclusion, said Ted Mitchell, under secretary of education, is that the department will assign each college one of three ratings, with the great majority of schools falling into the middle category, between high-performing and low-performing. "We want to avoid the false precision that we believe plagues lots of ratings," he said. "We think the top and the bottom will be relatively small categories."

PUTIN DOWNPLAYS ECONOMIC WOES: President Vladimir V. Putin tried to play down Russia's dire economic straits in his annual news conference on Thursday, attributing the troubles to declining oil prices that, following a short period of economic turbulence, were bound to recover along with global demand (*New York Times).* "We are going through a trying period, difficult times at the moment," Mr. Putin said at the three-hour get together with 1,200 reporters from Russia and around the world. "I would not call the situation a crisis. You may call it whatever you want." Russia's oil and gas-dependent economy crashed this week, with the ruble testing historic lows of 80 to the dollar before rallying to closer to 60, still down about 40 percent on the year. Analysts said the panic reflected not just the oil price drop but investors' distrust of the government's ability to cope with the crisis or to promote economic growth through something other than the extraction of natural resources. "Economically, socially and politically, the country will have to go through severe economic tests in the years to come," said Dmitri Trenin, the head of the Carnegie Moscow Center. "Not having a working, realistic, credible model for economic development, not just muddling through, will become critical." Addressing these concerns, a relaxed, at times even jovial Mr. Putin repeated several times that he thought the Central Bank of Russia and the government overall were doing the right things to halt the ruble's nose-dive, if acting slightly late. "I believe that the central bank and the government are taking adequate

measures," he said. "They won't leave it alone, because they will always seek to chain it," he said. "Once they manage to chain it, they will rip out the teeth and claws." The teeth and claws in this case are nuclear deterrence, he said.

HPI DAILY ANALYSIS: Sony Pictures made a stupid movie, didn't protect itself, and then caved to North Korea. Newt Gingrich called it the losing battle in the first cyber war, which is also a dumb assessment (i.e. remember the U.S. turning off Syria's air defenses for Israel could take out a nuke plant; or the Iranian centrifuge operation). - *Brian A. Howey*

Revenue Forecast

GOV. PENCE WILL 'EXERCISE CAUTION': "This revenue forecast confirms the growth we are seeing across our state and should be an encouragement to every Hoosier," said Gov. Mike Pence Thursday (*Howey Politics Indiana*). "While the December revenue forecast projects economic growth for our state, Hoosiers may be assured that our Administration will continue to exercise caution as we finalize our recommended budget for the next two years." The state revenue forecast comes on the heels of the Indiana Economic Outlook 2015 Forecast, published by the Ball State University Center for Business and Economic Research, which predicts an increase in the state's gross domestic product of 3.4 percent and an increase in personal income of 3.3 percent. It also follows solid revenue growth year over year in the current fiscal year. The Governor sounded a note of caution following flat revenue in fiscal year 2014 and the downward revision of the fiscal year 2015 estimate by $129 million from the December 2013 estimate.

CHAIRMAN BROWN REACTS: House Ways & Means chair Tim Brown, R-Crawfordsville, issued the following statement about today's revenue forecast (Gherardi and Spehler, *WXIN-TV*): "When considering today's revenue forecast, first and foremost, our focus should be on how this projection impacts Hoosiers all across the state. The forecast indicates signs of an improving economy, which means a brighter future for Hoosier families. After all, state government benefits from additional tax dollars only when Hoosiers are employed and have extra dollars to spend in the local economy. The numbers we saw today made it clear that Indiana is economically outperforming all of its neighbors, which is a direct result of the hard-fought economic policies put into place over the past decade. Many of the policies were challenging to enact, but there should be no doubt that these policies have paid dividends for Hoosier

families. The existence of new, spendable revenues will create challenges as well as opportunities when it comes to crafting the next biennial budget. Therefore, we must remain vigilant, in holding to the principles of fiscal discipline, that created the favorable financial position we enjoy today; mainly the principle that government should always live within its means. The new revenue and economic forecasts give us many reasons to be optimistic about the future of Indiana's economy but most importantly, the continued economic prosperity of Hoosier families."

ZODY REACTS: Indiana Democratic Party Chairman John Zody released the following statement Thursday following the release of the state's revenue forecast (*Howey Politics Indiana*): "Today's revenue forecast will force Governor Pence to make some tough choices. The question is, will he make the right choices for Hoosiers, or for his Presidential primary campaign? The lack of dollars coming in shows our state is struggling to meet its most basic needs and has proven unable to fulfill many of the duties required by state law. Roads, education and child services – these are just a few of the crucial public services where state government fails Hoosiers the most due to the lack of funding, or due to mismanagement in agencies like the BMV. All the while, the Governor continues his crusade against public and early childhood education. Personal income in Indiana is still nearly $10,000 than it was 10 years ago, and a report released in October ranked us last in personal income growth. Indiana Republicans should join with Democrats to right these wrongs for middle class Hoosiers. More educational opportunities for our children, and more money in the pockets of our hard working men and women means money injected into the economy now and in the future. It's simple math and logic that the GOP does not seem to understand. As long as Governor Mike Pence continues to hoard money for his surplus and fight wage increases while telling Hoosiers to do more with less, it is hard for anyone to see the light at the end of the economic tunnel in Indiana."

TALLIAN REACTS: Sen. Karen Tallian, D-Portage, said despite the good news of a growing Indiana economy and revenue, most agencies came in with budget requests that reflected a 3 percent budget cut right off the bat (Kelly, *Fort Wayne Journal Gazette*). And the Indiana Commission for Higher Education left out what is expected to be $90 million in new costs to fund the 21st Century Scholars Fund, which is an entitlement. "The governor needs to re-evaluate what he is doing. We are cutting services, letting our roads disintegrate, and risking educational obligations in order to fund his savings account. When is enough, enough?" Tallian asked. The Indiana surplus is expected to be at $2.17 billion in June. "We hear the governor insisting on additional reversions and promising little or no new spending," she said. "The truth of the matter is that agencies providing services are hurting – even if they won't or can't admit it."… "Today's revenue forecast set the stage for yet another year where Hoosiers will be

shortchanged while the governor pads his surplus," Tallian said (Weidenbener, *Statehouse File*). "The governor needs to reevaluate what he is doing. We are cutting services, letting our roads disintegrate, and risking educational obligations in order to fund his savings account."

PORTER REACTS: State Rep. Gregory W. Porter (D-Indianapolis), ranking Democrat on the Indiana House Ways and Means Committee, issued the following statement Thursday on the revenue forecast offered today to the State Budget Committee (*Howey Politics Indiana*): "It would be great to be happy about the fact that there will be an overall increase in state revenues over the next biennium, but we cannot do that without admitting that we are giving the people of Indiana an incomplete picture about the way we fund state government. For all the talk today, there is only one number that means anything when it comes to the way this administration runs your government: $2 billion. That is their cherished figure because it represents a surplus amount that is supposed to show the world that Indiana is being run the right way. So it really doesn't matter how much additional revenue our state expects to get, until you try and figure out how the administration will game the numbers to keep $2 billion in the bank at whatever cost. Past practice will indicate that services will run a poor second to keeping the bottom line healthy. We are still relatively early in the process of writing a new biennial state budget, but plenty of warning flags have been raised. The state's Department of Child Services (DCS) needs at least 77 new case managers to provide adequate services to Hoosier children at risk. However, agency officials have said they won't seek the funding for these positions…positions that could have been easily funded if DCS hadn't been so intent on reverting hundreds of millions of dollars back to feed the surplus. While the state Department of Health might claim that reducing infant mortality and tobacco usage are its two top priorities, the agency's budget proposal contains no new money for tobacco cessation and no funding at all for preventing infant mortality. The state Board of Accounts has finally come clean about its inability to do its job as a fiscal watchdog for local units of government, thanks to inadequate funding."

GOODIN REACTS: "With the forecast, is there enough money to do everything the Governor wants to do? I don't know," said State Representative, Terry Goodin (D – Austin) (Gherardi and Spehler, *WXIN-TV*). Goodin sits on the budget committee. With modest revenue gains, he's not so sure spending in the Hoosier state will be what it once was. "We have to approach this next budget writing session very cautiously. I think Senator Kenley said it well and so did Representative Brown that we're cautiously optimistic and I think we've all got to take that position as we move forward," he said.

Campaigns

2016: PETE SEAT ADVISES PREZ HOPEFULS TO 'JUST RUN' - Former Florida Gov. Jeb Bush's announcement this week that he is actively exploring a presidential bid is causing ripple effects as the 2016 electoral picture begins taking shape (Smith, *Indiana Public Media*). Pete Seat is a former spokesman for the Indiana Republican Party, Sen. Dan Coats, R-Indiana, and the Bush administration. He says presidents can't defer decisions of international or national importance once they're in office, so he asks why presidential candidates should get to do so when deciding to run. "If an individual believes that he or she is the most capable of occupying the Oval Office and the role of President of the United States, they should just run for the job," Seat says. Seat says that includes Gov. Mike Pence, who's received lots of attention regarding a potential candidacy but says he won't decide until next year. Don Cogman is the author of "Run Mitch, Run" about former Gov. Mitch Daniels' near-candidacy for president. Cogman, who was part of the circle of advisors for Daniels' decision, says it's not just the candidate who has to make the choice. "It's a difficult decision and it just depends on the family situation and sort of where they are in that particular stage of their life," Cogman says. Seat acknowledges that the upcoming legislative session could delay Pence's decision but notes there's rarely a perfect time for candidates to announce they're running for president.

2016: LoBIANCO REVIEWS 'TAKES' ON POTENTIAL PENCE PREZ BID - Gov. Mike Pence's flirtations with a White House run are continuing to draw national media attention to the Crossroads of America and the Indiana Statehouse (LoBianco, I*ndyStar*). Inside the state, Pence is perceived as a humble governor, known as much for his affable demeanor as the grueling battles he's had with Democratic state schools chief: Superintendent of Public Instruction Glenda Ritz. But in Washington, he's weaving a message of being an effective governor with the right solutions for Washington. Here's a quick rundown of national perspectives on Pence which have come out in the past week. As The Star's new political reporter/analyst, I've included a few of my own thoughts at the end of each blurb.

2014: MADISON CO. ELECTION BOARD ALLEGES FAMILY VOTER FRAUD - The Madison County Election Board believes three members of the family of Anderson city councilman Ollie H. Dixon have violated state election laws (de la Bastide, *Anderson Herald Bulletin*). The Election Board on Wednesday sent three letters, including documents in support of allegations of illegal activity by Dorothy Dixon, Dixon's wife, and his two daughters, Tamie Dixon-Tatum and Delisha Dixon, to Madison County Prosecutor Rodney Cummings. All three letters state the Election Board has found substantial reason to believe election laws were violated. Cummings said he will review the documents and determine whether an investigation should be conducted. He said the Indiana State Police would be asked to conduct the investigation. The Election Board earlier this year conducted several meetings concerning allegations raised by Major Brian Bell of the Madison County Sheriff's Department. Bell lost the Democratic Party nomination for sheriff in the May primary to Scott Mellinger, who defeated Republican Bruce Dunham and Libertarian Tim Basey in the November election. "My family has done nothing wrong," Dixon said. "It shouldn't matter as long as you only vote one time."

General Assembly

CASINOS CITING FIGURE THAT 25K HOOSIER JOBS IN GAMING: With casino revenue in Indiana falling, the head of the Casino Association hopes a new study will show lawmakers how much the state's economy would lose if casinos began to fail (Steele, *WIBC)*. At Thursday's announcement of state revenue projections for the coming year, the State Budget Committee learned that gaming taxes were more than 16-percent lowering than the same period of the previous budge year and about the same amount lower than the budget forecast from December 2013. That's because casinos aren't making as much money due in part to increased competition from neighboring states, and that's why the American Gaming Association commissioned the study from Oxford Economics. "It's important for the public and policy makers to get an idea of where we really stand when it comes to gaming revenue and jobs," said Mike Smith, former state representative and the president of the Casino Association of Indiana. The study says casinos, even though they aren't making as much money, still have an economic impact of more than $4 billion statewide. More importantly, Smith says, they are responsible for more than 25,000 jobs either directly or indirectly. "That's a pretty significant number when you look at a state of 6.5 million people," Smith said. "We have an unemployment rate of 5.7-percent right now, and the study calculated that rate would be 6.9-percent without the jobs tied to casinos." Those jobs are also in areas that otherwise wouldn't have them, Smith said. "When you go back to the 1993

law that legalized gaming, it was all intended to put these casinos in areas that had a depressed economic environment." The casinos still generate more than $700 million in gaming taxes for the state each year, but Smith says that could dwindle if lawmakers don't provide some help in the coming session. "There are properties that want to be able to move their properties on land instead of the boat. The two racetrack casinos would like to have live dealers at the table games that are currently automated," Smith said

CASINOS HOPE REVENUE WILL PROMPT LEGISLATIVE REFORMS: Casinos though were dealt the hardest hand of the year. Competition from casinos in neighboring states led to lower casino revenues here in Indiana (Gherarid and Spehler,*WXIN-TV*). The industry is now hemorrhaging money, with revenue dropping 30% in November alone. "From our peak, we're down about 4,000 machines. That would be like eliminating four casinos the size of Tropicana in Evansville," said Indiana Casino Association President, Mike Smith. What once was a winning source of revenue for the state is down nearly 10% from last year. "As time goes on, hopefully we can get some of our issues resolved at the legislature," said Smith. Many lawmakers, in an attempt to get that source of revenue closer to where it once was, are looking to pass pro-casino legislation in the upcoming session.

PELATH SAYS JOB ANNOUNCEMENT 'HYPE' IGNORES INCOME GAP: Indiana House Democratic Leader Scott Pelath from Michigan City issued the following statement Thursday in response to Gov. Mike Pence's announcement the same day about job creation this year (*Howey Politics Indiana*): "By now, most people are deservedly skeptical about these Hollywood productions designed to trumpet Indiana's alleged economic successes. All this sound and blather is at the service of jobs that 'might' be created over the next few years. By the time those years pass, and few of these jobs become reality, the administration will have moved on to other grand announcements about more jobs that 'might' be created even more years down the road. I suppose it makes people feel good, but I don't know if it helps at a time when Marion General Hospital is cutting 69 jobs, or Rolls-Royce in Indianapolis is cutting 200 jobs, or Union Hospital in Terre Haute is losing 150 jobs by the end of this year, or IU Health is losing 120 jobs by shutting down its proton therapy center. I know those job losses are happening, but those aren't the kinds of things that cause governors to conduct grand press conferences in the rotunda of the Indiana Statehouse. Those are the dirty little realities that politicians hope people ignore, but are all too commonplace for the people whose lives are disrupted. And even if you choose to keep your rose-colored glasses firmly in place, even the governor cannot deny the fact that Indiana may be a place that works, but it isn't paying its workers as much. According to the U.S. Census Bureau, Indiana's average household income has dropped from $53,482 in

2002 to $46,974 in 2013. Hoosiers rank 39th in per capita income, earning just over 87 percent of the U.S. average."

SEN. ARNOLD SAYS SUNDAY SALES COULD HELP REVENUE: The state of Indiana has a long history of banning carry out alcohol sales on Sundays (*WNDU-TV).* Some suspect this could this be the year lawmakers make history by changing that policy. "Now it's time for us to start looking for new ways of bringing in revenue," says Indiana Senator Jim Arnold. "We're competing with Michigan and, of course, I represent the area that borders Michigan right here. I haven't had any strong empirical data back from the Licensed Beverage Association about their feelings of it, and I know that most of them are probably against it because they feel they have to be open on Sunday, but the fact remains, maybe we're losing a number of sales across the line to Michigan. It's time to for us to step into the modern day." Arnold sits on the senate committee that would hear a Sunday sales bill. His son-in-law, Representative Tom Dermody, chairs the house.

REP. WESCO FEELS HIGHER PERFORMING SCHOOLS UNDERFUNDED: Some Indiana lawmakers feel the state's highest performing school districts are being underfunded (Peterson, *WNDU-TV*). Ind. Rep. Timothy Wesco, (R) Osceola is among those who plan to fight for 'equity' in the school funding formula. "The top ten worst performing school corporations in the state get 30 percent more in funding than the top ten best performing school corporations in the state," said Rep. Wesco. In Indiana, the average per pupil expenditure is $11,015. Larger urban school districts like the South Bend Community Schools tend to exceed that average at $12,577 (Mishawaka's per pupil expenditure is $12,100), while suburban or rural districts like Penn Harris Madison and John Glenn tend to be below the state average: PHM's per pupil expenditure is $10,125 and John Glenn's is $9,151. "So we're kind of looking at that money and saying its, we're investing all this additional funding into these school corporations and we're not seeing a return," said Rep. Wesco. "It's not bringing them up to the level of being the best so how could we be smarter about this?"

REP. WESCO WANTS SALES TAX, NOT GAS TAX FIX FOR ROADS: A local state lawmaker will soon hit the road with road funding on his mind *(WNDU-TV).* When Indiana Representative Timothy Wesco drives to Indianapolis in January for the start of the 2015 session of the general assembly, he'll do so with the goal of raising more money for road repairs. Wesco doesn't want to increase the sales tax on gasoline, but he does want to increase the amount of tax that funds roadwork. "Currently about 20 percent of the 7 percent sales tax that's currently paid on gasoline goes to roads," says

Wesco. "I would like to double that in this coming session and make it 40 percent." Wesco is still awaiting the results of a fiscal impact study but suspects the proposal would raise "hundreds of thousands of dollars" for road repairs.

Congress

DONNELLY ANNOUNCES COMMITTEE ASSIGNMENTS: Thursday, U.S. Senator Joe Donnelly announced his committee assignments for the 114th Congress (*Howey Politics Indiana*). He will continue to serve on the Senate Armed Services Committee, Agriculture Committee, and Special Committee on Aging. Starting next year, he will also serve on the Senate Banking, Housing, and Urban Affairs Committee. "I look forward to continuing my work on behalf of servicemembers on the Armed Services Committee, especially in the area of mental health," said Donnelly. "Further, there is ongoing work in the Agriculture Committee to properly implement the five-year Farm Bill and meet the needs of our ag sector. We have more to do in the Aging Committee, also, in the area of the protecting seniors from scams and fraud. "Finally, I look forward to the new opportunity to represent Hoosiers on the Banking Committee. From this new committee, I will be able to address issues affecting Indiana financial institutions and their customers, economic development, housing, and export financing."

BROOKS ADDRESSES PARTY POLITICS IN Q & A WITH USA TODAY: U.S. Rep. Susan Brooks talked with *USA TODAY* about her first term and the advantages and responsibilities Republicans will have next year when they will take over the Senate and expand their majority in the House (Groppe, Gannett). Question: When you were sworn into office, Congress' approval rating was 14 percent. It's now 16 percent. Is that progress? Answer: Obviously it's not the progress that the American people are hoping for, but the fact that our approval rating is slightly up is a small victory. But it's certainly not satisfactory. Part of why I ran — and one of our themes during the campaign — was trying to restore some confidence in Congress. The fact that only 16 percent of the American people like the way we do our job isn't good enough for me. There were opportunities in my first term that I have tried to take to restore some of that confidence in Congress. One was accepting the appointment to the Ethics Committee. ... That is a type of assignment that actually I hope allows my constituents to realize that members of Congress are certainly not above the law, not above the rules, and that's what this committee is in place to do.

BROOKS ADDRESSES BENGHAZI WORK, FUTURE CMTE ASSIGNMENTS: Q: You were appointed to the House committee investigating the 2012 attack on the American consulate in Benghazi, Libya (Groppe, Gannett). The panel will continue its investigation next year, even though the GOP-led House Intelligence Committee concluded last month that the Obama administration responded appropriately to the attacks. Why should this probe continue? A: The House Intelligence Committee's report was actually only focused on the intelligence part of the administration's role. It did not address the State Department's role or the White House's role ... so that's why our work is continuing. It really will heat up again beginning with a hearing in January. I think you will begin to see more regular hearings than what we've had thus far because there still are many questions that remain. Q: Your biggest committee assignment next year will be the Energy and Commerce Committee. Have you already started hearing from businesses, particularly those in Indiana, about issues they want the committee to address? A: Absolutely. I have heard from the health care community. ... Repeal of the medical device tax (included in the Affordable Care Act) is significant for the state of Indiana. That is a top priority. I have also heard from the energy sector ... (which) is very excited about my placement on the committee as well. I'm also on the Commerce, Manufacturing and Trade Subcommittee. With Indiana being one of the top manufacturing states in the country, I'm anxious to talk to a lot of manufacturers ... (to find out) what are the regulatory issues, what are the tax issues, that are impeding their growth?

State

GOVERNOR: PENCE MAKES END-OF-YEAR JOBS ANNOUNCEMENT - Gov. Mike Pence and executives from 16 companies announced new investments Thursday that are expected to bring 2,153 jobs to Indiana within what state officials are calling "the next few years (TenBarge, *Statehouse File*)." But actually, some of those jobs won't be created until 2023. Still, Pence lauded the deals – which involve tax credits and other incentives – as key to the state's economic growth. "From tech developers to manufacturing powerhouses, the collective energy of these Hoosier businesses will help power our economy into 2015, creating jobs, promoting opportunities and investing in our future," Pence said. Overall in 2014, the Indiana Economic Development Corporation announced it had secured job commitments from 285 companies from across the country and around the world. The companies anticipate investing $4.38 billion in their operations and are expected to create 25,317 jobs over the next decade. The new positions are projected to pay an average of $21.75, which is higher than the state's current average hourly wage of $20.17. The companies received tax credits, training grants and other incentives to either move to or expand in Indiana. In response to Pence's announcement, House Minority Leader Scott Pelath, D-Michigan City, said he

doesn't think the state's economic problems are solved by the jobs announcements. "I suppose it makes people feel good, but I don't know if it helps at a time when Marion General Hospital is cutting 69 jobs, or Rolls-Royce in Indianapolis is cutting 200 jobs, or Union Hospital in Terre Haute is losing 150 jobs by the end of this year, or IU Health is losing 120 jobs by shutting down its proton therapy center," Pelath said.

EDUCATION: GIVEN 1,800 APPLICATIONS, PRE-K PILOT EXPANDED TO 450 - Indiana's Office of Early Childhood and Out-of-School Learning (OECOSL) has received more than 1,800 applications from families in Allen, Lake, Marion and Vanderburgh counties who would like to enroll their 4-year-old children in the first phase of the On My Way Pre-K program beginning in January of 2015 (Howey Politics Indiana). "I am truly grateful to the many community partners who helped us reach out to families and open doors of opportunity for quality pre-k education to 1,800 disadvantaged children in our state," said Governor Pence. "The initial response to our pilot program confirms the need for high-quality early education for our most disadvantaged kids, and our Administration will continue to faithfully implement this program and determine how we might best serve more Indiana children in the years ahead." The goal for the first phase of On My Way Pre-K, which starts in January 2015, was to enroll a total of 350 children; however, with the demand being so great, OECOSL is looking to enroll 100 additional children in January for a target enrollment of 450

EDUCATION: PRIVATE SCHOOLS TO RETURN $3.9M IN VOUCHER FUNDS - Eighty of the more than 300 schools involved in the state's voucher system announced Wednesday they will return $3.9 million in voucher scholarship funds to the Indiana Choice Scholarship Program (Morello, *State Impact Indiana*). A new study on tuition and financial aid practices, released by the Indiana Non-Public Education Association, found the group overpaid those schools over the course of three years due to unintentional errors in calculating voucher costs. John Elcesser, executive director of the INPEA, tells The Indianapolis Star that most of the errors happened because schools forgot to apply discounts for parishioners (at Catholic schools), families enrolling more than one child or employees. He adds that families were not overcharged… A spokesman for state superintendent Glenda Ritz says her office is reviewing the information, according to the Associated Press.

EDUCATION: SHELBY CO. SCHOOLS WANT E-LEARNING ON SNOW DAYS - Officials with the Northwestern Consolidated Schools of Shelby County say teachers should still teach their students online when traditional school days are canceled because of snow (*Network Indiana*). The district filled out an application for e-learning

with the Department of Education, and has spent the last few months preparing teachers and students for the possible program… Superintendent Shane Robbins says he thinks implementing e-learning on snow days will prove effective compared to other alternatives. "We feel like what we're going to be able to on those snow days is far better and greater in preparing our students than it will be to tack days on at the end of the school year, when most of our kids have already checked out and are ready for summer vacation," Robbins said. In order to make the virtual learning effective, each teacher has to have online office hours and is required to have a Google Drive website with lesson plans available.

COURTS: SUPREME COURT SUSPENDS MUNCIE JUDGE - The Indiana Supreme Court on Thursday afternoon suspended Dianna Bennington from her duties as Muncie City Court judge "until further notice of this court (Walker, *Muncie Star Press*)." The order suspending the 43-year-old Muncie judge with pay — "effective at 12 a.m. Friday" — was signed by Indiana Chief Justice Loretta H. Rush, and issued shortly before 5 p.m. The action came a week after the Indiana Commission on Judicial Qualifications, which oversees Hoosier judges, filed a complaint against Bennington, citing 13 counts of misconduct. The commission alleged Bennington had abused her judicial power, taken "certain judicial actions" without the "legal authority to do so," and "engaged in injudicious and prejudicial public conduct related to her personal life."

ECONOMY: STATE WILL SEE GROWTH, BUT DEMOGRAPHICS A DRAG - A top U.S. economist is weighing in on the state of Indiana's economy (Corbin, *WIBC*). IHS Global Insight Chief U.S. Economist Douglas Handler told a committee of state lawmakers that economic growth in Indiana remains higher than in neighboring states. Handler says employment, personal income and real gross state product will all show slight gains in 2015. He says unemployment should drop to 5.5 percent. However, he adds that employment growth will slow due to large numbers of aging workers leaving the workforce nationwide. Manufacturing, especially the resurgence of the auto sector, is cited as key in Indiana's economic health. Handler says continued low gas prices could save Americans $1000 a year or roughly $20 per week. He adds that wage gains, auto sales and housing starts should remain steady.

TRANSPORTATION: NEW STATE APP WILL PROVIDE HAZARD INFO - Hoosiers now have access to a free mobile app that provides county travel status updates and alerts (*Network Indiana*). In addition to weather, the app, called Travel Advisory, includes notifications about flooding, hazardous materials spills and other events that could affect travel. Last winter, the Indiana Department of Homeland Security County

Travel Status Map was the most visited page on IN.gov, generating nearly 5 million unique visitors between the beginning of December 2013 and March 2014. The app is meant to be used as part of a system to stay aware of changing travel conditions.

Nation

WHITE HOUSE: CASTRO VISIT POSSIBLE - The White House said Thursday it wouldn't rule out a visit by Cuban president Raúl Castro to Washington for a meeting with President Obama *(The Hill).* "The president has had the leaders of both Burma and China to the United States," White House press secretary Josh Earnest said. "And for that reason, I wouldn't rule out a visit from President Castro."

IRS: AGENCY WARNS OF SHUTDOWN - The IRS is considering its own temporary shutdown due to recent budget cuts enacted by Congress, its chief said Thursday*(Politico*). IRS Commissioner John Koskinen said furloughs — forced unpaid days off for employees as part of an IRS closure — is one idea reluctantly being tossed about to save money, though they are hoping they will not have to go there. "There is no way we can say right now that that won't happen," Koskinen told reporters at a press conference on the upcoming tax season. "Again, I would stress that would be the last option." He said a one-day closure would save an estimated $29 million. The news comes a day after Koskinen warned IRS employees that overtime would be suspended and a hiring freeze enacted.

SECRET SERVICE: CALLS FOR MAJOR CHANGE - An independent panel on Thursday recommended sweeping changes at the Secret Service, saying the elite protective agency is "starved for leadership" and calling for an outsider as director, hundreds of new agents and officers, and a higher fence around the White House (*Washington Post*). The panel, created in October after a series of highly publicized security failures, said the fence protecting the executive mansion should be raised at least four feet to make it less vulnerable to jumpers. Panel members were reacting to a Sept. 19 incident in which a man scaled the fence and ran far into the White House through an unlocked front door. The four-member body also urged expanded and intensified training for agents, saying the service should run crisis response scenarios that possibly use a mock White House. The report especially targeted the Secret Service's highly insular culture, calling for new leadership from outside to shake up the agency — a suggestion sure to rankle some in the service's old guard. "The problems exposed by recent events go deeper than a new fence can fix," said the report's

executive summary, the only portion publicly released. “We believe that at this time in the agency’s history, the need for Service experience is outweighed by what the Service needs today: dynamic leadership that can move the Service forward into a new era and drive change in the organization.”

CUBA: POWELL BACKS CHANGE - President Obama announced Wednesday that more than 50 years after the U.S. cut diplomatic ties with Cuba, he would begin normalizing relations between the two countries. While critics from both parties voiced their concerns, some officials are optimistic” (*CBS News*). “This is still a terrible regime. We don't support their form of government. We don't like what they're doing," former Secretary of State Colin Powell said Thursday on "CBS This Morning." "But I think having diplomatic relations, as we have had with the Soviet Union, with Vietnam and so many other places, we can produce positive change." President George W. Bush supported the economic embargo on Cuba as did Powell during Mr. Bush's first term. Eleven years ago, Powell opposed relaxing restrictions against Cuba because he believed Fidel Castro would use it to enhance his power.“"Over the last 50 years I have watched this policy unfold, and I have been a part of it," he said. "And as secretary of state ... I supported it and even strengthened the sanctions against Cuba. But I think it's time now to turn that page of history."

MEDIA: COLBERT LIVES ON! - Instead of Stephen Colbert killing off his ultra-conservative pundit alter-ego on the final episode of “The Colbert Report” (as many assumed), he went with something different: Immortality (*Washington Post)*. It’s true: In the end, Colbert’s famous character, champion of America and truthiness, will live forever. Although at first, it didn’t seem like we would get such a definitive ending to the long-running Comedy Central show. “I am an emotionless, igneous news rock,” Stephen Colbert informed the audience at the beginning. Technically, he said it at the very end of “The Daily Show,” when Jon Stewart briefly cut to Colbert’s set to see how his real-life pal was holding up on his last night on Comedy Central. Colbert stayed in character and acted entirely nonplussed as Stewart’s show led into his for the final time, and the crowd chanted its typical “Steph-en! Steph-en!” chant. Colbert stood up and soaked in the applause, but then sat down at his desk for business as usual. He got in some jokes and reflected on all of the things that he had given to the nation over nine years (truthiness, mostly). He reflected on his more famous moments, such as running for president; starting a Super PAC; and the Rally to Restore Sanity and/or Fear. Colbert also looked back at when his show started (2005) and how many things were still the same in 2014. And that was okay by him. “If all we achieved over the last nine years was to come into your home each night and help you make a difficult day a little better — man, what a waste,” Colbert said, but offered this: “Nation I want you to know, if i had to do it all again, if I could do it with you, I would do it the same.” And then things

got weird. During what seemed be a routine intro to his famous "Cheating Death With Dr. Stephen Colbert, D.F.A." bit, Colbert faced off with his usual friend, the Grim Reaper ("Grimmy"). Would Grimmy finally off Colbert's character, putting an end to it all before real-life Colbert takes over "The Late Show" next year? Nope — Colbert accidentally shot and killed Grimmy. "I just killed death, I am immortal!" Colbert roared.

THE EPIC CAMEO: Colbert bid farewell to his audience by singing 'We'll Meet Again,' with Jon Stewart joining him by a piano manned by Randy Newman. ... There was Willie Nelson, Doris Kearns Goodwin, James Franco, Arianna Huffington, Jeff Daniels, Keith Olbermann, Samantha Power, Shane Smith, Katie Couric ... And then there was Ken Burns, Cyndi Lauper, Mark Cuban, Patrick Stewart, Michael Stipe, and Matt Taibbi, Sam Waterston, Paul Krugman ... [and] Mike Huckabee, Grover Norquist, Bill Clinton, and Henry Kissinger.

EDUCATION: PUBLIC UNIVS DEPEND MORE ON TUITION, THAN STATE FUNDING - According to a new study by the U.S. Government Accountability Office, these schools now receive a greater portion of revenues from student tuition than from state funding (*The Atlantic*). The study looked at the total breakdown of college revenues between 2003 and 2012. In 2003 state funding accounted for 32 percent of total revenues, while student tuition supplied just 17 percent. By 2012, the tables had turned: Students paid for 25 percent of total revenue, while states funded 23 percent. The additional revenue comes from federal grants and other sources, including private gifts and grants and auxiliary revenue streams, like hospitals and football games. The increase in tuition revenue seems—logically—to have come from a hike in tuition. In 2012 dollars, the average net cost to students—a value that measures what students actually pay, after all expenses and financial aid—rose 19 percent, from $1,874 in 2003 to $2,226 in 2012.

SUNDAY TALK LINEUP: "Fox News Sunday": Sony and North Korea: House Intelligence Chair Mike Rogers ... Cuba: Sens. Ron Johnson and Ben Cardin ... Morrill Worcester, Wreaths Across America ... Panel: George Will, Judy Woodruff, Liz Cheney, Juan Williams; "Face the Nation": Sen. Marco Rubio, Sen. Lindsey Graham, Rep. Chris Van Hollen ... Jeffrey Goldberg ... Annual CBS News correspondent roundtable: State Department Correspondent Margaret Brennan, Congressional Correspondent Nancy Cordes, Chief Legal Correspondent Jan Crawford, Political Director John Dickerson, Chief White House Correspondent Major Garrett, National Security Correspondent David Martin; "Meet the Press": Sen. Rubio; CNN's "State of the Union": For her last show, Candy interviews President Obama and Sen. McCain.

Local

CITIES: EVANSVILLE CONVENTION HOTEL DEAL FALLS THROUGH - A deal to build a convention hotel in downtown Evansville has collapsed and taken down a $71.3 million plan that also included an apartment tower, parking garage and infrastructure upgrades (*Associated Press*). Mayor Lloyd Winnecke announced the development at a Thursday news conference with Old National Bank President Bob Jones. Jones says a consultant to the bank found the value of naming rights for the convention hall long known as The Centre isn't worth the money the bank was prepared to invest in the project. The Evansville Courier & Press reports the financing gap came to $6.5 million. The bank last year pledged to be an investor along with developer HCW after the City Council set a $20 million cap on public financing. Winnecke says he'll keep working on the project.

CITIES: EVANSVILLE IU MED CENTER NOT INLUDED IN HIGHER ED BUDGET REQUESTS - The Mayor's Office has confirmed that Indiana's Commission for Higher Education did not include the med center in its list of projects it wants the state to approve (Raatz, *WFIE-TV*). Both Mayor Winnecke and Pat Shoulders with IU say this is a hurdle they had planned for. Shoulders says the three public universities requesting public funding from the general assembly for their portion of the IU Med School are IU, USI, and Ivy Tech. The officials on the front lines of getting this IU Med School project through its final hurdles still say they believe this project will happen.

CITIES: ELKHART ANNEXATION PLAN FACES THREE LAWSUITS - After an initial court date was pushed back past the New Year, road blocks to the annexation of three key areas in the City of Elkhart's 2015 plan are mounting (Hickey, *WNDU-TV*). There are currently three pending lawsuits that dispute the annexation of areas six, seven and eight, which were scheduled to be annexed on January 1 along with the other areas included in the plan. Members of the Elkhart "Stop Forced Annexation" group say they appeared at the Elkhart Superior Court Thursday only to learn that their hearing had been postponed due to the "judge's availability." Terry Karre, a homeowner in annexation area number eight and leader of the group opposing annexation, said he was not given a revised court date. The setback comes just days after the city distributed trash containers to the areas on the cusp of annexation with a note dated Dec. 15, 2014 welcoming the residents to the City of Elkhart

CITIES: FORT WAYNE COMPLETES FLOOD CONTROL PROJECT - Following a flood in 2013, the City of Fort Wayne began taking the steps to alleviate the problem which included the purchase of six homes which were demolished in order to provide an area to absorb floodwaters (*WANE-TV*). A larger stormwater pipe was also installed and other measures were taken, including the construction of a berm to block water from the Fairfield Ditch from entering the neighborhood.

CITIES: IMPD OFFICER ARRESTED ON 3 FELONY CHARGES - An Indianapolis Metropolitan Police Department officer was arrested Thursday on three felony charges, including official misconduct (Adams, *IndyStar)*. Officer Christopher Dickerson, a five-year veteran of the North District's operations division, was arrested on a warrant for felony charges of theft, obstruction of justice and official misconduct. The charges resulted from allegations that came from a November run Dickerson responded to, and his failure to follow department rules regarding proper handling of evidence. Detectives with IMPD and a special investigation unit were handling the investigation, which is still active, according to police. When the initial inquiry was complete, charges were filed by the Marion County prosecutor's office.

CITIES: INDY DEMS RAISE RED FLAGS OVER JUSTICE SITE - The proposed future home of the Marion County Jail could be in jeopardy after Democratic city-county councilors raised a red flag Thursday (Glavan*, WXIN-TV*). Questions are being raised after the release of emails between former city officials who worked on the troubled Regional Operations Center, or ROC. The ROC opened in the former Eastgate Mall ahead of the Super Bowl, as a place to make residents safer. However, just a year later it was evacuated after the building was deemed unsafe. A City-County Council committee has been investigating the circumstances surrounding the ROC's site and lease. Democratic councilors even went so far as to take the city to court, resulting in the release of the emails. "It shows a pattern. It shows a disregard for the process," said Councilor Joe Simpson. The emails seem to reveal that it was Mayor Greg Ballard, not former Public Safety Director Frank Straub as previously thought, who pushed for the east side location. "Drove by Eastgate, I'm a visionary (but) I thought it was horrible. It will be a long time before they get (that) space to look good," Straub said in one email.

CITIES: AMI INDUSTRIES PLANS 450 JOBS FOR MICHIANA BY 2017 - Governor Mike Pence and executives from 16 companies around the state announced over 2,000 new jobs are coming to Indiana, and some of the jobs are coming to Michiana (*WNDU-TV).* "Indiana's strong economy, fiscal responsibility and pro-growth

policies make days like this possible," says Pence. "Today's announcement includes some of the nation's fastest growing companies, and they have all either launched in Indiana or are choosing to move here." Heavy equipment parts manufacturer AMI Industries will invest $4.2 million to equip and expand agricultural component production in Plymouth. It will help create 250 new jobs by 2015. The company also plans to invest $4.35 million to equip and renovate its automotive manufacturing lines, creating 225 jobs by 2017.

COUNTIES: VANDERBURGH JAIL TO ADDRESS OVERCROWDING - New 2015 laws may cause a concern of overcrowding at the Vanderburgh County Jail (Kayser, *WFIE-TV*). Sheriff Dave Wedding says they are meeting with judges and the prosecutor's office to determine if they can do alternative sentencing, such as work release, and find ways so that overcrowding doesn't happen. House bill 1,006 will change the sentencing guidelines in Indiana and goes into effect July of 2015. This means more violent offenders or repeat offenders will serve longer sentences in the department of corrections and lower level offenders then have to go back into the custody of the county that their crime was committed. The Vanderburgh County Jail has nearly 500 inmates and its capacity is around 530.

COUNTIES: MARION SHERIFF DEPUTY ARRESTED ON RAPE CHARGE - A Marion County sheriff's deputy was arrested Thursday on a rape charge in a warrant issued out of Hendricks County (Adams, *IndyStar*). According to Hendricks County Superior court documents, rape charges against Deputy Craig Ryland were filed Nov. 30, and a $75,000 warrant for Ryland's arrest was issued Dec. 17. On Thursday morning, around 10:30 a.m., Ryland turned himself in, then immediately bonded out, said Hendricks County Sheriff's Department spokesperson Lt. Kelly Caldwell. Ryland, a 7-year veteran of the Marion County sheriff's department, was placed on unpaid administrative leave pending an ongoing investigation, according to Marion County Sheriff's spokesperson, Katie Carlson. He is a sergeant in the Marion County Jail.

Scott.A.Milkey

From: Espich, Jeff
Sent: Thursday, December 18, 2014 11:40 AM
To: Sharon Espich
Subject: Fwd: [Gov Clips] Howey
Attachments: 12-18-14 HPI Daily.pdf; ATT00001.htm; image001.jpg; ATT00002.htm; image002.jpg; ATT00003.htm; image003.jpg; ATT00004.htm

Sent from my iPhone

Begin forwarded message:

From: "Gilson, Katie" <KGilson@gov.IN.gov>
To: "Gilson, Katie" <KGilson@gov.IN.gov>, "Quyle, Lindsay" <LQuyle@gov.IN.gov>, "Cleveland, Bridget" <BCleveland@gov.IN.gov>, "Ahearn, Mark" <MAhearn@gov.IN.gov>, "Atkins, Chris" <catkins@gov.in.gov>, "Bailey, Brian (OMB)" <bbailey@gov.in.gov>, "Bauer, Zachary C" <ZBauer@gov.IN.gov>, "Berry, Adam (GOV)" <ABerry@gov.IN.gov>, "Brooks, Kara D" <kbrooks@gov.in.gov>, "Brown, Hannah" <HBrown@gov.IN.gov>, "Marshall, Sara (Cardwell)" <smarshall@gov.in.gov>, "Joyner Burroughs (Cissel), Jackie" <JJoynerBurroughs@gov.IN.gov>, "Crabtree, Chris" <CCrabtree@gov.IN.gov>, "Craig, Lindsey M" <LCraig@gov.IN.gov>, "Czarniecki, Cary (Lani)" <LaniCz@gov.IN.gov>, "Denault, Christina" <CDenault@gov.IN.gov>, "Espich, Jeff" <JEspich@gov.IN.gov>, "Fritz, Pam (GOV)" <pfritz@gov.IN.gov>, "Jarmula, Ryan L" <RJarmula@gov.in.gov>, "Kane, Kristen" <kkane@gov.in.gov>, "Vincent, Micah" <mvincent@gov.in.gov>, "Morales, Cesar (Diego)" <DMorales@gov.IN.gov>, "Myers, Janille" <JMyers@gov.IN.gov>, "Neale, Brian S" <BNeale@gov.IN.gov>, "Pavlik, Jennifer L" <JPavlik@gov.IN.gov>, "Pitcock, Josh" <jpitcock@sso.org>, "Price, Kendra" <kprice@gov.IN.gov>, "Schilb, Veronica J" <VSchilb@gov.IN.gov>, "Schmidt, Daniel W" <DSchmidt@gov.IN.gov>, "Simcox, Stephen" <SSimcox@gov.IN.gov>, "Streeter, Ryan T" <RStreeter@gov.IN.gov>, "Fernandez, Marilyn" <MFernandez@gov.IN.gov>, "Hodgin, Stephanie" <SHodgin@gov.in.gov>, "Karns, Allison" <AKarns@gov.IN.gov>, "Rosebrough, Dennis (LG)" <DRosebrough@lg.IN.gov>, "Cardwell, Jeffery" <JCardwell@gov.IN.gov>, "Dowd, Jaclyn (CECI)" <JDowd@ceci.in.gov>, "Keefer, Sean (GOV)" <skeefer@gov.IN.gov>, "Norton, Erin (Ladd)" <ENorton@gov.IN.gov>, "Johnson, Matt (GOV)" <MatJohnson@gov.IN.gov>, "Heater, Ryan" <RHeater@lg.IN.gov>, "Fiddian-Green, Claire (CECI)" <CFGreen@ceci.in.gov>, "Rosebrough, Dennis" <DRosebrough@idoi.IN.gov>, "Mantravadi, Adarsh V" <AMantravadi@gov.IN.gov>, "Rosebrough, Dennis (LG)" <DRosebrough@lg.IN.gov>, "Workman, James D" <JWorkman1@lg.IN.gov>, "McKinney, Ted" <TMckinney@isda.IN.gov>, "Bausman, David" <DBausman@isda.IN.gov>, "Atterholt, Jim" <jatterholt@gov.IN.gov>, "Davidson, Brenden" <BDavidson1@gov.IN.gov>, "Myers, Janille" <JMyers@gov.IN.gov>, "Fox, Joseph R" <JoFox@lg.IN.gov>, "McGrath, Danielle" <DMcGrath@gov.IN.gov>, "Brookes, Brady" <BBrookes@gov.IN.gov>, "Triol, Shelley" <STriol@idoa.IN.gov>, "Wall, Kathryn E" <KWall@gov.IN.gov>, "Reed, Katie" <KReed@gov.IN.gov>
Subject: RE: [Gov Clips] Howey

Katie Gilson, Staff Assistant
Office of Governor Mike Pence
KGilson@gov.in.gov<mailto:lquyle@gov.in.gov>
Phone: (317) 232-1198
Fax: (317) 232-3443
[cid:image001.jpg@01D01AB3.4C515090]<https://twitter.com/GovPenceIN>[cid:image002.jpg@01D01AB3.4C515090]<http://www.in.gov/gov/>[cid:image003.jpg@01D01AB3.4C515090]<http://www.in.gov/cutredtape/>

Scott.A.Milkey

From: Gilson, Katie
Sent: Thursday, December 18, 2014 11:11 AM
To: Gilson, Katie;Quyle, Lindsay;Cleveland, Bridget;Ahearn, Mark;Atkins, Chris;Bailey, Brian (OMB);Bauer, Zachary C;Berry, Adam (GOV);Brooks, Kara D;Brown, Hannah;Marshall, Sara (Cardwell);Joyner Burroughs (Cissel), Jackie;Crabtree, Chris;Craig, Lindsey M;Czarniecki, Cary (Lani);Denault, Christina;Espich, Jeff;Fritz, Pam (GOV);Jarmula, Ryan L;Kane, Kristen;Vincent, Micah;Morales, Cesar (Diego);Myers, Janille;Neale, Brian S;Pavlik, Jennifer L;Pitcock, Josh;Price, Kendra;Schilb, Veronica J;Schmidt, Daniel W;Simcox, Stephen;Streeter, Ryan T;Fernandez, Marilyn;Hodgin, Stephanie;Karns, Allison;Rosebrough, Dennis (LG);Cardwell, Jeffery;Dowd, Jaclyn (CECI);Keefer, Sean (GOV);Norton, Erin (Ladd);Johnson, Matt (GOV);Heater, Ryan;Fiddian-Green, Claire (CECI);Rosebrough, Dennis;Mantravadi, Adarsh V;Rosebrough, Dennis (LG);Workman, James D;McKinney, Ted;Bausman, David;Atterholt, Jim;Davidson, Brenden;Myers, Janille;Fox, Joseph R;McGrath, Danielle;Brookes, Brady;Triol, Shelley;Wall, Kathryn E;Reed, Katie
Subject: RE: [Gov Clips] Howey
Attachments: 12-18-14 HPI Daily.pdf

Katie Gilson, *Staff Assistant*
Office of Governor Mike Pence
KGilson@gov.in.gov
Phone: (317) 232-1198
Fax: (317) 232-3443

V20, N19

HOWEY POLITICS INDIANA

Thursday Dec. 18, 2014

Obamacare: An Indiana policy orphan

GOP loathes ACA, Dems won't defend, but a final verdict is years away

By BRIAN A. HOWEY

INDIANAPOLIS – In the Hoosier State, Obamacare is a policy orphan and a potential political liability.

The Republicans still vow to kill it and openly loathe it. Congressional offices normally dedicated to constituent service have largely taken a pass on Obamacare. Democrats have not defended the Affordable Care Act in any conspicuous way as the party sinks into irrelevance. Gov. Mike Pence is attempting to bend it into the market forces the GOP could have opted for when they controlled the White House and both chambers of Congress between 2001 and 2007.

Gov. Mike Pence makes an appeal to President Obama for a federal waiver on HIP 2.0 in Evansville last October. (White House Photo)

In May 2011, then-Gov. Mitch Daniels surveyed Obamacare and made no effort to hide his contempt. "No. 1, I believe it will be disastrous as far as health care policy," Daniels said. "No. 2, it will make the deficit far, far worse and now everybody understands. It should have been obvious all along. No. 3, it represents another government takeover of the private sector. We saw it in housing, we saw it in autos, we saw it in student loans. We've seen it in finance and banking and here comes another conquest of the private economy which I think is a very bad idea from a freedom standpoint and

Continued on page 3

If Marlin had held out …

By MARK SCHOEFF JR.

WASHINGTON – Congress wrapped up a lackluster session Tuesday night that could have been even more volatile had U.S. Rep. Marlin Stutzman stuck to his guns.

Last week, Stutzman, R-3rd CD, cast the deciding vote that allowed the House to proceed to a $1.1 trillion spending bill that ultimately was narrowly approved, 219-206. Stutzman opposed the final bill. He could have killed it altogether had he also voted against the rule that enabled floor debate on the measure.

Like many other conservatives, Stutzman was upset that the so-called cromnibus legislation did not directly con-

"I would be more than open to recommendations by Members of the General Assembly to expand education opportunities for more members of the Indiana National Guard in the coming session."

- Gov. Mike Pence

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Jack E. Howey, Editor
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email: HoweyInfo@gmail.com

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bhowey2@gmail.com
Howey's cell: 317.506.0883
Washington: 202.256.5822
Business Office: 317.602.3620

front the Obama administration over its executive orders on immigration. Instead, it was a combination of an omnibus appropriations measure that kept all government agencies except the Department of Homeland Security running through September. The homeland agency was given a continuing resolution through February, when Republicans can threaten it with shutdown as a way to pressure Obama on immigration policy.

Stutzman's explanation for his vote on the cromnibus rule – the one where he was decisive in keeping it alive – echoes his comments about the government shutdown last year. At that time, he told a reporter that he wasn't sure what the GOP was trying to accomplish by grinding the government to a halt but that the effort was important.

This time, Stutzman made an unusual explanation in the most official way, through a press release.

"Earlier today, I supported the rule because I was informed by (Republican) leadership that the cromnibus was dead and a short-term (continuing resolution) would take its place," Stutzman said. "I was very surprised and even more disappointed to see the cromnibus back on the floor. The American people deserve better."

In published reports, aides denied that House Speaker John Boehner, R-Ohio, assured Stutzman that the cromnibus was going to be discarded. That raises the question of just what Stutzman was trying to do. If he really wanted to drive a stake through the heart of the cromnibus, he could have voted against the rule. That would have forced House leadership to advance its backup plan, a three-month continuing resolution.

Stutzman was not made available for an interview, and his spokesman declined to comment.

That leaves us pondering questions about Stutzman heading into the new Congress next year. Will he develop into an influential hardline conservative who can sway close votes and be a constant challenge for Boehner? Or will he simply be a quirky back bencher who commands attention because everyone wants to see what he'll say and do next?

He has proved that he can make his presence felt, at least momentarily. Last year, he forced the House to split the farm bill into one measure that addressed agricultural programs and another that focused on food stamps. But the legislation was eventually recombined and approved over Stutzman's objections.

During the just-concluded lame-duck session of Congress, Stutzman again put himself in the opposition camp that ultimately came up short. Essentially, he joined the vanguard led by Sen. Ted Cruz, R-Texas, who forced the Senate to delay a vote on the cromnibus so that it would take up a measure to stop the Obama administration's immigration executive order.

Cruz's gambit failed, and drew the opprobrium of many of his Senate GOP colleagues. They resented that he threw sand in the gears of Senate procedure to force action on immigration that had no chance of succeeding.

Stutzman was the only member of the Indiana congressional delegation who was part of the Cruz caucus during the lame-duck session. Other conservatives who have lined up behind the rambunctious Texan in the past chose to stand with House leadership this time and get the spending bill over the line.

U.S. Rep. Todd Rokita, R-4th CD, for instance, highlighted the fact

that the bill cut funding for the Environmental Protection Agency and the Internal Revenue Service. It wasn't everything he wanted, but the benefits of the measure outweighed the drawbacks, he concluded. "This is a good bill with dozens of gains to be locked in," he said.

Just as almost all Hoosier Republicans decided to cast their lot with their get-things-done leadership, a Hoosier Democrat also backed his leadership – and the White House.

Democratic Sen. Joe Donnelly voted in favor of the cromnibus, putting himself on the other side of his party's suddenly assertive liberal wing that tried to derail the measure because of a provision that would alter a derivatives provision of the financial reform law. The Senate approved the legislation, 56-40.

"This bill is far from perfect, but I supported it because Hoosier families and businesses cannot afford another shutdown," Donnelly said in a statement.

In staking out his position on the cromnibus, Donnelly also has set himself up as someone to watch next year. His actions could be crucial in determining how the Senate Democrats operate in the minority. They have plenty of votes to sustain filibusters, but the party will need to have Donnelly on board to make such a strategy work.

The decisions that Stutzman and Donnelly make next year will help set the tone, and determine the productivity, of the new Congress. ❖

Schoeff is HPI's Washington correspondent.

Obamacare, from page 1

a very bad idea in terms of remaining a nation of opportunity."

Beyond the propaganda, the policy picket lines and all the whistling past the death panels and graveyards, how is Obamacare doing, both nationally and here in Indiana?

It's a mixed picture.

Over the years, Republicans repeatedly told us that Obamacare was a job killer while it would send the federal budget deficit skyrocketing. In 2014, the first full year of Obamacare, the U.S. unemployment rate dropped from 6.7% in January to 5.8% in November, when 321,000 jobs were added to the work force, the 10th consecutive month where the number topped 200,000. In Indiana, the jobless rate declined from 6.8% in December 2013 to 5.7% in October.

The $483 billion deficit for 2014 was the smallest since George W. Bush's last full year as president, according to the Daily Finance website. When measured against the size of the economy, the deficit equaled 2.8% of gross domestic product, below the average for the last four decades. By comparison, the deficit for 2013 was $680 billion, or 4.1% of GDP. The Congressional Budget Office is forecasting that the deficit for the 2015 budget year, which runs through next September, will fall to $469 billion from $483.3 billion in 2014. That would be an improvement of 3% for the full year.

In April 2011, the U.S. had a $1.5 trillion deficit, prompting President Obama to propose a "comprehensive, balanced deficit reduction framework" designed to rein in U.S. government spending, reduce the country's debt and strengthen its battered fiscal reputation. Under this plan, the nation's debt would represent 2.5% of its gross national product (GDP) – the market value of all the goods and services a country produces – by 2015, heading toward 2% by 2020, Daily Finance reported.

Bloomberg News reported on Dec. 10: The budget deficit in the U.S narrowed more than economists projected in November from a year earlier, Treasury Department figures showed, as rising employment helped boost receipts and spending fell. Outlays exceeded receipts by $56.8 billion last month, compared with a $135.2 billion shortfall a year earlier, the department said in a report released in Washington. The median estimate in a Bloomberg survey of 21 economists was for a $64 billion deficit. Stronger hiring has helped to shrink the country's annual deficit from a record $1.42 trillion in 2009, and economists expect the decline to continue in the fiscal year that started Oct. 1. The Treasury in October said the shortfall in the 12 months ended Sept. 30 was $483 billion, or 2.8% of gross domestic product, and the Congressional Budget Office said in August that it expects the deficit to shrink to 2.6% of GDP this fiscal year.

"The trend is toward smaller and smaller deficits,"

Paul Edelstein, U.S. economist and director of financial economics at IHS Global Insight told Bloomberg News. "The improving economy is boosting tax revenues."

130,000 more Hoosiers are insured

More Hoosiers are now insured. Carla Anderson of the healthinsurance.org website, reported that during 2014 open enrollment, 132,423 Hoosiers signed up for qualified health plans, according to federal government reports. Eighty-nine percent qualified for financial assistance. In addition, 95,495 people qualified for Medicaid or the Children's Health Insurance Program (CHIP) under existing eligibility rules.

When 2015 open enrollment began on Nov. 15, Indiana residents found the number of insurers doubling, going from four to nine. And, the number of available plans jumped from 278 to 975, according to healthinsurance.org.

According to the Kaiser Foundation, Indiana ranked 19th in the nation in its pre-Obamacare uninsurance rate with 14.8% of the population uninsured. That is projected to decline to 12.78%, or a 2.02% decrease.

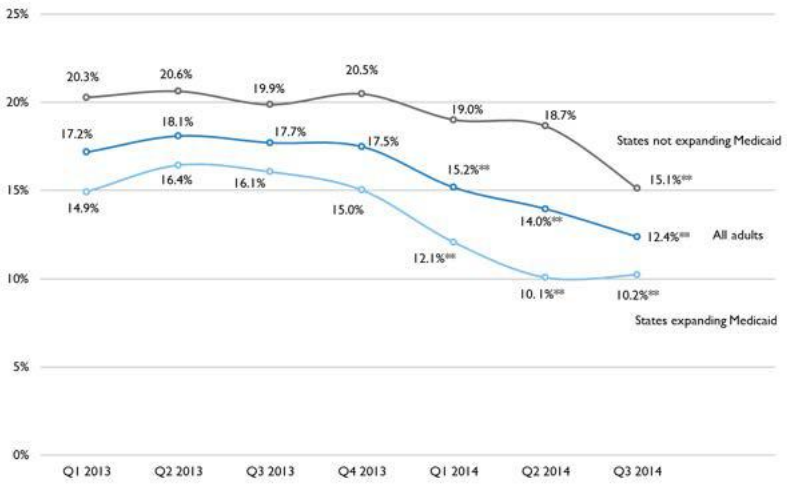
Massachusetts with its "RomneyCare" health plan had a 4.35% uninsured rate pre-Obamacare, and 1.2% afterwards. Kentucky, with one of the best performing state exchanges, saw its uninsured rate decline 8.95% from 17.3% to 9.6%, according to Rand Corporation.

The states with the highest uninsured rates include Texas as 26.8%, Nevada at 26.5%, Florida at 24.7%. The national rate was 17.87% in pre-Obamacare uninsured, 14.2% post-Obamacare for a decline of 3.66%.

The Urban Institute Health Policy Center reported that the number of uninsured nonelderly adults fell by an estimated 10.6 million between September 2013 and September 2014 in the United States, a drop of 30.1% in the uninsurance rate. In September 2014, the uninsurance rate for nonelderly adults was estimated to be 12.4% for the nation, a drop of 5.3 percentage points since September 2013. Adults in states that implemented the ACA's Medicaid expansion sustained the largest coverage gains from the previous quarter, and insurance coverage also rose sharply for adults in nonexpansion states. The uninsurance rate for adults in expansion states dropped 5.8 percentage points since September 2013; the rate dropped 4.8 percentage points in the nonexpansion states. This is a decline in the uninsurance rate of 36.3% in expansion states and 23.9 percent in nonexpansion states.

In a special New England Journal of Medicine report, an analysis of nationally representative survey data from January 2012 through June 2014, found a significant decline in the uninsured rate among nonelderly adults that coincided with the initial open-enrollment period under the ACA. Combined with 2014 Census estimates of 198 million adults 18 to 64 years of age, this corresponds to 10.3 million adults gaining coverage, although depending on the model and confidence intervals, our sensitivity analyses imply a wide range from 7.3 to 17.2 million adults.

Figure 1. Trends in Uninsurance for Adults Ages 18 to 64 from Quarter 1 2013 to Quarter 3 2014



Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.
Notes: Estimates are regression adjusted.
*/** Estimate differs significantly from quarter 3 2013 at the .05/.01 levels, using two-tailed tests.

TMP reported that a key provision of the Affordable Care Act that was designed to keep insurers from overspending on administrative costs or else be forced to rebate premiums to customers "looks to be succeeding in not only reducing those costs but in lowering premiums."

"The medical loss ratio requirement and rate review mandated by the ACA put downward pressure on premium growth," officials from the federal Centers for Medicare and Medicaid Services wrote in their report, according to TMP. Overall private insurance spending, of which premiums are a part, grew at a 2.8% rate, the lowest since at least 2007. As Larry Levitt, vice president at the non-partisan Kaiser Family Foundation, put it to TMP in an email: "That is how it's intended to work."

CNBC reported that people with insurance through an employer are paying more in premiums and deductibles than ever before as those costs outpace the growth of wages. Total premiums for covering a family through an employer-based plan rose 73% from 2003 through 2013, while workers' personal share of those premium costs leaped 93% during the same time frame, the Commonwealth Fund report said, according to CNBC. At the same time, median family income grew just a measly 16%. Families are "being squeezed by health-care costs," said report co-author Sara Collins, vice president for Health-Care Coverage and Access at the Commonwealth Fund. "Growth in family income is so slow that people still feel a pinch from health costs."

A personal journey

As for a personal experience, this writer spent about 30 minutes on the healthcare.gov website on Sunday evening and signed up for an Anthem Bronze Health Savings Account plan for $546 a month. In 2014, I was

on a silver MDWise plan for $714 a month. While the deductible rose from $2,500 to $4,000, the new plan pays 100% of preventive procedures. For instance, a colonoscopy will have zero out-of-pocket costs. In the pre-ACA era, I was facing an out-of-pocket cost of at least $1,200.

In the two years prior to the ACA, my Anthem plan increased from $330 a month to $440 a month. The $714 in the first Obamacare year was a shocker. This time around, there was more competition, more options and the cost declined, though still not below pre-Obamacare levels.

But the key element was access. As someone with a pre-existing condition, just getting on an insurance plan in the past was arduous and frustrating. With the ACA, I was able to get on a plan with about an hour of research and a 30-minute session on the website.

An informed and reliable health insurance source who has worked with several states, including Indiana, and has advised HPI on health care issues, said of the ACA over the past year, "The prediction or forecast of economic disaster to businesses caused by the ACA has not occurred and the cost shift to individuals and families has. I have not heard much about companies dropping plans and employees to avoid the penalties. That threat was loud and clear before the ACA was rolled out."

The source added, "There was some unconfirmed speculation that insurers inflated rates in 2011 and 2012 in 'preparation' for the ACA rollout last year. If so, the percentage increases now will be less than if they didn't do that."

Ratings of Quality of Healthcare and Healthcare Coverage

Among those newly insured through a government exchange this year, and among all who have health insurance

	Newly insured this year*	All with health insurance**
	%	%
QUALITY OF HEALTHCARE		
Excellent	32	38
Good	42	43
Only fair	20	15
Poor	5	4
HEALTHCARE COVERAGE		
Excellent	25	29
Good	46	43
Only fair	19	22
Poor	9	5

* Oct. 22-Nov. 11, 2014
** Nov. 6-9, 2014

GALLUP

Table 1: Monthly Silver Premiums for a 40 Year Old Non-Smoker Making $50,000 / Year

State	Major City	2nd Lowest Cost Silver Before Tax Credit			2nd Lowest Cost Silver After Tax Credit		
		2014	2015	% Change from 2014	2014	2015	% Change from 2014
Alabama	Birmingham	$258	$264	2.5%	$209	$208	-0.8%
Alaska	Anchorage	$380	$488	28.4%	$165	$164	-0.8%
Arizona	Phoenix	$197	$177	-10.0%	$197	$177	-10.0%
Arkansas	Little Rock	$306	$299	-2.3%	$209	$208	-0.8%
California	Los Angeles	$255	$257	0.8%	$209	$208	-0.8%
Colorado	Denver	$250	$211	-15.6%	$209	$208	-0.8%
Connecticut	Hartford	$328	$312	-5.0%	$209	$208	-0.8%
Delaware	Wilmington	$289	$301	4.1%	$209	$208	-0.8%
DC	Washington	$242	$242	-0.2%	$209	$208	-0.8%
Florida	Miami	$260	$274	1.8%	$209	$208	-0.8%
Georgia	Atlanta	$251	$255	1.8%	$209	$208	-0.8%
Hawaii	Honolulu	$183	$200	9.3%	$181	$179	-0.8%
Idaho	Boise	$231	$210	-9.3%	$209	$208	-0.8%
Illinois	Chicago	$212	$215	1.6%	$209	$208	-0.8%
Indiana	Indianapolis	$354	$329	-7.0%	$209	$208	-0.8%
Iowa	Cedar Rapids	$255	$246	-3.5%	$209	$208	-0.8%

What's coming in the future

Here are elements of the ACA that merit watching:

■ How will the IRS reconcile subsidy problems in the upcoming tax season for 2014? The IRS track record is not good, Congress just slashed its budget, and if the IRS gets aggressive, that could produce a lot of public discord.

■ The longer term health cost improvement gains will come from improving wellness and preventive benefits. This promises to be the best part of the ACA but perhaps the most difficult to quantify.

■ The emergence of Accountable Care Organizations and the reporting of population health outcomes is a huge work in process and healthcare organizations need to become more transparent about what they do and how successful they are.

■ The ongoing consolidation of healthcare providers and the reduction of reimbursement will reduce access to patients at some point, HPI sources say. Insurers will squeeze providers and cutbacks in facilities and staff will occur. County hospitals are in true jeopardy, especially in Indiana without Medicaid expansion and HIP 2.0 off the table to date.

HIP 2.0

The biggest expansion of health coverage for Hoosiers could come under Gov. Pence's Healthy Indiana Plan 2.0. He is still awaiting word from the Obama administration.

Pence told HPI on Wednesday afternoon about a meeting he had in Febuary 2013 with President Obama. "I looked him right in the eye and I said, 'I just want to say to you from my heart you know I'm really interested in doing this. This is not just a proposal. This is not politics.' He looked at me and said, 'Mike, I've looked over the waiver and it's a very serious proposal. I get that. I know you're sincere about it.'"

Pence added, "There's nothing in the law that would be a barrier to them approving HIP 2.0. There's no requirement of any change in the law for them to approve HIP 2.0. That's a very important point. We submitted a good faith proposal that I think is faithful to the principles of the Healthy Indiana Plan." Penced also noted that the Obama administration has already approved three HIP waivers.

If Pence can get the Centers of Medicaid/Medi-

care to sign off, it would launch the biggest health coverage expansion in modern Indiana history. But he hopes it comes mostly on his terms. (See the entire HPI Interview with Gov. Pence on pages 7-9).

Coats and Donnelly perspectives

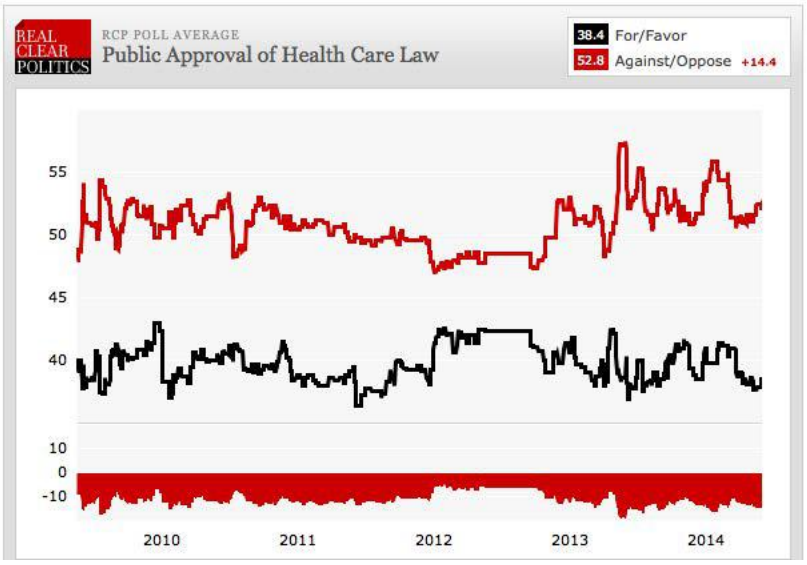
Indiana's two U.S. Senators are giving tell tales as to the political and policy fate of Obamacare as control of Congress shifts to Republicans.

Coats still talks of repealing Obamacare. It is almost a prerequisite for a Hoosier Republican officeholder to not only denounce Obamacare, but to argue for its repeal. The political reality is such rhetoric is necessary to fend off a potential primary challenge.

Public Approval of Health Care Law

Polling Data					
Poll	Date	Sample	For/Favor	Against/Oppose	Spread
RCP Average	10/8 - 12/9	--	38.4	52.8	Against/Oppose +14.4
FOX News*	12/7 - 12/9	1043 RV	38	58	Against/Oppose +20
Rasmussen Reports*	12/5 - 12/6	1000 LV	44	52	Against/Oppose +8
Quinnipiac	11/18 - 11/23	1623 RV	40	54	Against/Oppose +14
Gallup	11/6 - 11/9	828 A	37	56	Against/Oppose +19
Pew Research	11/6 - 11/9	1353 A	45	51	Against/Oppose +6
CBS News	10/23 - 10/27	1269 A	36	55	Against/Oppose +19
Associated Press/GfK	10/16 - 10/20	968 LV	31	48	Against/Oppose +17
NBC News/Wall St. Jrnl	10/8 - 10/12	1000 RV	36	48	Against/Oppose +12

All Public Approval of Health Care Law Polling Data



The reality on the Senate floor is that even with Republican control of the chamber, the GOP doesn't have the 67 votes necessary to override a veto by President Obama. "The odds are against us. To date we don't have any Democrats to join us," Coats said on Tuesday.

With that reality, Coats, who will join the Senate Finance Committee which will have jurisdiction over Obamacare, explained, "It needs a major overhaul. We're going to make a run at it and we'll look at individual pieces and start replacing them with other provisions."

He called the coming efforts "piecemeal" and said that Republicans will look into getting "more consumer input, more consumer choices, more competition based on the ability to cross state lines, allowing small businesses or associations to form groups so they can leverage better prices and plans." There will be attempts to change the 40-hour work week as related to Obamacare employment, malpractice reform as well as the individual mandate.

For Sen. Joe Donnelly, he is Exhibit A when it comes to a red state Democrat surviving an election despite his Obamacare vote in March 2010. In fact, he's done it twice. He fended off a challenge to his House seat that year from Republican Jackie Walorski, then won his Senate seat against Richard Mourdock, a vociferous opponent of Obamacare. From the earliest moments of passage, Donnelly maintained that Obamacare would be a work in progress, and would need tweaks and changes.

"Many things about the ACA are really good," Donnelly told HPI on Tuesday. "For the first time people with diabetes and heart condition can get health care," he said of people with pre-existing conditions. "I had a conversation with a health system CEO right after ACA went into effect, and he said 'We saw a huge increase with a number of people with heart conditions' coming in for treatment.'" When the CEO explored the increase, he discovered that these were new patients who were able to get on health plans. "Those were all people who didn't have health coverage before. They were just getting sicker and sicker," Donnelly said.

A victory or a loss?

HPI's health care source, who has worked with Republican state administrations, was critical of the ACA as it was forged, and was skeptical of its potential impact. The source told HPI, "I think it's too early to call the ACA a victory or a loss. The short term signs look OK but I think the real costs are yet to come. With healthcare being the second most costly part of the household budget young families will change their buying habits soon and the economy may not be as good as the past year."

Potentially aggravating parts of the ACA that are not performing well is the scenario that the coming majority party in Washington is invested in the destruction of the ACA, as opposed to working to improve it. Democrats have lost power, and in a political context, have been reluctant to defend it, even with some of the successes and as well as pointing out how a number of the warnings on the federal deficits and job creation have not occurred.

The Real Clear Politics polling average on the ACA is 38.4% favoring, and 52.8% opposing. ❖

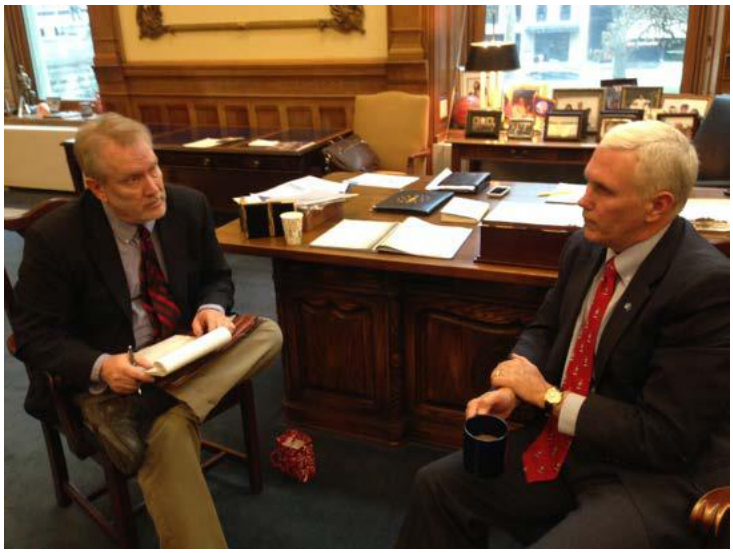
Pence expects session on education, some tax relief; open to more Guard grant funding

By BRIAN A. HOWEY

INDIANAPOLIS – Gov. Mike Pence sat down with Howey Politics Indiana on Tuesday afternoon for a year-end interview and discussed the biennial budget, education needs and the pending decision from the Obama administration on Healthy Indiana Plan 2.0.

He expects the coming 2015 Indiana General Assembly session to focus on teachers and wants an "honestly balanced budget" but could rule in broader tax relief if the forecast numbers are rosier than expected. He said he is open to legislative proposals to fully fund education grants for Indiana National Guard members. For the second consecutive year, those higher education grants for the spring semester were rescinded due to budget considerations.

Here is our conversation that took place in the governor's Statehouse office:



HPI: What's your take on Jeb Bush's exploratory committee for 2016? Does he qualify as one of the Republican governors who would look good in the White House? Does that change the dynamic politically?

Pence: I haven't really thought about it very much. I have a lot of respect for Jeb Bush and for his record as governor. I spoke to him about a year ago when we were crafting Indiana's pre-K program. As governor of Florida, he had launched the voluntary pre-K. We talked about some of his experience with that. I haven't spoken to him in the last year.

HPI: How does the Republican presidential race shake out in the next six months?

Pence: For me, I am incredibly excited about this coming session of the General Assembly. I am encouraged about the response to our education agenda; for me this should be an education session. When I first came into office unemployment was above 8%. One of the things I campaigned on was my commitment from reform to results. We came through a season of very strong reform in state government at many levels, but we still weren't seeing the results in the broader economy. That's why we focused on tax reform, tax relief, to really jumpstart the Indiana economy. Unemployment was over 8% when I came in and now it's 5.6%, below the national average, and our labor force is growing; I think we had the fifth largest growth in our labor force in the country in real terms, and the growth in jobs in the state was all very encouraging. We have our economy going in the right direction. Passing a very honestly balanced budget will be central to that. But focusing on the goal that I minted a week and a half ago, to see 100,000 more kids be in better schools by 2020, a broad range of policy reforms, that's the right focus for the coming session. We'll have the revenue forecast in the next week.

HPI: Any sneak preview on that forecast?

Pence: I have not received a sneak preview. As you can imagine, the budget we've been crafting has a plan A, a plan B and a plan C. We're going to be ready to go after the first of the year. I expect we will be able to increase funding for traditional K-12 schools, be able to increase performance funding. I want to strengthen our foundation under public charter schools financially, lift the cap on our voucher program, but I also want to advance these policy innovations that will allow traditional public schools to move resources around, to pay good teachers more, to give more dollars into the classroom. I'd like to see more innovative operators invest in Indiana in proven models, and of course the whole subject of our turn-around schools is a big part. The other big innovation that will take up a lot of this coming session is a commitment to make vocational education a priority in every high school. It has been unanimously supported in the General Assembly. I just chatted with the superintendent and she made reference to her enthusiasm for what we're doing in career and technical education and I am grateful for that. She's been a strong advocate for that from her office.

HPI: Are free text books on your radar?

Pence: On the career technical piece, finishing a thought on that, we spent about $100 million on career technical education and I want to look for ways where we can spend that money smarter in ways that are more relevant to jobs available. I also want to increase the funding and create incentives for businesses to partner with our

local high schools in creating career education opportunities that are relevant to jobs available in those communities. I know there's been talk about free text books. We're looking at the revenue forecast to see if we can do some of that.

HPI: We've been pondering free text books for years. Decades.

Pence: We have. One of the things many people don't know is that school corporations have the ability now under the law to shift money for textbooks. I want to keep an open mind on that. At the end of the day, what most contributes to student achievement is having good teachers in the classrooms. One of the ways you get good teachers is that you pay good teachers more. We want to make more resources available and create policy reforms to pay good teachers more.

HPI: Are you concerned about the steep dropoff in Ball State teacher candidates that the Star Press reported this week?

Pence: I am concerned about that. Not only is my wife a school teacher, but my father-in-law was the Indiana state teacher of the year in 1986. It's one of the reasons I would like this to be a teacher-centric session . . . where the policies we pass make it more possible for us to get more dollars into the classroom and pay good teachers more. Some good analysis lately shows that when you look over the past 30 years and the amount of money that we have increased in administrative spending, versus increased teacher salaries, there's room for improvement.

HPI: Any updates on HIP 2.0? Isn't the federal government putting you in a box as far as not being able to get things rolling?

Pence: I spoke with (Health and Human Services) Secretary Burwell again on Monday. We've had an on-going dialogue since we submitted the waiver in the middle of this year. I continue to remain hopeful that federal officials will allow us to expand coverage to some 350,000 uninsured Hoosiers through the Healthy Indiana Plan.

HPI: Does she understand how a lack of a decison is putting Indiana in a box?

Pence: I've got a picture over there when I was chatting with the President outside Air Force One several months ago in Evansville (see page 1). One of the two things I said to him at the end of our 10-to 12-minute conversation was, "Time is of the essence here. We had all hoped to work in good faith and start this program on Jan. 1." And as I sit here today, the State of Indiana working and our health providers have been working very diligently to start this program shortly after we receive approval. We haven't been waiting to start to prepare. We've been preparing. I've made that very, very clear. Time is of the essence; that is more true today. In the first two years of his administration, I was in Republican leadership. I was in meetings at least once a month with the President for one reason or another. We've always had a decent rapport. I'm about as conservative as he is liberal, but we've always had the ability to talk to one another. That's continued since I was governor. He pulled me aside in Washington in February '13 and he kept me about 10 or 15 minutes after a luncheon at the White House, just the two of us talking. I looked him right in the eye and I said, "I just want to say to you from my heart you know I'm really interested in doing this. This is not just a proposal. This is not politics." He looked at me and said, "Mike, I've looked over the waiver and it's a very serious proposal. I get that. I know you're sincere about it."

So my hope is that the dialogue has gone forward in the months since then, there's been some give and take. We've made it very clear that we're committed to preserving the essential framework of the Healthy Indiana Plan, which is consumer-driven health care, where people make a contribution on a monthly basis. To be enrolled in the program encourages people to take ownership of their own health, but beyond that we've been working through issues. I would say we still have some separation between what they're prepared to accept and what we've proposed. One other item worth noting, what we submitted could have been approved by the administration the day we submitted it. There's nothing in the law that would be a barrier to them approving HIP 2.0, and no requirement of any change in the law. That's a very important point. We submitted a good faith proposal that I think is faithful to the principles of the Healthy Indiana Plan. I did say to Secretary Burwell several months ago – and she did say she wanted me to know how committed they were – and I said to her, "Sylvia, I accept that." But I said, "I hope you know how committed we are to the Healthy Indiana Plan."

(**Publisher's note:** After the HPI audio stopped rolling, Gov. Pence said that he had had a 45-minute conversation with presidential senior aide Valerie Jarrett the night before President Obama spoke in Princeton, Ind. Pence said that Jarrett was seeking more details on HIP 2.0 and needed to apprise the President before the two

met on the Evansville tarmac the next day).

HPI: I've written about how higher education grants for National Guardsmen and women are not available for the spring semester, due to a lack of funding. This is the second spring semester this has happened and these guardsmen are being forced to take out student loans. As governor, would you back a fully funded program for these men and women?

Pence: I think the debt we owe to those who serve in uniform can never be fully repaid. I am especially grateful to be the governor of the state with the finest National Guard in the country. We have one of the largest National Guard contingents in the country. Our men and women particularly over the last 10 years since the advent of Operation Enduring Freedom and Operation Iraqi Freedom have won a national reputation for professionalism. It is truly extraordinary. Right now we have the largest deployment of the Indiana Air National Guard in 10 years. Karen and I attended the deployment ceremony in Fort Wayne. Our A-10 pilots and aircraft went down range. They have our prayers. That's all my context. I was aware of the reports about the program. I defer to the (higher education) commission and the budget amounts that have been approved by the legislature, but I would be more than open to recommendations by members of the General Assembly to expand education opportunities for more members of the Indiana National Guard in the coming session.

HPI: Do you feel you have your sea legs going into this biennial session more than in your first?

Pence: Well, that goes without saying.

HPI: I still can't imagine what it was like to run and win a campaign, put an administration together and come up with a biennial budget in two months.

Pence: We worked long hours in December 2012 piecing together our budget proposal. The prior administration had done the spadework on an agency-by-agency basis, but I can tell you the assembling of our team and making decisions about agency heads and cabinet members, we spent some long hours going line by line through the budget we would submit in January 2013. I'm proud of the budget we submitted. The budget we'll be bringing forward will have some of the same characteristics. It will be honestly balanced budget. We're going to hold the line on spending. By that I mean we will propose a budget that does not grow any faster than the family budgets of the people of Indiana, using the rate of inflation over the past 10 years as the benchmark. And we'll put a real premium on maintaining strong and adequate reserves. But beyond that I'm hopeful our revenue forecast will come through in a way that we'll be able to increase investments, particularly in education and also beyond that, really look for opportunities to make room for the tax cuts that we've already enacted. I don't anticipate proposing broad-based tax relief, unless the revenue forecast surprises everybody, then we may reconsider that. What we are looking at are a number of targeted tax measures, beginning with tax simplifications, but also a number of other measures that will target making Indiana more competitive in attracting investment. ❖

Are presidential polls too early to matter?

By JACK COLWELL

SOUTH BEND – A Quinnipiac poll shows Jeb Bush favored among Republicans for their party's 2016 presidential nomination, by just a smidgen over Chris Christie. But among the general electorate, the poll finds Bush trailing Hillary Clinton by 5 percentage points, while Christie trails Clinton by only a single point, a statistical tie.

Too early to matter? A Bloomberg poll finds Clinton beating either Bush or Christie by 6 percentage points and ahead of Rand Paul by 8 and over Ted Cruz by 13.

Who cares right now? A poll of Idaho Republicans – yes, there's polling even in states as small as Idaho – finds the lead going to "Someone else/Not sure."

Reflective of an electorate not exactly focused on the next presidential race? Well, the sampling of candidate potential does matter, and the contenders know it's not too early to try to get known and look impressive in any evaluation of potential to win the nomination and the presidency.

Most voters aren't focused on the 2016 presidential race, but important people who will decide what choices the voters will have are looking at their options right now. Those decision makers include big money contributors and political operatives who bundle hundreds of millions of dollars of those contributions to boost choices and starve out or in other ways knock out other candidates.

Stories in the national news media tell of prominent Republican donors trying to decide on a choice now in order to avoid a long, chaotic and damaging battle in the presidential primaries, like the costly primary circus in 2012 that got Mitt Romney off to a slow start that summer.

They also don't want to risk the nomination going in a wild scramble to some risky choice that would self-destruct in a fall campaign against Clinton, now regarded as the likely Democratic nominee.

Some of those donors would like to see Bush or Christie or maybe Romney again, figuring one of those more established figures would have the best chance to win the White House. They wouldn't want all three running, thus splitting the party establishment vote and enabling some choice with limited appeal beyond the tea party to wind up as the nominee.

But the big money folks aren't just looking at those so-called big three contenders. A story in Politico tells of how the Koch brothers and their allies are building an organization for polling, message-testing, advertising and data-collecting on 250 million Americans, something to rival the organizing skill of the Obama campaign in 2012. The big conservative PACs relied too heavily in 2012 on negative TV and neglected direct appeals to the voters that seemed to be more effective.

Indiana Gov. Mike Pence, with ties to and well-received appearances before the Koch operation, has been cited as a possible choice for Koch backing if he shows signs of gaining support. Pence wasn't measured in those early polls, but indications of powerful backing, more moves toward running and enhancing appeal to voters in the early primary states could put him on the list.

Pence is trying, moving away from the more moderate approaches he took initially as governor and taking more hard-line conservative stands for which he was known in Congress.

And now a nine-day trip to Israel. Pence isn't going there to work on his state of the state address. Some big conservative donors want an unflinching supporter of Israel in the White House. The trip will attract news coverage, perhaps leading to listing in those polls. Also, it will bring some foreign policy credentials.

Too early to matter? It's getting late. Attract the big money early – or get left out. Get moving in the polls, or move out of the picture as the donors and other power brokers in the party decide on their choices. Their choices will determine the candidates left with much of a chance. ❖

Colwell has covered Indiana politics over five decades for the South Bend Tribune.

2016 Republican Presidential Nomination

Iowa GOP Caucus | New Hampshire GOP Primary | Democratic Nomination | General Election Match-Ups

Polling Data

Poll	Date	Bush	Ryan	Christie	Paul	Huckabee	Carson	Walker	Cruz	Perry	Rubio	Kasich	Jindal	Spread
RCP Average	**11/18 - 12/14**	**15.2**	**10.8**	**10.4**	**9.0**	**9.0**	**9.0**	**8.2**	**6.3**	**4.5**	**4.0**	**2.5**	**2.0**	**Bush +4.4**
ABC/Wash Post	12/11 - 12/14	14	11	7	10	7	8	7	8	5	7	2	3	Bush +3
McClatchy/Marist	12/3 - 12/9	16	7	10	6	12	8	3	5	5	3	3	1	Bush +4
CNN/ORC	11/21 - 11/23	14	9	9	8	10	11	5	7	5	3	3	1	Bush +3
Quinnipiac	11/18 - 11/23	14	7	11	8	7	9	6	5	3	3	2	3	Bush +3
Rasmussen Reports	11/20 - 11/21	18	20	15	13	--	--	20	--	--	--	--	--	Tie

All 2016 Republican Presidential Nomination Polling Data

Weigh in on the 2015 HPI Power 50 List

By BRIAN A. HOWEY

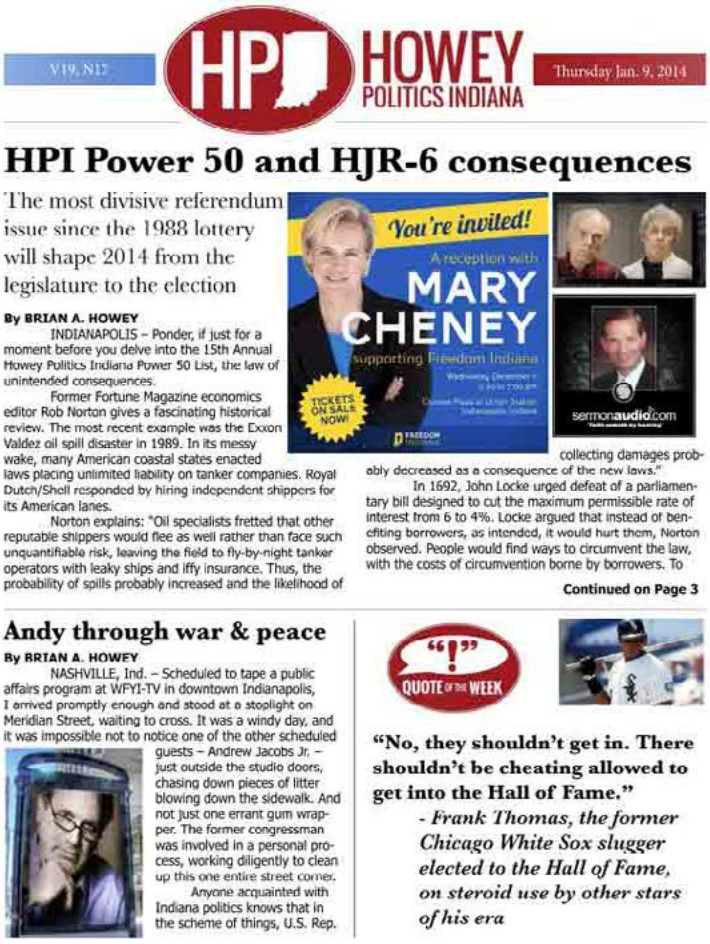
INDIANAPOLIS – Since 1999, Howey Politics has presented the Power 50 list as a guide to who is most likely to shape events in the coming year.

As always, we hope it stirs a debate that lends to good governance and policy that creates a better Indiana for the 6.7 million of us who call Indiana home.

Please send us your nominees, or submit an entire list to me at bhowey2@gmail.com. We'll publish the 2015 list in our Jan. 15, 2015, edition.

HPI's 2014 Power 50 List

1. Gov. Mike Pence
2. Speaker Brian Bosma
3. Senate President David Long
4. FSSA Commissioner Deb Minott
5. State Rep. Tom Dermody
6. Curt Smith, Micah Clark and Eric Miller
7. Megan Robertson
8. State Rep. Robert Behning
9. U.S. Rep. Jackie Walorski and Joseph Bock
10. U.S. Sen. Joe Donnelly
11. U.S. Sen. Dan Coats
12. U.S. Rep. Todd Young
13. U.S. Rep. Susan Brooks
14. Indianapolis Mayor Greg Ballard
15. Evan Bayh
16. Joe Hogsett
17. Hammond Mayor Thomas McDermott Jr.
18. Baron Hill
19. Senate Appropriations Chairman Luke Kenley and Ways & Means Chairman Tim Brown
20. Chief-of-Staff Bill Smith
21. Supt. Glenda Ritz
22. Lt. Gov. Sue Ellspermann
23. Claire Fiddian-Green
24. Attorney General Greg Zoeller
25. U.S. Rep. Marlin Stutzman
26. House Minority Leader Scott Pelath
27. Jim Bopp Jr.
28. Secretary of State Connie Lawson
29. Marion Mayor Wayne Seybold
30. State Rep. Ed Clere
31. State Rep. Ed DeLaney
32. Evansville Mayor Lloyd Winnecke
33. Fort Wayne Mayor Tom Henry
34. State Reps. Greg Steuerwald & Jud McMillin, Sen. Brent Steel, and David Powell
35. Kokomo Mayor Greg Goodnight
36. South Bend Mayor Peter Buttigieg
37. Richard Lugar
38. U.S. Rep. Luke Messer
39. U.S. Rep. Todd Rokita
40. Republican Chairman Tim Berry
41. Democrat Chairman John Zody
42. State Sen. Brandt Hershman and State Rep. Eric Turner
43. Goshen Mayor Allan Kauffman and Terre Haute Mayor Duke Bennett
44. State Sen. Jim Merritt
45. Purdue President Mitch Daniels
46. U.S. Rep. Larry Bucshon
47. Rod Ratcliff
48. Doug Brown
49. State Rep. Mike Karickhoff
50. Jennifer Hallowell



V19, N17 HPI HOWEY POLITICS INDIANA Thursday Jan. 9, 2014

HPI Power 50 and HJR-6 consequences

The most divisive referendum issue since the 1988 lottery will shape 2014 from the legislature to the election

By BRIAN A. HOWEY

INDIANAPOLIS – Ponder, if just for a moment before you delve into the 15th Annual Howey Politics Indiana Power 50 List, the law of unintended consequences.

Former Fortune Magazine economics editor Rob Norton gives a fascinating historical review. The most recent example was the Exxon Valdez oil spill disaster in 1989. In its messy wake, many American coastal states enacted laws placing unlimited liability on tanker companies. Royal Dutch/Shell responded by hiring independent shippers for its American lanes.

Norton explains: "Oil specialists fretted that other reputable shippers would flee as well rather than face such unquantifiable risk, leaving the field to fly-by-night tanker operators with leaky ships and iffy insurance. Thus, the probability of spills probably increased and the likelihood of collecting damages probably decreased as a consequence of the new laws."

In 1692, John Locke urged defeat of a parliamentary bill designed to cut the maximum permissible rate of interest from 6 to 4%. Locke argued that instead of benefiting borrowers, as intended, it would hurt them, Norton observed. People would find ways to circumvent the law, with the costs of circumvention borne by borrowers. To

Continued on Page 3

Andy through war & peace

By BRIAN A. HOWEY

NASHVILLE, Ind. – Scheduled to tape a public affairs program at WFYI-TV in downtown Indianapolis, I arrived promptly enough and stood at a stoplight on Meridian Street, waiting to cross. It was a windy day, and it was impossible not to notice one of the other scheduled guests – Andrew Jacobs Jr. – just outside the studio doors, chasing down pieces of litter blowing down the sidewalk. And not just one errant gum wrapper. The former congressman was involved in a personal process, working diligently to clean up this one entire street corner.

Anyone acquainted with Indiana politics knows that in the scheme of things, U.S. Rep.

"!" QUOTE OF THE WEEK

"No, they shouldn't get in. There shouldn't be cheating allowed to get into the Hall of Fame."

- Frank Thomas, the former Chicago White Sox slugger elected to the Hall of Fame, on steroid use by other stars of his era

Honorable Mention

Senate Minority Leader Tim Lanane, Policy Director Chris Atkins, INDOT Commissioner Karl Browning, Chris Chocola, Kevin Brinegar, Pat Kiely, U.S. Rep. Pete Visclosky, Marilee Springer, Matt Greller, State Sen. John Waterman, Craig Hartzer, Bill Bailey, U.S. Rep. Andre Carson, Don Bates Jr., Sasheer Zamata, LaPorte Mayor Blair Milo, Marion County Clerk Beth White, Auditor Suzanne Crouch, State Sen. Carlin Yoder, State Sen. Jim Banks, State Rep. Christina Hale, State Rep. Milo Smith, State Rep. Jerry Torr, State Rep. Ed Soliday, Eric Holcomb, State Rep. Steve Braun, Jeff Cardwell, and Dan Elsener. ❖

Donnelly seeks to lead Democrats by example

By BRIAN A. HOWEY

INDIANAPOLIS – If leading by example is the route for a revival of the beleaguered Indiana Democratic Party, then U.S. Sen. Joe Donnelly is the man to follow.

"In my official capacity, I have visited all 92 counties," Donnelly told Howey Politics Indiana in a phone interview from Washington on Tuesday. "In my spare time, I have visited all 92 counties in an effort to help rebuild the party. We'll be more successful when we have more people involved with local campaigns. It begins with the city and township level."

In the Dec. 4 edition of Howey Politics Indiana, our analysis laid out a comprehensive look at the losses Indiana Democrats have sustained in its Congressional delegation, both legislative chambers of the General Assembly, its control of only one constitutional office at the Statehouse, and the loss of county courthouses and city halls, particularly in Southern Indiana in counties and cities that were considered Democratic strongholds less than a decade ago.

"I read it from front to back." Donnelly said of the HPI analysis. "There is no lack of desire to work nonstop to win elections and to win elections from Fort Wayne to Evansville, from Merrillville to Rising Sun. And that is in the county parties where there are enough volunteers, that is at the state party level. In some of the discussions I have had, one of the things we need to do a better job of is talking about what we have accomplished."

Sen. Donnelly campaigns with Indiana Senate candidate J.D. Ford in October. Donnelly visited all of Indiana's 92 counties, appeared at more than 400 events in 200 days in more than 120 Indiana cities and towns last year.

He expects the 2016 cycle to be much different than the 2014 debacle. "You look at Chrysler where almost every single job was gone in Kokomo," Donnelly said of 2008 and 2009. "Before then, 5,000 people were employed. Nobody was left. A lot of tough decisions were made by union folks, salaried employees who took cuts, lawmakers stood up with local plants and the President. Today, 7,000 people are working for Chrysler in Kokomo and Tipton, they're working at that stamping plant in Marion, at the Fort Wayne Silverado plant, and at the foundry in Bedford. I hate to think of what might have happened."

Donnelly pointed out that in his U.S. Senate race in 2012, he carried the very Republican 5th Congressional District. "Part of that was I have never been afraid to talk about incredibly difficult economic challenges we've had in 2008 and 2009," he said of the near collapse of the U.S. economy as well as the domestic auto industry. "The fact is we had to do some really tough things such as the auto restructuring, trying to make sure we didn't have a financial system collapse, and those were not easy decisions, but they were the right decisions. They were made because we stand for working families, and that's what we need to continue to do; we have to continue to talk about as a party. Our first and foremost concern has always been is making sure that every Hoosier family, whether in Columbus, in Jeffersonville, that at the end of the year their paycheck goes a little further, that new job is little bit better, and that their future is a little bit safer."

HPI asked Donnelly about the "disconnect" between recent campaign cycles and the issues. The classic was a study published in October showing a 60% increase in poverty in Southern Indiana, while Republicans were making major inroads in Clark, Warrick, Spencer, Posey and DuBois counties and traditionally Democratic cities like Jeffersonville, Evansville, Terre Haute and Jasper.

"We were promised during the two past administrations how we were going to see bigger paychecks, that we were going to see greater wealth for everybody, and it hasn't turned out that way," Donnelly said of the Daniels and Pence administrations. "Our commitment has to be where we look at the working family with a couple of kids and that house payment, that we make sure that your paycheck is bigger and that your life is better. That's what our mayoral candidates need to be saying. That's what our state, county and federal candidates need to be talking about. It's about jobs and opportunity. Our jobs have come back, but our wages have not."

Donnelly added, "We came from 20%-plus unemployment from many parts of our state, from a devastating event, and to this day there's still a concern and fear that that's not too far away. We've just lived through that and while things seem better, they are not back to where they were. Our job is to work every day to make sure they get back to that point."

Told of 2012 gubernatorial nominee John Gregg's assessment that local Democratic parties need more investment, Donnelly pointed to the Emerging Leaders Pro-

gram as an example of redeveloping a base. He said that State Chairman John Zody "is out there every day working at the local level."

"You don't rebuild the baseball team by focusing on just two or three players on the major league team," Donnelly explained. "You rebuild it by building a really, really good farm system. That is our obligation."

As for sorting out a potential 2016 ticket when a U.S. Senate seat and governor are up for reelection, Donnelly said he wants the process to play out. "I'm not going to dictate who runs," he said. "We have wonderful candidates. I think we'll have terrific nominees."

Merritt passes on Indy mayoral race

Can you say "Mayor Joe Hogsett?" At a time when Indiana Democrats are as close to rock bottom as a major party can get, it is the cowering Republican Party in Indianapolis that is acting like a lapdog. One by one, prominent Republicans have weighed running for Indianapolis mayor and all have folded, setting the stage to cede the most powerful mayorship in Indiana to the Democrats, who view it as an essential building block to attempt a comeback.

The latest was State Sen. Jim Merritt, who told Howey Politics Indiana earlier this month that after poring over election data since 1999, "A Republican candidate can win." But he was singing a different tune Tuesday, saying in a statement, "After careful deliberation, I have decided not to run for mayor in 2015. I love the city of Indianapolis, but my responsibilities as a state senator and majority caucus chairman are my top priorities. The Republican mayoral candidate will need to hit the ground running, and due to the 2015 legislative session, I will be unable to wholeheartedly commit myself to the race for the first four months of the year. While I appreciate the encouragement I have received, my focus will remain on serving the people of Senate District 31."

A number of prominent Indianapolis Republicans tell HPI they see their party nominee starting with a 20,000- to 25,000-vote disadvantage to Hogsett in a city that has been trending Democratic for more than two decades. But Mayor Greg Ballard won two races with pluralities under 10,000 votes by running as a non-politician, staying positive and emphasizing policy. That military "can-do" mojo has escaped the GOP this year.

Merritt joins former Indiana Republican chairman J. Murray Clark, Councilman Michael McQuillen and Ryan Vaughn, former chief of staff to Mayor Ballard, to take a pass on the race. Councilman Jefferson Shreve and Public Safety Director Troy Riggs, former councilman Jeff Cardwell and a few other unnamed Republicans are now the names being bandied around in Republican circles. Riggs and Shreve have been short-term residents of Indianapolis, which could be a significant flaw in either candidacy.

Merritt envisioned himself as a power broker, taking part in talks over the past week to lure the Rev. Charles Harrison into the race for the GOP nomination. But a key conservative wing of the party would have no part of the United Methodist pastor, even though he helped Mayor Ballard make significant inroads within the black church community that helped the mayor win reelection over Melina Kennedy in 2011.

Harrison has told HPI when he formed an exploratory committee that he would run as either an independent or a Libertarian. The latter option, which would break new ground for that party which hasn't had a prominent African-American candidate, would give Harrison easier ballot access. If he were to run as an independent, Democrats could be expected to vigorously challenge many of the thousand signatures he would need to collect for the ballot.

Riggs didn't arrive in Indianapolis until October 2012, when Mayor Ballard appointed him as public safety director. Riggs had served as deputy mayor in Corpus Christi, Tex., and before that as a police officer in Louisville, Ky. Indianapolis mayors ranging from Dick Lugar to Stephen Goldsmith have had candidacies compromised by police scandal and controversies. Lugar dealt with one when he challenged U.S. Sen. Birch Bayh in 1974 and the Meridian Street police brawl in August 1996 destroyed Goldsmith's gubernatorial campaign, where his ham-handed efforts in dealing with it set up his shocking upset to Democrat Frank O'Bannon. As a sitting public safety director in a city experiencing a homicide spike and where the TV newscasts feature a litany of "if it bleeds it leads" every night, Riggs would face daunting political obstacles well beyond his short tenure in the city.

It's fascinating that with the Indiana GOP's booted foot firmly on the throat of Indiana Democrats, the party is now on the verge of ceding the most influential mayoral seat. Both former senator and governor Evan Bayh and 2012 gubernatorial nominee John Gregg have told HPI that any Democratic comeback in the state has to begin with the Indianapolis mayoral race. "To win the governor's office, we have to have that mayor's seat in Indianapolis," Gregg told HPI in October 2013.

When Bayh opted out of the 2016 gubernatorial race last September, he told HPI that electing Hogsett mayor is critical for any Democratic comeback. "Fifty percent of all Hoosiers get Indianapolis television, so if all across Central Indiana every night, they see a successful, dynamic mayor who happens to be a Democrat, then they start concluding, 'Well, these Democrats can grow the economy, they really do know what they're doing with education, combating crime and so forth. We can trust them with some other things, too." So I think these mayors' races can really be, in Indianapolis, the big first step in trying to make the two-party system competitive again in our state." ❖

What if Bennett had faced a grand jury?

By SHAW FRIEDMAN

LaPORTE – Remember how the character George Bailey in the movie, "It's a Wonderful Life," was given the gift of being able to see how events would have unfolded in his hometown of Bedford Falls if he'd never been born?

Well, we're now given the "gift" of wondering what if the U.S. attorney or the Marion County prosecutor had taken up the issue of former Supt. of Public Instruction Tony Bennett's allegedly criminal behavior in a grand jury in 2014? Several of us, including Hammond Mayor Tom McDermott, practically pleaded in November 2013 for a grand jury to be convened, only for those pleas to fall on deaf ears including many in our own party. How different would the political landscape look in Indiana today?

It's a question worth pondering as that timeless movie favorite starring Jimmy Stewart and Donna Reed plays again for appreciative audiences. Would the Legislature look a little bit more like Bedford Falls than Pottersville next year? Would we have a few more Democrats who might have survived close races in the house of representatives and state senate? I suggest that's the case.

It's pretty damning when an investigator for the inspector general's office states conclusively in a report that former State Supt. Bennett "devised a scheme or artifice to defraud the State of Indiana by using State of Indiana paid employees and property, for his own personal gain, as well as his own political benefit to be elected."

The full report was released, not after investigative work done by either the Marion County prosecutor or U.S. attorney to unearth the material, but by an intrepid reporter with the Associated Press. It showed that from Jan. 1, 2012, to Dec. 31, 2012, more than 100 alleged violations of federal wire fraud laws occurred. The claims included 56 alleged violations by 14 different Bennett employees and 21 days in which Bennett allegedly misused his state issued SUV. Former Chief of Staff Heather Neal had the most alleged violations, 17.

Bennett and his top staff clearly viewed that state office as nothing more than a campaign headquarters and tales of arrogance and abuse of power are littered throughout the full 95-page report.

How different would the political terrain have been in 2014 had Tony Bennett and his cronies at the Indiana Department of Education been dealing with grand jury subpoenas and having to spend time and money with attorneys preparing to testify under oath? Bet the Tony Bennett alumni organization would not have had the time, resources or inclination to staff the "shadow" education department known as CECI that worked almost daily in 2014 to strip authority from Supt. Glenda Ritz or defame her in leaked reports to the media.

Had there been a criminal investigation ongoing, can you imagine the hay Indiana Democrats could have legitimately made about the "culture of corruption" under Bennett? Imagine the Democratic mailers featuring a photo of the embattled, scandal-plagued Tony Bennett arm in arm with targeted Republican legislators. That would have been a far more potent attack than going after little Rep. Eric Turner of Cicero whose name ID was nonexistent statewide and whose alleged ethics misbehavior was hard to understand even for voters in his own district. No, the Bennett allegations involved clear misuse of a state office and taxpayer dollars and would have been easy to convey. It's the kind of issue that can turn close legislative contests like the ones we lost in Lake County.

Alas, it was not to be. Unlike the Republicans, who have no hesitation about barking and braying for grand juries at even the hint of misbehavior by Democrats (see Philpot, Van Til and Butch Morgan prosecutions as examples), too many Hoosier Democrats are timid about pursuing allegations of Republican misbehavior.

This was no secret back then. Despite news leaking out in November 2013 about Bennett keeping multiple campaign databases on Department of Education servers and his calendar listing more than 100 instances of "campaign calls" during regular work hours, as well as staff directed to dissect a Glenda Ritz campaign speech for misstatements, calls were slow or nonexistent in requesting a criminal probe.

I suggest at this season of reflection that many of my Democratic brethren take a deep breath and commit to regaining some backbone and some nerve that our friends on the other side of the aisle clearly have honed in their years of winning statewide campaigns.

When they have a political opponent on the run with ethics issues, they don't let up. It's been 14 years since we had a state opposition research program the likes of which was run by Tom New, Pat Terrell and Robin Winston for the O'Bannon reelection, and I submit we better regain our nerve or we run the risk of many more lost statewide elections.

A few lessons in hard-nosed campaign politics from our Republican friends is just what we need in our stockings this Christmas. If not, we will be condemned to wandering the wilderness for another 20 years. As Chris Matthews says at the start of every show, "Let's play hard ball." ❖

Shaw R. Friedman is former legal counsel for the Indiana Democratic Party and a regular contributor to HPI.

Divided government and dysfunction

By LEE HAMILTON

BLOOMINGTON – Divided government does not have to be dysfunctional.

Given all the words and images devoted to the midterm elections over the past few weeks, you'd think the results had told us something vital about the future of the country. In reality, they were just a curtain-raiser. It's the next few weeks and months that really matter.

The big question, as the old Congress reconvenes and prepares to make way for next year's version, is whether the two parties will work more closely together to move the country forward or instead lapse back into confrontation and deadlock. I suspect the answer will be a mix: Modest progress on a few issues, but no major reforms.

Overall, the deep frustration Americans feel toward Washington will likely continue. Especially since, despite the urgent problems confronting us, the House leadership has announced an astoundingly relaxed 2015 agenda that includes not a single five-day work week, 18 weeks with no votes scheduled, and just one full month in session: January.

Still, there is hope for at least a modicum of progress. The President wants to enhance his legacy. More politicians these days seem to prefer governing to posturing. The Republican Party may have won big in the elections, but it still cannot govern alone; it will need Democratic votes in the Senate and the cooperation of the President. And both parties want to demonstrate that they recognize they're responsible for governing.

Congress faces plenty of issues that need addressing, which means that skillful legislators who want to show progress have an extensive menu from which to choose. Trade, health care, terrorism, responsible budgeting, rules on greenhouse gas emissions... All of these are amenable to incremental progress.

Which is not to say that progress is inevitable. President Obama acted to halt deportations of millions of illegal immigrants, though he did so without Congress. His action could unleash unpredictable consequences. Meanwhile, the new Republican Senate is almost certain to give the President's nominees a hard time; while GOP senators are unlikely to want to appear too tough on Loretta Lynch, the nominee for attorney general, the gloves will almost certainly come off for nominees who must negotiate hearings after her.

Yet indications of what next year may be like have already begun to emerge. Bills with a relatively narrow focus that enjoy bipartisan support — boosting agricultural development aid overseas, funding research into traumatic brain injuries, giving parents with disabled children a tax break on savings for long-term expenses — either have passed the "lame-duck" Congress or stand a good chance of doing so.

In the end, 2015 will see a mix of small steps forward and backward. There's little chance of a minimum wage increase and it's unlikely the budget will be passed in an orderly and traditional manner. Similarly, significant and difficult issues like major entitlement and tax reform will prove hard to budge, and comprehensive immigration reform is a near impossibility. There will be no knockdown punch on Obamacare, but we'll see plenty of efforts to chip away at it.

On the other hand, Congress can probably manage to avoid a government shutdown, and it faces decent prospects of expanding and protecting our energy boom, promoting fast-track trade authority, and funding key infrastructure needs. Defense spending will not be further reduced.

The parties on Capitol Hill are highly suspicious of one another. Incoming Senate Majority Leader Mitch McConnell has said the right things about wanting more openness, a more traditional process, and more ability on the minority's part to offer amendments, but he'll be under great pressure from members of his caucus to make life hard for Democrats. Similarly, Democrats in the Senate, still fuming over what they view as obstructionism from the Republicans over the last several years, will face pressure to make life as hard as possible for the new majority.

Yet here's the basic truth: Divided government does not have to be dysfunctional. It can be made to work, and if incremental progress on small issues is the way to get started, then let's hope Congress and the President pursue that course. ❖

Lee Hamilton is director of the Center on Congress at Indiana University. He was a member of the U.S. House of Representatives for 34 years.

HPJ HOWEY POLITICS INDIANA

Grimes to block Paul dual run

FRANKFORT, Ky. -- Six weeks after she lost her own bid for the U-S Senate, Secretary of State Alison Lundergan Grimes tells WHAS11 if U.S. Sen. Rand Paul tries to appear on the same ballot for both Senate and President in 2016, she will challenge him in court. "The law is clear," Grimes said. "You can't be on the ballot twice for two offices." Democrats are not cooperating as Paul considers mounting simultaneous campaigns for Senate and President. Democrats maintained control of the Kentucky House in last month's election, a roadblock to legislation favored by the Republican Senate to remove the prohibition. ❖

RDA most contentious issue for NW legislators

By RICH JAMES

MERRILLVILLE – The most contentious issue for Northwest Indiana legislators during the upcoming session of the General Assembly likely will be the area's Regional Development Authority.

The discussion – which has been in the works for almost a year – is the ongoing funding of the RDA.

For almost a decade, the state has contributed $10 million annually to the RDA. Whether the state extends the funding for another decade is in doubt.

In addition to the state money, the cities with casinos contribute $3.5 million annually, as do Lake and Porter counties.

Two recent developments will give the region a couple of good arguments to support ongoing state funding.

And, there is opposition from Republican legislative leaders who aren't terribly keen about giving additional money to an area largely controlled by Democrats.

Some of the RDA money has been used to help fund projects that are part of U.S. Rep. Peter Visclosky's Marquette Plan that is designed to reclaim part of the Lake Michigan shoreline for public use.

And in other cases, the money has helped waterfront cities develop projects on the lake.

As they go about seeking continued state funding for the RDA, local legislators likely will point to the extensive waterfront development in Whiting.

With the help of the RDA, Whiting has turned the Whiting Park lakefront into an attractive facility that allows residents and visitors to interact with the lakeshore. A baseball stadium is part of the lakefront development.

And during this holiday season, Whiting Mayor Joseph Stahura has put up an impressive light display along the drive through the park. The mayor says the light show has allowed the city to showcase itself to thousands of visitors from the greater Chicago area.

Area legislators will also have another card to play during the legislative session.

With the help of RDA funding, the Portage Lakefront and Riverwalk Park, which is part of the Indiana Dunes National Lakeshore, opened four years ago. While the park has had rave reviews, there is one problem – access is difficult.

That problem is being corrected with the help of the RDA.

The Portage Redevelopment Commission, with the help of the U.S. Army Corps of Engineers and private sector concerns, is financing a $1.7 million project to link the lakefront park and the Portage/Ogden Dunes South Shore Railroad stop.

From there will be walking and bicycling trails to the waterfront. There also will be 300 additional parking spots.

Future plans also include a visitors center and a trolley to transport visitors to the park.

In terms of the Portage development, Visclosky said that while it can be difficult to start a project, "It is more difficult to keep it going." ❖

Rich James has been writing about state and local government and politics for more than 30 years.

Chicago raises the minumum wage

By MICHAEL HICKS

MUNCIE – If the minimum wage is set above the market wage, some workers will lose jobs while some will be better paid.

Chicago has just enacted a series of minimum wage changes that are worth watching, simply because they reveal all that is true of the minimum wage debate. The new rules lift the minimum wage for non-food service hourly workers from $8.25 to $10 per hour this summer and then progressively to $13 per hour by 2019. Given today's muted inflation rate that $13 will be roughly $11.83 in today's dollars. Dissecting this policy begins by reviewing what economists know about the minimum wage.

Wages are largely determined by labor markets, and so workers typically receive pay that is commensurate with what they can earn for their employer. So, if the minimum wage is set above the market wage, some workers will lose jobs while some will be better paid. There is no disagreement on this among economists, or frankly anyone with a modest understanding of the matter, but low-paid jobs are not the issue.

Existing research reveals that the minimum wage rules can have several effects. In some instances the minimum wage costs jobs, but in most instances there is no effect. In only one, now largely discredited study was there a positive employment effect. I think research convincingly details that in most instances, local minimum wage laws have no discernable effect. The same will be

true in Chicago. There are two reasons for this; few workers work at the minimum wage, and the minimum wage is typically set well beneath the market wage.

First, few workers toil at minimum wage jobs. Nationally, only one in 50 workers hold minimum wage jobs, and half are in food service where tips are earned. Of those who hold minimum wage jobs, more than half are teenagers working casually. If we apply these numbers to the Chicago Metro area, perhaps 20,000 adults out of 4.5 million workers work at minimum wage jobs, virtually none of them in the city of Chicago.

Second, it is probably difficult to find anyone working at less than $10 an hour in Chicago. In 15 minutes on an employment website I found no job offering less than $10.50 an hour in the Chicago area. Probably fewer than four out of every 1,000 working adults in the entire Chicago area now work near the minimum wage. Of course these men and women matter. Both they and the work they perform have dignity and value. If we wish to help them better their lives, as most among us would suggest we should, surely we can figure some better way to do so than the blunt and impersonal minimum wage.

Of course I am being silly here. The minimum wage is not about helping low-wage workers. It never was. The goal of the minimum wage debate is not to boost the incomes of the working poor, or to make business pay the full cost of hiring workers. The minimum wage debate isn't about lifting all boats or rewarding honest labor. The minimum wage debate in Chicago is all about Mayor Rahm Emmanuel keeping his job. ❖

Michael J. Hicks, PhD, is the director of the Center for Business and Economic Research and the George and Frances Ball distinguished professor of economics in the Miller College of Business at Ball State University.

HPJ HOWEY POLITICS INDIANA

Are wages not keeping up with productivity?

By MORTON MARCUS

INDIANAPOLIS – Many Americans complain their incomes are not rising fast enough to offset inflation. The press and politicians echo this view and have declared it a major problem. In addition, some workers are distressed that compensation (wages and salaries plus benefits and bonuses) are not keeping up with the gains in labor productivity.

But is it true? To find the answer we have to go to the data. This is like wrestlers going to the mat. It's a sweaty business of getting knocked around until you are dizzy, exhausted, banged up and unsure what happened.

Fortunately, the U.S. Bureau of Labor Statistics is there to answer our questions. Their latest data lets us compare the third quarter of 2014 with the same quarter a year earlier. We'll look at non-farm business, that portion of the economy responsible for about 74 percent of Gross Domestic Product (GDP). To do that we exclude farming, government, not-for-profit institutions and private households.

On this year-over-year basis, hourly labor compensation rose by 2.2 percent. After adjusting for inflation, real hourly labor compensation grew by only 0.4 percent. For a worker making $20 per hour, that's a gain of eight cents or $3.20 for a 40-hour week.

Real output in the non-farm business sector rose by 3.1 percent in this period. The number of hours worked to produce that output increased by 2.1 percent. That means labor productivity (output divided by labor hours) increased one percent.

Some people, including many in the labor movement, argue that such an increase in labor productivity should be rewarded by a comparable increase in real wages. If you produce more you should earn more buying power.

This noble ideal does not mesh with reality. More than labor is involved in producing goods and services. For two centuries, we've increased uses for machinery. Owners of that equipment and the people who make it expect to see their share of rewards in those productivity gains. There are payments to be made to those who supply energy. Managerial innovation likewise enhances worker productivity (think of the assembly line) without increasing labor hours.

Most importantly, an hour of labor today is not necessarily equal to an hour of labor yesterday or 10 years ago. Today's workers may know more about how to produce goods and services, to work with machinery, to be efficient when employing energy, (including bonuses) and to adapt to management changes.

The standard measure of labor productivity (real output divided by hours of labor input) is a number of decreasing usefulness. To link that number with real compensation is an error made too often. If increasing education raises output, without raising hours of work, then wages should rise as a payment for what economists call "human capital."

We need to use different measures to answer that ancient question: "What is a just wage?" ❖

Mr. Marcus is an economist, writer, and speaker who may be reached at mortonjmarcus@yahoo.com.

John Sugden, Open Secrets: Following mixed results in the 2014 midterms, Club for Growth last week announced a change of leadership. As of Jan. 1, former Indiana Rep. David McIntosh (R) will replace current Club president Chris Chocola, whose tenure saw the group go through ups and downs. Club chairman Jackson T. Stephens Jr. praised the outgoing president in a statement, saying "under Chris Chocola's leadership, the Club for Growth made tremendous gains in the fight for economic freedom and individual liberty." The group's anti-tax, free market principles have led it to favor lesser-known tea party candidates. In fact, its super PAC, Club for Growth Action, has spent most of its money in recent cycles opposing more mainstream GOP candidates during primaries rather than bashing Democrats in general elections. The main focus of the Club's independent expenditures in 2014 was Mississippi's Republican Senate primary, in which six-term Sen. Thad Cochran faced an unexpectedly stout struggle with Chris McDaniel. Club for Growth Action's 2014 spending was up from its 2010 midterm total, but the $7.8 million it laid out pales in comparison to the more than $16 million the super PAC spent in 2012. Though it was a presidential election year, the Club's spending spike was due largely to its support for Sen. Ted Cruz (R-Texas). The Club also spent big on the Indiana Senate race in 2012, investing in Republican primary challenger and state treasurer Richard Mourdock. With the Club's help and tea party backing, Mourdock beat six-term Sen. Richard Lugar in the GOP primary. Mourdock had little trouble finding room to Lugar's right, however he couldn't manage to beat his Democratic opponent, Joe Donnelly, in the general election. Club for Growth Action spent $3.6 million on the race. ❖

Jonah Goldberg, Los Angeles Times: I think Time missed an opportunity in not putting Jonathan Gruber on the cover. Tea partyers and Wall Street occupiers disagree on a great many things, but there's one place where the Venn diagrams overlap: the sense we're all being played for suckers, that the rules are being set up to benefit those who know how to manipulate the rules. The left tends to focus on Wall Street types whose bottom line depends more on lobbying Washington than satisfying the consumer. But Gruber is something special. He was supposed to be better, more pure than the fat cats. Touted by press and politicians alike as an objective and fair-minded arbiter of healthcare reform, the MIT economist was in fact a warrior for the cause, invested emotionally, politically and, it turns out, financially through undisclosed consulting arrangements. In speeches and interviews, Gruber admitted he helped the Obama administration craft the law in such a way that it would seem like it didn't tax the American people when it did. Using insights gleaned in part from his status as an advisor to the Congressional Budget Office, Gruber helped construct an actuarial Trojan Horse that could smuggle a tax hike past the CBO bean counters. If the individual mandate was counted as a tax it would be a big political liability for President Obama (fortunately for Obamacare, the Supreme Court saw through the subterfuge and called it tax, rendering it constitutional). Gruber then mocked the "stupidity of the American voter" for not seeing through the camouflage he helped design. Last week, in a congressional hearing that came as close to an auto-da-fé as our politics can manage, Gruber apologized for his "arrogance" as a way to duplicitously deny his previous duplicity. It was a brilliant and cynical public relations ploy. By making the issue his personality, he could avoid the tougher questions about the substance of what he said. It worked, in part, because Gruber really is arrogant. But Gruber's arrogance goes beyond the personal. He represents the arrogance of the expert class writ large. They create systems, terms and rules that no normal person on the outside can possibly penetrate. It's not that Americans are stupid, it's that the experts have been geniuses at creating a system that makes normal people feel stupid. ❖

Rich Lowry, Politico: After waiting out 10 other U.S. presidents, the Castro regime finally hit the jackpot in Obama, whose beliefs about our Cuba policy probably don't differ much from those of the average black-turtleneck-clad graduate student in Latin American studies. Every dictator around the world must be waiting anxiously for a call or a postcard from Obama. The leader of the free world comes bearing gifts and understanding. ❖

Nicholas Kristoff, New York Times: Is there any element of American foreign policy that has failed more abjectly than our embargo of Cuba? When I hear hawks denouncing President Obama for resolving to establish diplomatic relations with Cuba and ease the embargo, I don't understand the logic. Is their argument that our policy didn't work for the first half-century but maybe will work after 100 years? We probably helped keep the Castro regime in power by giving it a scapegoat for its economic and political failures. Look around the world, and the hard-line antique regimes that have survived — Cuba and North Korea — are those that have been isolated and sanctioned. Why do we think that isolating a regime is punishing it, rather than protecting it? Few initiatives failed more catastrophically than the American-backed Bay of Pigs invasion of Cuba in 1961. Yet while an armed invasion failed, I bet that we would have done better if we had permitted invasions of tourists, traders and investors. American tourists in Havana are already asking plaintively why Wi-Fi is so scarce — or why the toilet paper is so rough. We need hordes of them, giggling at ancient cars held together with duct tape, or comparing salaries with Cubans. Sometimes the power of weaponry fades next to the power of mockery. ❖

Obama opens up to Cuba

WASHINGTON — The United States and Cuba ended more than a half-century of enmity Wednesday, announcing that they would reestablish diplomatic relations and begin dismantling the last pillar of the Cold War (Washingon Post). The historic move, following 18 months of secret negotiations and finally made possible by Cuba's release of detained U.S. aid contractor Alan Gross, fulfilled one of President Obama's key second-term goals. The decision is likely to reverberate across many political frontiers where the standoff between Washington and Havana has played a role — including across much of Latin America, where U.S. policy on Cuba has long been a source of friction. "These 50 years have shown that isolation has not worked," Obama said in a televised, midday address. "It's time for a new approach." Saying that he was "under no illusion about the continued barriers to freedom that remain for ordinary Cubans," Obama said he was convinced that "through a policy of engagement, we can more effectively stand up for our values and help the Cuban people help themselves." In simultaneous remarks in Havana, Cuban President Raúl Castro affirmed his government's willingness for dialogue on "profound differences" between the countries, "particularly on issues related to national sovereignty, democracy, human rights and foreign policy." Castro said that "Obama's decision ... deserves the respect and acknowledgment of our people." Obama and Castro — who spoke by phone Tuesday, the first such exchange between leaders of the two countries since the 1959 Cuban revolution — thanked Pope Francis and the Vatican, which they said were instrumental in promoting their dialogue, and the government of Canada, where secret talks that began in June 2013 were held.

In addition to reopening an embassy in Havana, the administration plans to significantly ease trade and financial restrictions, as well as limits on travel by Americans to Cuba, by using its regulatory and enforcement powers to evade limits imposed by a congressionally mandated embargo. Americans will be permitted to send more money to Cuban nationals, use their debit and credit cards in Cuba, and bring $100 worth of Cuban cigars into this country. U.S. exports to Cuba will be made easier, and additional items will be authorized. U.S. banks will be allowed to open correspondent relations with banks in Cuba.

Coats calls move 'appeasement'

INDIANAPOLIS – Reaction on Capitol Hill to President Obama's agreement to normalize relations with Cuba is mixed and Indiana Senator Dan Coats is one of the people who is speaking out against the President's agreement with Cuba (WISH-TV). He expressed his concerns first on Twitter. The Indiana Republican first welcomed the return of accused spy Alan Gross and said "I celebrate his release from imprisonment." But then he went on the offensive saying that "since 1961 nine Presidents opposed normalizing relations with Cuba." He said the announcement is "evidence that the Obama foreign policy objective is appeasement" and then he tweeted that the action "rewards the Castro regime at the expense of the Cuban people." In a 24-Hour News 8 interview he said he relies on Florida Senator Marco Rubio for advice on this matter. "And he said look, this is a communist dictatorship there that has oppressed the people," said Sen. Coats. "They try to paint a nice picture but what's going on down in Cuba still under the Castros, first Fidel and now his brother Raoul, he said is bad, bad stuff."

Stutzman wants to see Cuba steps

INDIANAPOLIS – Rep. Marlin Stutzman, R-3rd, said in a statement that Cuban government leaders "need to show significant steps toward freeing its people by opening their political system, transitioning towards democracy, expanding human rights, and reject working with our enemies" before the U.S. considers normalizing relations (Fort Wayne Journal Gazette). Sen. Joe Donnelly, D-Ind., did not take sides on the plan. Donnelly "will continue to review the president's proposal for normalizing relations with Cuba, understanding that our foreign policy should always promote and protect the economic and security interests of the United States," Elizabeth Shappell, communications director for Donnelly, said in an email.

U.S. says NKorea behind Sony attack

WASHINGTON — American officials have concluded that North Korea was "centrally involved" in the hacking of Sony Pictures computers, even as the studio canceled the release of a far-fetched comedy about the assassination of the North's leader that is believed to have led to the cyberattack (New York Times). Senior administration officials, who would not speak on the record about the intelligence findings, said the White House was debating whether to publicly accuse North Korea of what amounts to a cyberterrorism attack. Sony capitulated after the hackers threatened additional attacks, perhaps on theaters themselves, if the movie, "The Interview," was released. Officials said it was not clear how the White House would respond. Some within the Obama administration argue that the government of Kim Jong-un must be confronted directly. But that raises questions of what actions the administration could credibly threaten, or how much evidence to make public.

Scott.A.Milkey

From: Hill, John (DHS)
Sent: Thursday, December 18, 2014 10:44 AM
To: Atterholt, Jim
Subject: FW: Advice on State Agency

Sent from my Windows Phone

From: Kane, David
Sent: 12/18/2014 9:59 AM
To: sminier@indianahistory.org
Cc: Czarniecki, Cary (Lani); Hill, John (DHS)
Subject: RE: Advice on State Agency

Mr. Minier,

Your inquiry to the Governor's Office has been passed to me for action. This morning I spoke with our Budget Manager who personally is walking payment for these services through IDOA and the Auditor's Office. We are informed that necessary paperwork is in order and payment will be made next week. Please call me directly if payment is not received by 12/23/14. My mobile number is 317-[redacted]

I regret this long delay in your claim being processed in a timely manner has occurred.

Thank you for the professionalism approach of your inquiry.

David W. Kane
Executive Director
Indiana Department of Homeland Security

From: Scott Minier [mailto:SMinier@indianahistory.org]
Sent: Wednesday, December 17, 2014 7:05 PM
To: Hill, John (DHS); Czarniecki, Cary (Lani)
Subject: RE: Advice on State Agency

John and Lani,

More than another month has passed, so I wanted to give you an update, as we begin closing out our Indiana Historical Society books for another calendar and fiscal year.

I received a courtesy call from Mary Moran of IDHS last Monday, Dec. 8, 2014, notifying me the agency's fiscal people were unable to play the pledge paperwork as presented. (Mary has been very responsive and helpful throughout this final attempt to receive the $10,000 state commitment dated Nov. 28, 2012, for the "You Are There 1913: A City Under Water" exhibit.) Four weeks after my last communication with you, Mary politely and professionally explained she had been told the pledge notice was not considered an invoice and did not meet IDHS guidelines for payment. I asked for a contact person in the IDHS finance office, to see if I could rectify the situation without further frustration and delay.

Mary talked to them again and said someone would call me, but no call has been received from the IDHS finance office. For our part, we immediately re-issued the pledge notice as an invoice -- although we had been instructed all along by

IDHS that it could not be presented as an invoice. Twenty-plus monthly notices, reminders and now an invoice later, including by registered mail, our understanding is the written commitment may finally have been approved for processing, but no check has arrived.

You asked that I keep you posted as to payment or failure to pay. I just wanted you to know our IHS bookkeepers are closing accounts for yet another year, as not-for-profits' fiscal years coincide by federal law with the calendar year. I'm not sure if the Auditor of State can issue a check in time for deposit yet this month, but it would be very helpful for all parties involved.

Thanks in advance for anything you can do, as WISH TV8 is also an active IHS partner on this particular exhibit.

Scott Minier
Director, Corporate Relations
Indiana Historical Society
Eugene and Marilyn Glick Indiana History Center
450 West Ohio Street
Indianapolis, Indiana 46202

317-234-8853 office
317-234-0076 fax

www.indianahistory.org

See the newest features of the *Indiana Experience:*
You Are There 1939: *Healing Bodies, Changing Minds*
You Are There 1913: *A City Under Water*
You Are There 1904: *Picture This*

Scott.A.Milkey

From: Atterholt, Jim
Sent: Wednesday, December 17, 2014 8:02 PM
To: Keefer, Sean (GOV)
Subject: Fwd: Advice on State Agency

Just looping you in:

Jim
James Atterholt
Chief of Staff
Governor Mike Pence
jatterholt@gov.in.gov
Executive Assistant: Janille Myers
Office: 317-232-1800

Begin forwarded message:

> **From:** Scott Minier <SMinier@indianahistory.org>
> **Date:** December 17, 2014 at 7:05:01 PM EST
> **To:** "'Hill, John (DHS)'" <jhill@gov.in.gov>, "Czarniecki, Cary (Lani)" <LaniCz@gov.IN.gov>
> **Subject: RE: Advice on State Agency**
>
> John and Lani,
>
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You Are There 1913: *A City Under Water*
You Are There 1904: *Picture This*

From: Hill, John (DHS) [mailto:jhill@gov.in.gov]
Sent: Wednesday, November 12, 2014 5:51 PM
To: Czarniecki, Cary (Lani); Scott Minier
Subject: RE: Advice on State Agency

Scott:
Jan Crider retired and I suspect this has escaped someone's watchful eye. I will get on it and find out the status.
John
Office of Governor Mike Pence
Deputy Chief of Staff for Public Safety
200 W. Washington Street - Room 206
Indianapolis, IN 46204
317-234-4743 (O)
317-[redacted] (M)

From: Czarniecki, Cary (Lani)
Sent: Wednesday, November 12, 2014 4:25 PM
To: Scott Minier
Subject: Re: Advice on State Agency

Got it Scott!

I am on the road for the remainder of today but I can run the traps on this first thing tomorrow.
Best regard,
lani

Lani Czarniecki
765-[redacted]
Lanicz@gov.in.gov
www.in.gov/gov

On Nov 12, 2014, at 12:17 PM, "Scott Minier" <SMinier@indianahistory.org> wrote:

> Lani,
>
> Thank you again for working together so well on **Governor and Mrs. Pence's** participation in the funeral of former **Marion County Sheriff Jack L. Cottey.**
>
> When you get a chance, I'd like to seek your advice on how to approach a state agency about a major outstanding pledge the **Indiana Historical Society** seems to be having trouble collecting.
>
> Nearly two years ago, Nov. 28, 2012, the **Indiana Department of Homeland Security** agreed in writing to fund **$10,000** toward our "**You Are There 1913: A City Under Water" exhibit,** which opened in March of 2013. Since then, several reminders have been mailed and emailed to Jan Crider, IDHS Mitigation, who appears to have signed the funding agreement, and to Manuela Johnson, IDHS Disaster Relief Fund, who has been kind enough to at least return phone calls from IHS. Both Jan and Manuela reportedly served on an advisory panel for this impactful and popular interactive exhibit.
>
> It is only with the support of funders that IHS is able to create educational experiences like **"A City Under Water," which highlights disaster aid, relief and prevention efforts.**
>
> Your guidance on how we might best approach IDHS to successfully close this outstanding pledge would be greatly appreciated. It is a matter that continues to be discussed in many meetings involving folks in high circles. I'm sure you can appreciate my desire to prevent any further embarrassment for the administration. My hope is that either you or Jim Atterholt can help me solve this situation quietly and quickly.
>
> Thanks, my friend.
>
> **Scott Minier**
> Director, Corporate Relations
> Indiana Historical Society
> Eugene and Marilyn Glick Indiana History Center
> 450 West Ohio Street
> Indianapolis, Indiana 46202
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Scott.A.Milkey

From: Gilson, Katie
Sent: Tuesday, December 16, 2014 8:46 AM
To: Gilson, Katie;Quyle, Lindsay;Anderson, Christopher M;Madden, Virgil;Hodgin, Stephanie; #All Governor's Office;Bailey, Brian (OMB);Pitcock, Josh;Baker, Lou Ann (CECI);Rosebrough, Dennis (LG);Rosebrough, Dennis (LG);Dowd, Jaclyn (CECI);Rossier, Sarah (CECI);Wickham, Michelle (CECI);Fiddian-Green, Claire (CECI);McKinney, Ted;Bausman, David;Atterholt, Jim;#All Lieutenant Governor's Office;'smith@sextonscreek.com';'tomrose@[redacted]';Karns, Allison;Brookes, Brady;Triol, Shelley;Wall, Kathryn E;'Marty Obst';Reed, Katie
Subject: Morning Clips - December 16, 2014

GOVERNOR

Donnelly, Wicker: 'Sexton Act will soon be law'
Greensburg Daily News
U.S. Senators Joe Donnelly (D-IN) and Roger Wicker (R-KS) welcomed the Senate passage of the National Defense Authorization Act (NDAA) today with support from both parties, by a vote of 89 - 11. The national defense bill includes their Jacob Sexton Military Suicide Prevention Act of 2014, which would require an annual mental health assessment for all servicemembers. The bill now heads to President Obama to be signed into law. Governor Mike Pence commended the passage of the Jacob Sexton Act, which passed the U.S. Senate as part of the National Defense Authorization Act (NDAA). Jacob Sexton, of Farmland, Indiana, tragically passed away in October of 2009 while on leave from his overseas duties as a soldier within the Alpha Company, 2nd Battalion, 151st Infantry Regiment of the Indiana National Guard.

Indiana Gov. Mike Pence praises Jacob Sexton Military Suicide Prevention Act
The Examiner
Indiana Gov. Mike Pence this morning praised the passage of the Sexton Act; a provision in the National Defense Bill that will allow all members of the military to have an annual mental health assessment. The bill passed the Senate on Friday with an 89-11 vote.

3 Avon Boy Scouts honored for heroic actions
Wish TV 8
Four Central Indiana Boy Scouts received a big honor on Monday. At the annual Governor's Luncheon for Scouting three scouts from Avon received National Heroism Awards for their quick actions to save their leader who had a medical emergency during a car crash.

Special access to Gov. Pence available for $10K
Indy Star
Anyone with $10,000 to burn and a deep, abiding love of Indiana politics scored top access to Gov. Mike Pence Monday evening, as he delivered his "year end 'round-up' reception" to donors at a posh Downtown hotel…The money and the level of access are hardly new — top-level donors often give well more than $10,000 to their favorite politicians — but the event comes as Pence is getting ready to head into a crucial state legislative session tinged by his consideration of a White House run in 2016.

Pence sounds out GOP donors in Palm Beach
National Review Online
Indiana governor Mike Pence on Friday dined with a group of about 40 top Republican donors at Palm Beach's exclusive Everglades Club. The dinner was hosted and organized by investment manager Thomas W. Smith, who has been a generous donor to conservative causes. The billionaire investor Wilbur Ross was also present.

LEGISLATIVE

Food and beverage taxes on Indiana legislators' menu

Herald Bulletin
When state Rep. John Price buys a meal or drink in the state capital, he pays a small tax for local police, fire and other public services. The Greenwood Republican would like to see every community have the option of collecting a little extra revenue from bar and restaurant patrons, too. That's why, as chairman of the House Local Government Committee, Price wants the General Assembly to cede control over who may impose food and beverage taxes, giving cash-strapped communities a taxing option that could generate millions of dollars…

Republicans choose state House replacement
Kokomo Tribune
The former superintendent of the Hamilton Heights School Corporation has been selected to fill the term of Eric Turner in Indiana House District 32…Turner was the subject of an ethics investigation involving his encouragement of Republican members of the House to defeat legislation that would have prohibited the construction of new nursing homes in the state. His family is in the nursing home business…He was prompted to consider running for the vacant seat by Rep. Cathy Richardson because he was familiar with the district, he said. "I was surprised," he said of Turner's announcement prior to the November election. "I didn't expect that to happen. I had thought about running in 2016, so when this opportunity presented itself, I decided to run for the seat."

Cook elected to replace Turner
Herald Bulletin
The former superintendent of Hamilton Heights Schools will fill the term of Eric Turner in Indiana House District 32.

STATE AGENCIES
State commission requests immediate suspension of Muncie judge facing misconduct allegations
The Columbus Republic
A state commission on Monday requested the immediate suspension of a Muncie city court judge who faces misconduct allegations including abuse of judicial power.

State commission seeks suspension of Muncie judge
Fort Wayne Journal Gazette
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Stage collapse victim asks appeals court to throw out state's liability cap
Indy Star
After a stage collapsed at the 2011 Indiana State Fair, killing seven people and injuring dozens of others, the state began to make some financial compensations.

Ohio girl hurt at fair challenges Ind. damages cap
Fort Wayne Journal Gazette
Attorneys for a 13-year-old victim of the 2011 Indiana State Fair stage collapse are arguing the state's cap on liability damages is unconstitutional and should be thrown out by the Indiana Court of Appeals.

Pacers and Fever partner with Jakks Pacific for holiday toy giveaway
NBA
It started as a simple friendship between two men. Over the past five years the friendship has provided smiles to nearly 175,000 children throughout Central Indiana. Indiana Pacers and Indiana Fever owner Herb Simon has teamed with his pal, JAKKS Pacific Toys Co-Founder and CEO Stephen Berman to donate toys to various Central Indiana charities over the past five year. This month, 20,000 toys will be distributed to various organizations and volunteer groups throughout Central Indiana and as always, the toys will be distributed through the efforts of the Indiana National Guard. These toys are in addition to the 10,000 Halloween costumes JAKKS provided to kids this fall through the efforts of the Indianapolis Fire Dept…

Historical Society details heritage program
Inside Indiana Business

The Indiana Historical Society (IHS) is pleased to announce the creation of its new Indiana Heritage Support Program, an initiative funded by a $3.43 million grant from Lilly Endowment Inc.

AROUND THE STATE

Memorial dedicated to firefighters killed in crash
WLFI
A new memorial has been dedicated to honor five northern Indiana firefighters who died in a crash while on their way to a house blaze more than 30 years ago. More than 100 people gathered for Sunday's dedication ceremony at the black stone monument near the crash scene along Indiana 17, a few miles west of Plymouth.

Hamilton Southeastern school board approves new redistricting plan
Indy Star
The Hamilton Southeastern school board approved a new redistricting plan Monday that could affect thousands of students in Fishers.

Demolition starts on former Fort Wayne school
Inside Indiana Business
Demolition work began today at the former Franklin School site on St. Marys Avenue. Mayor Tom Henry and community and neighborhood leaders attended today's launch of the demolition process. The City of Fort Wayne is investing more than $330,000 for the demolition of the property.

'Tip the hat award' grant program grows
Inside Indiana Business
The LIDS Foundation, a charitable 501(c)(3) organization and the philanthropic support arm of LIDS Sports Group, is presently accepting applications for its largest annual grant, the "Tip the Hat Award." Now in its third year, the grant program has nearly doubled in size, offering a total of $300,000 in funding for 2015.

45 arrested at Valpo drinking party; 26 are VU athletes
NWI Times
Police said 45 people were arrested after police responded to a report of a loud party in the 1100 block of Lind Lane in Valparaiso early Saturday morning.

Gunman, 2 hostages die in fiery end to Sydney siege
Indy Star
A tense, 16-hour Australian hostage standoff ended with an eruption of gunfire in Sydney when heavily armed police stormed a cafe in the heart of the city's financial center.

Outrage over 'PIG' spray-painted on officer's grave
Indy Star
Thirty-one years ago, he was shot while taking down a homicidal man who declared war on the town of Aurora, Indiana.

JOBS/ECONOMY

Navistar shutting down Indianapolis operation
Inside Indiana Business
The company laid off hundreds of workers in Fort Wayne in 2011 and 2012 at its Truck Development Technology Center. Navistar also announced major facility shutdowns in 2009 and 2010 in Indianapolis, cutting a total of more than 1,700 jobs. Sources: Inside INdiana Business, The Indiana Department of Workforce Development and Navistar International Corp.

Canadian Investor plugging into IPL
Inside Indiana Business
The AES Corporation (NYSE:AES) announced today that it has entered into an agreement with La Caisse de dépôt et placement du Québec (CDPQ), a long-term institutional investor headquartered in Quebec, Canada. Pursuant to the agreement, CDPQ will purchase 15 percent of AES US Investments, Inc. (AES US Investments), a wholly-owned

subsidiary of AES that owns 100 percent of IPALCO Enterprises, Inc. (IPALCO), for US$244 million. In addition, CDPQ will invest approximately US$349 million in IPALCO through 2016, in exchange for a 17.65 percent equity stake, funding existing growth and environmental projects at Indianapolis Power & Light Company (IPL).

EDITORIALS

Gov. Mike Pence: National Government is not the nation

Town Hall

If success at the state level were enough to recommend someone for president of the United States, Gov. Mike Pence of Indiana would be among the frontrunners for the 2016 GOP presidential nomination.

A transparent need

Fort Wayne Journal Gazette

Almost everyone agrees that governmental transparency is crucial to making democracy work. Putting transparency into practice is a different matter, which is why current efforts to upgrade open-records laws at the state and national level deserve your support.

Winning the peace

Fort Wayne Journal Gazette

The suicides of servicemen and servicewomen are just as tragic as the deaths on the uncertain battlefields of Iraq and Afghanistan. And as those conflicts have wound down, the suicide rates have remained high.

Scott.A.Milkey

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Food and beverage taxes on Indiana legislators' menu

Herald Bulletin
When state Rep. John Price buys a meal or drink in the state capital, he pays a small tax for local police, fire and other public services. The Greenwood Republican would like to see every community have the option of collecting a little extra revenue from bar and restaurant patrons, too. That's why, as chairman of the House Local Government Committee, Price wants the General Assembly to cede control over who may impose food and beverage taxes, giving cash-strapped communities a taxing option that could generate millions of dollars…

Republicans choose state House replacement
Kokomo Tribune
The former superintendent of the Hamilton Heights School Corporation has been selected to fill the term of Eric Turner in Indiana House District 32…Turner was the subject of an ethics investigation involving his encouragement of Republican members of the House to defeat legislation that would have prohibited the construction of new nursing homes in the state. His family is in the nursing home business…He was prompted to consider running for the vacant seat by Rep. Cathy Richardson because he was familiar with the district, he said. "I was surprised," he said of Turner's announcement prior to the November election. "I didn't expect that to happen. I had thought about running in 2016, so when this opportunity presented itself, I decided to run for the seat."

Cook elected to replace Turner
Herald Bulletin
The former superintendent of Hamilton Heights Schools will fill the term of Eric Turner in Indiana House District 32.

STATE AGENCIES
State commission requests immediate suspension of Muncie judge facing misconduct allegations
The Columbus Republic
A state commission on Monday requested the immediate suspension of a Muncie city court judge who faces misconduct allegations including abuse of judicial power.

State commission seeks suspension of Muncie judge
Fort Wayne Journal Gazette
A state commission on Monday requested the immediate suspension of a Muncie city court judge who faces misconduct allegations including abuse of judicial power.

Stage collapse victim asks appeals court to throw out state's liability cap
Indy Star
After a stage collapsed at the 2011 Indiana State Fair, killing seven people and injuring dozens of others, the state began to make some financial compensations.

Ohio girl hurt at fair challenges Ind. damages cap
Fort Wayne Journal Gazette
Attorneys for a 13-year-old victim of the 2011 Indiana State Fair stage collapse are arguing the state's cap on liability damages is unconstitutional and should be thrown out by the Indiana Court of Appeals.

Pacers and Fever partner with Jakks Pacific for holiday toy giveaway
NBA
It started as a simple friendship between two men. Over the past five years the friendship has provided smiles to nearly 175,000 children throughout Central Indiana. Indiana Pacers and Indiana Fever owner Herb Simon has teamed with his pal, JAKKS Pacific Toys Co-Founder and CEO Stephen Berman to donate toys to various Central Indiana charities over the past five year. This month, 20,000 toys will be distributed to various organizations and volunteer groups throughout Central Indiana and as always, the toys will be distributed through the efforts of the Indiana National Guard. These toys are in addition to the 10,000 Halloween costumes JAKKS provided to kids this fall through the efforts of the Indianapolis Fire Dept…

Historical Society details heritage program
Inside Indiana Business

The Indiana Historical Society (IHS) is pleased to announce the creation of its new Indiana Heritage Support Program, an initiative funded by a $3.43 million grant from Lilly Endowment Inc.

AROUND THE STATE

Memorial dedicated to firefighters killed in crash
WLFI
A new memorial has been dedicated to honor five northern Indiana firefighters who died in a crash while on their way to a house blaze more than 30 years ago. More than 100 people gathered for Sunday's dedication ceremony at the black stone monument near the crash scene along Indiana 17, a few miles west of Plymouth.

Hamilton Southeastern school board approves new redistricting plan
Indy Star
The Hamilton Southeastern school board approved a new redistricting plan Monday that could affect thousands of students in Fishers.

Demolition starts on former Fort Wayne school
Inside Indiana Business
Demolition work began today at the former Franklin School site on St. Marys Avenue. Mayor Tom Henry and community and neighborhood leaders attended today's launch of the demolition process. The City of Fort Wayne is investing more than $330,000 for the demolition of the property.

'Tip the hat award' grant program grows
Inside Indiana Business
The LIDS Foundation, a charitable 501(c)(3) organization and the philanthropic support arm of LIDS Sports Group, is presently accepting applications for its largest annual grant, the "Tip the Hat Award." Now in its third year, the grant program has nearly doubled in size, offering a total of $300,000 in funding for 2015.

45 arrested at Valpo drinking party; 26 are VU athletes
NWI Times
Police said 45 people were arrested after police responded to a report of a loud party in the 1100 block of Lind Lane in Valparaiso early Saturday morning.

Gunman, 2 hostages die in fiery end to Sydney siege
Indy Star
A tense, 16-hour Australian hostage standoff ended with an eruption of gunfire in Sydney when heavily armed police stormed a cafe in the heart of the city's financial center.

Outrage over 'PIG' spray-painted on officer's grave
Indy Star
Thirty-one years ago, he was shot while taking down a homicidal man who declared war on the town of Aurora, Indiana.

JOBS/ECONOMY

Navistar shutting down Indianapolis operation
Inside Indiana Business
The company laid off hundreds of workers in Fort Wayne in 2011 and 2012 at its Truck Development Technology Center. Navistar also announced major facility shutdowns in 2009 and 2010 in Indianapolis, cutting a total of more than 1,700 jobs. Sources: Inside INdiana Business, The Indiana Department of Workforce Development and Navistar International Corp.

Canadian Investor plugging into IPL
Inside Indiana Business
The AES Corporation (NYSE:AES) announced today that it has entered into an agreement with La Caisse de dépôt et placement du Québec (CDPQ), a long-term institutional investor headquartered in Quebec, Canada. Pursuant to the agreement, CDPQ will purchase 15 percent of AES US Investments, Inc. (AES US Investments), a wholly-owned

subsidiary of AES that owns 100 percent of IPALCO Enterprises, Inc. (IPALCO), for US$244 million. In addition, CDPQ will invest approximately US$349 million in IPALCO through 2016, in exchange for a 17.65 percent equity stake, funding existing growth and environmental projects at Indianapolis Power & Light Company (IPL).

EDITORIALS

Gov. Mike Pence: National Government is not the nation
Town Hall
If success at the state level were enough to recommend someone for president of the United States, Gov. Mike Pence of Indiana would be among the frontrunners for the 2016 GOP presidential nomination.

A transparent need
Fort Wayne Journal Gazette
Almost everyone agrees that governmental transparency is crucial to making democracy work. Putting transparency into practice is a different matter, which is why current efforts to upgrade open-records laws at the state and national level deserve your support.

Winning the peace
Fort Wayne Journal Gazette
The suicides of servicemen and servicewomen are just as tragic as the deaths on the uncertain battlefields of Iraq and Afghanistan. And as those conflicts have wound down, the suicide rates have remained high.

Scott.A.Milkey

From: Brooks, Kara D
Sent: Tuesday, December 02, 2014 3:04 PM
To: Bauer, Zachary C; Pavlik, Jennifer L; Crabtree, Chris
Cc: Keefer, Sean (GOV); Norton, Erin (Ladd); Denault, Christina
Subject: FW: Gov. Pence BGD LegCon needs
Attachments: 2014 LegCon _ Agenda.DOCX

FYI—I responded to this email but wanted to share the details from the third bullet. Thanks.

From: Beatty, Leah J. [mailto:LBeatty@bgdlegal.com]
Sent: Tuesday, December 02, 2014 2:40 PM
To: Brooks, Kara D
Subject: Gov. Pence BGD LegCon needs

Hi Kara,

I wanted to quickly touch base with you about BGD LegCon on Thursday. We are thrilled to welcome back Governor Pence, and look forward to his legislative agenda announcement.

I have two questions for you:

1. Will Governor Pence be taking questions from the media immediately following his presentation? We will have the media room available.

2. Will any other staff members be attendance? Here is our current list:
   - Jim Atterholt
   - Sean Keefer
   - Danielle McGrath
   - Jeff Espich
   - Chris Atkins
   - Ryan Streeter
   - Christy Denault
   - Kara Brooks
   - Chris Crabtree

3. Right now, we have the Governor and his staff coming in the back entrance of Sagamore 3|4 through a private hallway before his speech; John Gregg and Sebastian Smelko plan to greet the Governor upon his arrival. Is there anything else needed?

I've attached the full agenda here for your reference; feel free to give me a call if that is easiest! See you on Thursday.

Leah Beatty
Marketing Communications Lead
Bingham Greenebaum Doll LLP
2700 Market Tower | 10 W. Market Street | Indianapolis, IN 46204
Indianapolis | Louisville | Lexington | Cincinnati | Jasper | Evansville | Vincennes
Direct: 317-968-5536 | Mobile: 317-[redacted] | Fax: 317-236-9907
Email: lbeatty@bgdlegal.com | http://www.bgdlegal.com
Follow us on Twitter | Visit our Blog: http://www.bgdlegal.com/blog

2014 LEGISLATIVE CONFERENCE

INDIANA CONVENTION CENTER

December 4, 2014

8:00 – 9:00	***REGISTRATION	CONTINENTAL BREAKFAST***	**2ND FLOOR** SERPENTINE LOBBY
8:15 – 8:30	***WELCOME***	**Toby McClamroch**, Managing Partner, BINGHAM GREENEBAUM DOLL LLP ***SPEA SCHOLARSHIP AWARD***	**Ed Feigenbaum**, Esq., Publisher, INGroup	SAGAMORE 3|4
8:30 – 9:00	***BOWEN INSTITUTE SURVEY RESULTS*** **| Annual Hoosier Survey Findings and Analysis**	SAGAMORE 3|4

A look at the findings from and analysis of the annual Hoosier Survey conducted by the Bowen Center for Public Affairs at Ball State University that offers policy makers an indication of public sentiment heading into the legislative session.

Introduction by: **Ed Feigenbaum**, Esq., Publisher, INGroup

- **Dr. Joseph Losco**, Chair, Department of Political Science, Ball State University; Co-Director, Bowen Center for Public Affairs, Ball State University
- **Dr. Raymond Scheele**, Professor of Political Science, Ball State University; Co-Director, Bowen Center for Public Affairs, Ball State University

9:00 – 9:45 ***MORNING BREAKOUT SESSIONS***

EDUCATION **| The Future of K-12 Education in Indiana** — SAGAMORE 1

How will the legislative session impact the relationship between the Department of Education and the State Board of Education? What is next in the world of Charter Schools in Indiana? Are Adult High Schools the solution and how should they be funded? How are the teacher evaluations working? Our panel will discuss these and other important topics revolving around K-12 education within Indiana.

MODERATOR: **Philip A. Sicuso**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Senator Carlin Yoder** (R), Ranking Member, Committee on Education and Career Development
- **John Barnes**, Director of Legislative Affairs, Indiana Department of Education
- **Dr. Lewis D. Ferebee**, Superintendent, Indianapolis Public Schools
- **Dr. Brad Oliver**, Member, Indiana State Board of Education

***ENERGY, UTILITIES AND TELECOMMUNICATIONS* | Indiana's Energy Future** — SAGAMORE 6

Our panel will discuss the Governor's Energy Strategy and the ongoing debate over demand-side management programs. Additionally, this panel will take up what the future is or can be for consumers of energy – particularly large energy users; how communities are dealing with Consent Decrees from the US EPA (to a tune of $9 billion); how municipal utilities are coping with rising energy costs; and how the US EPA's rule on greenhouse gas emissions could change the way Indiana sets energy policy.

MODERATOR: **Peter H. Grills**, Esq., BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Rep. Eric Koch** (R), Esq., Assistant Majority Caucus Chair; Chair, Committee on Utilities and Energy
- **Allen R. Mounts**, Director of Utilities, Evansville Water and Sewer Utility
- **Chris Olsen**, Vice President | Community and Government Affairs, Tate & Lyle
- **Tristan Vance**, Director, Indiana Office of Energy Development

9:00 – 10:00 ***ETHICS*** | **Changes in Law, Regulations and Policy** featuring **James J. Bell**, Esq., Partner, BINGHAM GREENEBAUM DOLL LLP — SAGAMORE 2

*James will lead our annual look at laws, administrative regulations and policies impacting executive and legislative branch ethics, as well as executive and legislative lobbying. He will speak with **retired State Representative Ralph Foley** (R-Martinsville) on the difficulty in balancing a citizen-legislature. We will also hear from **State Ethics Director Cynthia Carrasco** relative to legislative recommendations. Attendees will also get an update on legal ethics issues relevant to attorneys, whether they practice in the courtroom or the Statehouse.*

9:45 – 10:00 ***MORNING REFRESHMENT BREAK*** — SERPENTINE LOBBY

10:00 – 10:45 ***GOVERNOR'S ADDRESS*** **| The Honorable Governor Mike Pence Announces His 2015 Legislative Agenda** — SAGAMORE 3|4

10:45 – 11:45 ***THE LEGISLATIVE LEADERS LOOK AT 2015*** **| What Issues to Expect on the Session Agenda** — SAGAMORE 3|4

Republican and Democrat leaders from the Senate and the House gather to offer their insight into the issues they expect to be on the session agenda, and how the process might unfold.

MODERATOR: **John R. Gregg**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Sen. Brandt Hershman** (R), Esq., Majority Floor Leader
- **Sen. Tim Lanane** (D), Esq., Minority Leader
- **Rep. Jud McMillin** (R), Esq., Majority Floor Leader
- **Rep. Scott Pelath** (D), Minority Leader

11:45 – 1:00 ***LUNCHEON*** **| KEYNOTE SPEAKER: Chief Justice Loretta H. Rush** — SAGAMORE 5

1:00 – 2:00 ***THE 2015-16 BUDGET PLENARY SESSION*** **| What to Expect in the Budget Session** SAGAMORE 3|4

State executives and legislative officials explain what to expect in the FY 2015-2016 budget and which policy decisions will be pressure points. What is a proper surplus? What policies become sacrificed through executive branch reversions? Are we providing enough services to our citizens? These and other important issues will be discussed with our budgetary leaders.

MODERATOR: **John Ketzenberger**, President, INDIANA FISCAL POLICY INSTITUTE

PANELISTS:

- **Rep. Tim Brown** (R), M.D., Chair, Committee on Ways and Means
- **Sen. Luke Kenley** (R), Esq., Chair, Committee on Appropriations
- **Rep. Greg Porter** (D), Committee on Ways and Means
- **Chris Atkins**, Esq., Director, Indiana Office of Management & Budget

2:00 – 2:45 ***AFTERNOON BREAKOUT SESSIONS I***

STAYING AHEAD OF THE GAME **| A Look at Casinos of the Future and How to Re-Invent the Customer Experience** SAGAMORE 2

Hear presentations from forward-looking experts in casino design and digital game content as they explore ways the Indiana casino industry can differentiate itself from competitors in neighboring states and become more relevant to the next generation of casino patrons. How can Indiana law encourage innovation?

MODERATOR: **Philip A. Sicuso**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **David Chang**, Esq., Chief Marketing Officer, Gamblit Gaming, LLC
- **Thomas L. Hoskens**, AIA, NCARB, LEED® AP, Founding Principal, Cuningham Group Architecture, Inc.

ECONOMIC COMPETITIVENESS **| How Indiana Can Continue to Gain Economic Advantage** SAGAMORE 1

As the State recognizes the need to blend college-based knowledge with workplace skills and vocational training, the workforce and workplace are changing as well. Indiana has traditionally touted its manufacturing experience and multi-modal logistics strengths as a competitive advantage, but how will Indiana be able to bring all these factors to bear under new economic and demographic realities in order to outshine our neighbor states (yet team with them where appropriate) and be a player in national and world markets? This panel will address the education, training, workforce, and logistics needs to allow Indiana the ability and flexibility we need going forward.

MODERATOR: **Brenda K. DeVries**, Esq., BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Steve Braun**, Commissioner, Indiana Department of Workforce Development
- **Rich Cooper**, Chief Executive Officer, Ports of Indiana
- **Eric Doden**, Esq., President, Indiana Economic Development Corporation
- **Douglas Noonan**, Ph.D., Associate Professor, Director of Research, Indiana University Public Policy Institute, School of Public and Environmental Affairs

***HEALTH CARE* | What's in Store for the Future of Indiana Health Care?** SAGAMORE 6

Our panel will discuss a variety of important health care-related topics, including the HIP 2.0 Waiver application, the approval of the contingency waiver for HIP, the INSPECT program, and Medicaid therapy and funding for addiction. We will also explore whether Indiana is prepared for the rollout of a broader risk-based managed care program and what the budget session has in store.

MODERATOR: **Alan J. Dansker**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Rep. Ed Clere** (R), Chair, Committee on Public Health
- **Rep. Steve Davisson** (R), Chair, Interim Study Committee on Public Health, Behavioral Health, and Human Services
- **Stephen C. McCaffrey**, Esq., President, Mental Health America of Indiana
- **Joe Moser**, Medicaid Director, Indiana Family and Social Services Administration

2:45 – 3:00 ***AFTERNOON REFRESHMENT BREAK*** SERPENTINE LOBBY

3:00 – 3:45 ***AFTERNOON BREAKOUT SESSIONS II***

***GAMING* | Reaction and Policy Analysis Following Comprehensive Summer Study Committee** SAGAMORE 1

State regulators and policy makers join with industry sources to analyze what to expect in the upcoming legislative session while reviewing the gaming summer study. How does Indiana respond (if at all) to the increased competition in surrounding states? Will new technologies be permitted to adjust for market changes? Will properties push for a land-based option? What can we expect from Indiana's diverse group of casino operators?

MODERATOR: **Joseph L. Champion**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Rep. Tom Dermody** (R), Assistant Majority Floor Leader; Chair, Committee on Public Policy
- **Ed Feigenbaum**, Esq., Publisher, INGroup; Editor, Indiana Gaming Insight
- **Michael Smith**, President and Chief Executive Officer, Casino Association of Indiana
- **Ernest Yelton**, Esq., Executive Director, Indiana Gaming Commission

***INFRASTRUCTURE* | Identifying Ways to Pay for What We Need** SAGAMORE 2

As automobiles become more efficient and alternatives to gasoline/diesel become more prevalent, the State is searching for alternative funding mechanisms for critical highway projects. This panel will review some of these potential mechanisms and discuss the potential of utilizing the public-private partnerships in order to overcome infrastructure challenges that impact the state and local officials.

MODERATOR: **Matthew M. Price**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Rep. Ed Soliday** (R), Chair, Committee on Roads and Transportation
- **Karl Browning**, Commissioner, Indiana Department of Transportation
- **Bill Hanna**, Esq., President & Chief Executive Officer, Northwest Indiana Regional Development Authority

***LOCAL GOVERNMENT* | The Ongoing Tension Between State and Local Government** SAGAMORE 6

With the implementation of the local options to institute super-tax abatements or other economic development incentives, what is next in this difficult and complex relationship? Will the State restrict tax-increment financing tools? What can we expect to see with regard to annexation and business personal property tax? Our panel of experts will discuss these, and other, critical items.

MODERATOR: **Sue A. Beesley**, Esq., Partner, BINGHAM GREENEBAUM DOLL

PANELISTS:

- **Mayor Greg Goodnight**, City of Kokomo
- **Jeffrey Quyle**, Member, Morgan County Council
- **Rep. John Price** (R), Chair, Committee on Local Government
- **Matt Greller**, Executive Director & Chief Executive Officer, Indiana Cities and Towns

3:45 – 4:30 ***THE POLITICS OF 2014 AND WHAT IT MEANS FOR 2015* | How Will 2014 Politics and Policy Impact 2015?** SAGAMORE 3|4

This media panel closes the day by looking at how the politics and policy of 2014 will impact elections in 2015.

MODERATOR: Jim Shella, WISH-TV

PANELISTS:

- **Eric Berman**, WIBC and Network Indiana
- **Amos Brown**, WTLC-AM and Radio One/Indianapolis
- **Mary Beth Schneider**, former Indianapolis Star political reporter
- **Lesley Weidenbener**, TheStatehouseFile.com

Scott.A.Milkey

From: Espich, Jeff
Sent: Tuesday, November 18, 2014 12:05 PM
To: Sharon Espich
Subject: Fwd: [Gov Clips] Howey
Attachments: ATT00001.htm; image002.jpg; ATT00002.htm; image003.jpg; ATT00003.htm; 11-18-14 HIP Daily.pdf; ATT00004.htm

Sent from my iPhone

Begin forwarded message:

From: "Gilson, Katie" <KGilson@gov.IN.gov>
Date: November 18, 2014 at 8:41:31 AM EST
To: "Gilson, Katie" <KGilson@gov.IN.gov>, "Quyle, Lindsay" <LQuyle@gov.IN.gov>, "Cleveland, Bridget" <BCleveland@gov.IN.gov>, "Ahearn, Mark" <MAhearn@gov.IN.gov>, "Atkins, Chris" <catkins@gov.in.gov>, "Bailey, Brian (OMB)" <bbailey@gov.in.gov>, "Bauer, Zachary C" <ZBauer@gov.IN.gov>, "Berry, Adam (GOV)" <ABerry@gov.IN.gov>, "Brooks, Kara D" <kbrooks@gov.in.gov>, "Brown, Hannah" <HBrown@gov.IN.gov>, "Marshall, Sara (Cardwell)" <smarshall@gov.in.gov>, "Joyner Burroughs (Cissel), Jackie" <JJoynerBurroughs@gov.IN.gov>, "Crabtree, Chris" <CCrabtree@gov.IN.gov>, "Craig, Lindsey M" <LCraig@gov.IN.gov>, "Czarniecki, Cary (Lani)" <LaniCz@gov.IN.gov>, "Denault, Christina" <CDenault@gov.IN.gov>, "Espich, Jeff" <JEspich@gov.IN.gov>, "Fritz, Pam (GOV)" <pfritz@gov.IN.gov>, "Jarmula, Ryan L" <RJarmula@gov.in.gov>, "Kane, Kristen" <kkane@gov.in.gov>, "Vincent, Micah" <mvincent@gov.in.gov>, "Morales, Cesar (Diego)" <DMorales@gov.IN.gov>, "Myers, Janille" <JMyers@gov.IN.gov>, "Neale, Brian S" <BNeale@gov.IN.gov>, "Pavlik, Jennifer L" <JPavlik@gov.IN.gov>, "Pitcock, Josh" <jpitcock@sso.org>, "Price, Kendra" <kprice@gov.IN.gov>, "Schilb, Veronica J" <VSchilb@gov.IN.gov>, "Schmidt, Daniel W" <DSchmidt@gov.IN.gov>, "Simcox, Stephen" <SSimcox@gov.IN.gov>, "Streeter, Ryan T" <RStreeter@gov.IN.gov>, "Fernandez, Marilyn" <MFernandez@gov.IN.gov>, "Hodgin, Stephanie" <SHodgin@gov.in.gov>, "Karns, Allison" <AKarns@gov.IN.gov>, "Rosebrough, Dennis (LG)" <DRosebrough@lg.IN.gov>, "Cardwell, Jeffery" <JCardwell@gov.IN.gov>, "Dowd, Jaclyn (CECI)" <JDowd@ceci.in.gov>, "Keefer, Sean (GOV)" <skeefer@gov.IN.gov>, "Norton, Erin (Ladd)" <ENorton@gov.IN.gov>, "Johnson, Matt (GOV)" <MatJohnson@gov.IN.gov>, "Heater, Ryan" <RHeater@lg.IN.gov>, "Fiddian-Green, Claire (CECI)" <CFGreen@ceci.in.gov>, "Rosebrough, Dennis" <DRosebrough@idoi.IN.gov>, "Mantravadi, Adarsh V" <AMantravadi@gov.IN.gov>, "Rosebrough, Dennis (LG)" <DRosebrough@lg.IN.gov>, "Workman, James D" <JWorkman1@lg.IN.gov>, "McKinney, Ted" <TMckinney@isda.IN.gov>, "Bausman, David" <DBausman@isda.IN.gov>, "Atterholt, Jim" <jatterholt@gov.IN.gov>, "Davidson, Brenden" <BDavidson1@gov.IN.gov>, "Myers, Janille" <JMyers@gov.IN.gov>, "Fox, Joseph R" <JoFox@lg.IN.gov>, "McGrath, Danielle" <DMcGrath@gov.IN.gov>, "Brookes, Brady" <BBrookes@gov.IN.gov>, "Triol, Shelley" <STriol@idoa.IN.gov>, "Wall, Kathryn E" <KWall@gov.IN.gov>
Subject: [Gov Clips] Howey

Katie Gilson, *Staff Assistant*
Office of Governor Mike Pence
KGilson@gov.in.gov
Phone: (317) 232-1198
Fax: (317) 232-3443

Scott.A.Milkey

From: Gilson, Katie
Sent: Tuesday, November 18, 2014 8:42 AM
To: Gilson, Katie;Quyle, Lindsay;Cleveland, Bridget;Ahearn, Mark;Atkins, Chris;Bailey, Brian (OMB);Bauer, Zachary C;Berry, Adam (GOV);Brooks, Kara D;Brown, Hannah;Marshall, Sara (Cardwell);Joyner Burroughs (Cissel), Jackie;Crabtree, Chris;Craig, Lindsey M;Czarniecki, Cary (Lani);Denault, Christina;Espich, Jeff;Fritz, Pam (GOV);Jarmula, Ryan L;Kane, Kristen;Vincent, Micah;Morales, Cesar (Diego);Myers, Janille;Neale, Brian S;Pavlik, Jennifer L;Pitcock, Josh;Price, Kendra;Schilb, Veronica J;Schmidt, Daniel W;Simcox, Stephen;Streeter, Ryan T;Fernandez, Marilyn;Hodgin, Stephanie;Karns, Allison;Rosebrough, Dennis (LG);Cardwell, Jeffery;Dowd, Jaclyn (CECI);Keefer, Sean (GOV);Norton, Erin (Ladd);Johnson, Matt (GOV);Heater, Ryan;Fiddian-Green, Claire (CECI);Rosebrough, Dennis;Mantravadi, Adarsh V;Rosebrough, Dennis (LG);Workman, James D;McKinney, Ted;Bausman, David;Atterholt, Jim;Davidson, Brenden;Myers, Janille;Fox, Joseph R;McGrath, Danielle;Brookes, Brady;Triol, Shelley;Wall, Kathryn E
Subject: [Gov Clips] Howey
Attachments: 11-18-14 HIP Daily.pdf

Katie Gilson, *Staff Assistant*
Office of Governor Mike Pence
KGilson@gov.in.gov
Phone: (317) 232-1198
Fax: (317) 232-3443

Nov. 18, 2014 HPI Daily Wire

Tuesday, November 18, 2014 7:58 AM

HEALTHY INDIANA PLAN RENEWED BY FEDS: Federal health officials have granted seemingly early renewal of the original Healthy Indiana Plan, guaranteeing some 60,000 low-income Hoosiers will maintain their health coverage through at least 2015 (Carden,*NWI Times*). A HIP renewal decision by the U.S. Department of Health and Human Services was not expected until at least Tuesday, following a mandatory 30-day public comment period on the state's renewal application that HHS deemed complete Oct. 18. The HHS approval notice was date-stamped Friday, just 27 days after the application was opened for public comment. Attempts to reach HHS officials for an explanation of the early renewal decision were unsuccessful. Republican Gov. Mike Pence announced the HIP renewal approval Monday afternoon. In 2013, HHS took four months after receiving a complete application to approve Indiana's request to renew HIP for one additional year. The state's latest renewal request, seeking a three-year extension, also was pared down to one year. "This decision by the federal government to renew our current Healthy Indiana Plan is welcome news and will bring certainty to the more than 60,000 Hoosiers who currently enjoy the benefits of this proven health care program," Pence said. It's still not clear when Indiana will find out if the federal government will approve Pence's Healthy Indiana Plan 2.0 concept. That proposal, pending at HHS since Aug. 21, would provide health coverage to some 450,000 low-income Hoosiers as an alternative to the Medicaid expansion envisioned by the Affordable Care Act. Pence last week said, "The time has come for the federal government to make a decision" on HIP 2.0. He's optimistic renewal of original HIP is a promising first step. "We hope that this decision signals an openness by this administration to move forward with approval of HIP 2.0, which is built on the same principles of personal responsibility and consumer choice," Pence said. The primary sticking point is the state's insistence on HIP 2.0 participants making monthly premium payments of up to $25 to remain in the program.

LONG, BOSMA SAY "DYSFUNCTION" MIGHT FORCE APPOINTED SUPT: Legislative leaders say they remain frustrated at the "dysfunctional" relationship among state education officials and will step in if the sides can't resolve their differences – soon (Weidenbener, *Statehouse File)*. On the eve the legislature's Organization Day for the 2015 session, House Speaker Brian Bosma said he's concerned enough that he's thinking about whether to pursue legislation to make the state superintendent of public instruction an appointed rather than elected position. He acknowledged that would create a "firestorm of protests" because the current superintendent, Glenda Ritz, is a Democrat while Republicans have supermajorities in the House and Senate. But Bosma said the fighting between Ritz and the rest of the

State Board of Education – all appointed by Republican Gov. Mike Pence – is unacceptable. "This has to stop one way or another," Bosma said. "We can't let this go on." Bosma made his comments at an Indiana Chamber of Commerce legislative preview that featured a panel discussion among Republican and Democratic leaders of the General Assembly. Chamber President Kevin Brinegar also outlined the group's legislative priorities. On the list is eliminating the superintendent as an elected position and making it a job appointed by the governor. It's something the chamber – and leaders in both political parties – have supported at different times in the past. But the issue has come to the forefront as Ritz, who chairs the state board, and members have battled over big issues including A-F grades for schools and small things like how to run a meeting. "I would encourage – in fact challenge – each and every one of you to watch just one meeting of the State Board of Education and you will see how incredibly dysfunctional it is and how poorly it is serving the children and their parents of the state of Indiana," Brinegar told chamber members who attended the panel discussion. But Democratic leaders warned that Hoosiers won't want to give up electing a superintendent. "This is a person we trust who knows about education and whose sole duty is to do what's best for education and children in our state," said Senate Minority Leader Tim Lanane, D-Anderson. "I think that's what people want." "We may have to dictate how the board meetings are going to run," Long said. "It needs to change on both sides for the betterment of our kids."… Daniel Altman, spokesman for current Superintendent Glenda Ritz, says voters deserve the right to say how their children are educated (Morello, StateImpact Indiana). "Two years ago, Hoosier voters clearly said that they wanted Glenda Ritz to be Indiana's top education official and a vital check and balance at the Statehouse," Altman said. "Taking such an important and personal decision away from voters because of petty partisan bickering is short-sighted and simply wrong."

LEGISLATIVE LEADERS PROMISE BIPARTISAN ETHICS REFORM: The leaders of all four legislative caucuses say they will work together to produce an ethics reform package in the upcoming session, an issue they say rises above political party lines (Smith*, Indiana Public Media).* Speaker Brian Bosma, R-Indianapolis, named ethics reform one of his caucus' top priorities after dealing with a scandal involving Rep. Eric Turner, R-Cicero, over the summer. Turner, accused of influencing legislation that netted him and his family millions of dollars from their nursing home business, was cleared of any wrongdoing by the House Ethics Committee. But Bosma says lawmakers shouldn't be involved at all in issues where they have substantial personal or financial interests. "Perhaps we need to be a little bit clearer in our rules which really, frankly, are not that clear on this topic," Bosma says. "It's clear that you shouldn't vote and that's it. So we're going to embellish that." House Minority Leader Scott Pelath, D-Michigan City, says the hard part of ethics reform will be keeping in mind that Indiana is – and should remain – a citizen legislature. "Just because somebody gained a business advantage because of something that happened in the General Assembly doesn't mean

you don't want to have businessmen serving in the General Assembly," Pelath says. All four caucus leaders agree that they don't want the General Assembly to become a full-time legislature.

CHAMBER FOR SUNDAY SALES, REP. DERMONDY TO CONSIDER: Hoosiers could get the opportunity to buy alcohol every day of the week as the Indiana Chamber pushes the legislature to allow Sunday alcohol sales (Smith, *Indiana Public Media*). Indiana Chamber of Commerce President Kevin Brinegar says though it's not a top priority, promoting Sunday sales will be one of the efforts it pushes when the legislature convenes in January. House Speaker Brian Bosma says he personally doesn't have a problem with legalizing Sunday sales, but says it likely won't have a significant fiscal impact. "There are those who say it's going to increase tax revenues by 17-percent – false. I mean, most Hoosiers are smart enough to buy on Saturday if they need something on Sunday so I don't think there's a mass exodus to the liquor stores after church," Bosma says…State Rep. Tom Dermody, R-LaPorte, was appointed chairman of the House Public Policy Committee last year. Laws looking to change legislation regarding alcohol-related sales will start with him. Dermody recognizes the arguments of both sides of the issue (Checkley, Purdue Exponent). "You have to keep in mind these local liquor stores who are hometown people who sponsor little league teams and they're family-owned businesses," Dermody said. "We can't just ignore their concerns." Dermody doesn't openly advocate what should be done, but says regardless of the outcome, all facets of the problem will be discussed and evaluated in the future. "My goal is to continue to bring all sides involved in this issue together to see what we can discuss before the first of the year," he said. "Let's make sure it's something positive for our state and also make sure we understand what the concerns are."

KASSIG MAY HAVE BEEN KILLED IN U.S. AIRSTRIKE: Peter Kassig's execution may have been faked by Jihadi John after the US hostage was killed in an US-led airstrike, according to extraordinary claims from the leader of a Syrian underground group (*Daily Mail*). Speaking over Skype from a hiding place near the Turkish border, the head of the anti-ISIS resistance group Raqqa is Being Slaughtered Silently claimed there are reports that Mr Kassig died on November 5, when coalition fighter planes and drones pounded Tel-Abyad in northern Syria. The extraordinary allegation could not be independently verified. The claims come among increased speculation over why Mr Kassig's full body was not shown in the video. Unlike ISIS' previous sickening filmed murders, he did not speak directly to camera before being killed and his body was not shown after the murder. U.S. sources have suggested that Mr Kassig could have been killed before the video was shot because he did not cooperate with the jihadists, either refusing to give a final speech on camera or possibly even fighting back while the murder was taking place. American forces have previously attempted a daring rescue of

U.S. hostages and President Obama has said that he would make all efforts to rescue U.S. citizens if their location could be identified. Western planes have carried out a series of raids on the Isis weapons stockpile and refinery where Peter Kassig is claimed to have been hit but if there had been any intelligence suggesting where he was being held such strikes would have been highly unlikely to be authorized. The U.S. Central Command has not responded to the report.

KASSIG FAMILY GRIEVES: In their first public appearance since their son's execution, the parents of Indianapolis humanitarian worker Abdul-Rahman Kassig spoke not of anger but of healing, saying that their "hearts are battered, but they will mend (Eason and Tuohy, *IndyStar)*." Ed and Paula Kassig briefly addressed the media Monday afternoon at Epworth United Methodist Church in Indianapolis, a day after learning their son, 26, had been killed by the Islamic State group. The militant group, also known as ISIS or ISIL, announced in a video early Sunday that it had beheaded their son, drawing swift rebukes from around the globe. But in a departure from the outrage expressed by leaders in Indianapolis and around the world, the Kassigs struck a conciliatory tone, asking well-wishers to pray for their son and those still being held against their will. "Please allow our family the time and privacy to mourn, cry — and yes, forgive — and begin to heal," Ed Kassig said. "Our hearts are battered, but they will mend," Paula Kassig said. "The world is broken, but it will be healed in the end. And good will prevail as the one God of many names will prevail." After weeks of highlighting their son's conversion to Islam — which they had hoped might earn him mercy from his captors — Kassig's parents for the first time publicly acknowledged their own Christian faith, in the lobby of the church where they have been members for at least three decades, according to church officials. The family's prepared statement began with a Bible verse. "Greater love hath no man than this: than to lay down his life for another," Ed Kassig said. "Our hearts, though heavy, are held up by the love and support that has poured into our lives these last few weeks."

HPI DAILY ANALYSIS: Since the appointed state superintendent issue has resurfaced, Hoosier taxpayers – and lawmakers – need a full accounting on education agency funding. CECI's complete budget and salary structure needs to be made public. We need to understand what the funding for DOE is, as well as CECI. It's the classic "follow the money" deal. Once we have a better understanding of how the funding is flowing into Indiana public education policy implementation, we'll have a better understanding on the appointed/elected superintendent issue. – *Brian A. Howey*

Campaigns

2016: BERRY, ZODY SEE COMPETING STRATEGIES FOR NEXT ELECTION - Democrats will have to pick their battles and Republicans will have to continue showing they can lead in order for their respective parties to win in 2016, the state's party chairmen say (LoBianco, *Associated Press*). Republican Party Chairman Tim Berry and Democratic Party Chairman John Zody spent an hour last week looking back on the 2014 election results and talking about their plans for 2016 at the Bulen Symposium for American Politics at Indiana University-Purdue University Indianapolis. Senate Republicans added three seats to their supermajority, gaining a walloping 40-10 advantage, while House Republicans netted two seats to give them a 71-29 edge, the largest in four decades. In the run-up to Election Day, neither Berry nor Zody foresaw the drubbing that Republicans delivered. Rather than losing seats that both sides saw as vulnerable, Republicans added to their already overwhelming supermajorities, taking out some Democratic stalwarts from Lake County and Terre Haute in the process. Afterward, it seemed clear that Republicans and conservatives showed up on Election Day, while Democrats and their supporters stayed home. That was reflected in an estimate showing that Indiana had the lowest voter turnout in the nation — 28 percent — compiled by a University of Florida political science professor Michael McDonald. Zody used the example of House Republicans, who were in the minority a little more than a decade ago, and then-House Minority Leader Brian Bosma, R-Indianapolis, who would hold news conferences in front of the governor's statehouse office. "Bosma was in front of the governor's office every other day talking about what (former Democratic Gov.) Frank O'Bannon should be doing differently," Zody said. "We have to be for things, you can't just be against, against, against. And that's a key component of not being whiners."

General Assembly

NO BUSINESS FOR ORGANIZATION DAY, REP. TURNER TO RESIGN: Indiana lawmakers are meeting for one day to tackle formalities before they begin full-time work on their 2015 session in January (*Associated Press*). The General Assembly will technically start its new session Tuesday on its Organization Day. Republican House Speaker Brian Bosma said Monday he will not take up any legislation or proposals during the one-day meeting despite many requests from House members. Bosma will preside over a newly strengthened Republican supermajority in the House. Republican Rep. Eric Turner is also expected to submit his resignation Tuesday after being sworn in. Turner won re-election, but announced before the election he would step down to take a job with a church group in Atlanta. Turner's secret efforts to protect his family's lucrative nursing home business spurred a promise of ethics reform this session.

CHAMBER UNVEILS TOP 7 LEGISLATIVE PRIORITIES FOR 2015: Providing relief to small business personal property tax filers and the development of a statewide publicly-funded preschool program headline the Indiana Chamber of Commerce's Top 7 priorities for the 2015 session (*Howey Politics Indiana)*. These key objectives were announced at the organization's annual Central Indiana Legislative Preview in Indianapolis Monday. The Indiana Chamber proposes exempting the bottom half of all business personal property tax filers from having to go through the process. This group, while approximately 150,000 strong, pays only 1% of the total tax collected. The organization's president and CEO, Kevin Brinegar, says the math simply doesn't add up for the businesses or local governments to make it worthwhile. "These small businesses have to do extensive inventory on their machinery and equipment, and then prepare and file the tax return. That usually means they have to hire someone to guide them in this effort. All for a tax that, in the end, amounts to between $10 and $50 for most small businesses," he explains. "For local government, it's a similar story: People have to process all of these tax returns and audit a portion of them. That takes time, costs money and diverts attention from other more productive activities." Education is also top of mind, with three of the organization's seven priorities coming in this area. Brinegar believes making significant improvements to the state's educational levels will remain challenging as long as large numbers of children are entering kindergarten unprepared for school. "These challenges are compounded and ultimately impact all Indiana students as schools are forced to deal with wide gaps in achievement levels," he notes. "The state needs to provide funding that will help low-income parents access their choice of preschool programs that are educationally-based and accountable for outcomes." The Indiana Chamber also will continue to support development and funding for the state's new K-12 academic standards, but will be pushing for "fiscal restraint and common sense" when it comes to the testing component, according to Brinegar. "It's just uncalled for to spend tens of millions of dollars to come up with a brand new assessment when an existing consortia test can be modified slightly to what's unique about Indiana's standards. The state would be far better served seeing that additional money devoted to a statewide preschool program." The third education priority is a lasting way to mitigate any policy divide between a governor and state superintendent of public instruction. The Indiana Chamber will be seeking to have the superintendent position become an appointed one beginning in 2016. "I want to make it clear that we have had this policy position for over 20 years – covering when we've had Republican and Democratic governors," Brinegar emphasizes. "Our state's governor is seen as the true leader on education policy and our administrative structure should reflect that and allow for a superintendent of the governor's choosing. Both parties know this makes sense and is what's best for the state's education system and our students."

OTHER CHAMBER PRIORITIES: Other legislative priorities for the Indiana Chamber: A state budget that not only puts a focus on preschool but also includes a new funding formula for education and workforce training with increased designations for high wage career areas; Increased funding for upkeep of Indiana roads by devoting the full seven cents (on the dollar) from the gasoline sales tax to the state's highway fund. The current model allots a penny with the other six cents going to the state's general fund; A work sharing program that will allow employers to maintain a skilled stable workforce during temporary downturns and for employees to keep their jobs but with reduced hours and salary (which is partially offset by unemployment insurance). In addition, the Indiana Chamber announced six other "areas of focus" for the upcoming session. "These are issues that are also very important to us. We want to open or continue the dialogue on these topics – some of which are complicated or involve changing how Indiana does thing," Brinegar notes. A statewide water policy to assure future resources, allowing employers to screen prospective employees for tobacco use and further reduction in the state's dependence on the taxation of business machinery and equipment are among those on this list.

JOBS, CRIME, SCHOOLS TOP ISSUES: Jobs, crime and schools are the top concerns of Hoosiers, and they top the priorities that Hoosiers want lawmakers to focus on during the next legislative session (Hayden, *CNHI)*. Three of four people surveyed for the annual Hoosier Poll said job creation is the most important task of the General Assembly when it convenes in January. That comes even as Indiana's unemployment rate, at 5.7 percent, continues to drop below the national average. "Jobs always end up on the top of the list," said Ball State University political scientist Ray Scheele, who helped design the poll. "The economy is still the highest priority in the minds of Hoosiers." The WISH-TV/Ball State University survey, now in its seventh year, also found that a majority wants lawmakers to do something to reduce violent crime, though the survey didn't specify what. Pollsters did ask specific questions about education. They found a majority wants more money for local schools. And more than 80 percent want to see the state fund pre-school for all 4-year-olds – which doesn't exist now – and end the policy that makes parents pay for children's textbooks. "Hoosiers like their public schools," said Ball State's Joe Losco. "But they're getting the message that schools might be getting starved for funds." Survey results were released Monday, just a day before legislators gather at the Statehouse for their annual Organization Day. The 2015 session won't start until the first week of January. Other findings from the survey: Forty-five percent say protecting the environment should be a top focus for legislators, while 42 percent think immigration reform should be a priority; Two-thirds believe the state needs to strengthen ethics laws for elected officials; Just over one-third say the state should hold onto its $2 billion budget surplus, but almost as many say the state should spent some of the surplus to fund programs cut in recent years, including fire and police protection and road repair; Support for same-sex marriage, made legal in Indiana earlier this year, is holding steady at 47 percent. But there is wide variation by

age and political party, with younger Hoosiers and Democrats as the most supportive. A majority (56 percent) also believe that Indiana should recognize same-sex marriages performed in other states; and, Hoosiers have significantly more trust in state government than they do in the federal government. Forty-five percent trust the state government to do what is right all or most of the time, while only 21 percent feel the same way about the national government.

NORTHEAST FRIENDS OF EDUCATION WANT SUPERINTENDENT TO STAY ELECTED: The Northeast Indiana Friends of Public Education released this statement Monday about the issue (Kelly, *Fort Wayne Journal Gazette*): "Having an elected superintendent of public instruction allows the people of Indiana to have a voice with regard to education. The 1.3 million voters who elected Superintendent Ritz suggested that the citizens of Indiana want a voice, especially when the citizens of Indiana are currently not being heard. Until recently, the state superintendents have worked well with the state legislature regardless of party affiliation. As we can see with the SBOE, appointees have little accountability to the citizens of this state, which makes it much easier to hide a specific agenda. It is not surprising that the Chamber of Commerce and the legislators would propose this move to further eviscerate the authority of the superintendent of public instruction."

GROCERY-DRUG STORES RENEW PUSH FOR SUNDAY SALES: The grocery stores, convenience stores and pharmacies that have been pushing for a change hope Dermody will break the logjam this year (Sikich and Cook, I*ndyStar*). John Elliott, a spokesman for Kroger, said Sunday is the second-biggest shopping day of the week. He said an internal study estimates that Indiana businesses lose $300 million to $600 million in annual revenue because they can't sell alcohol on Sundays. His study estimates that allowing the sales would generate $25 million to $40 million in taxes. Elliott thinks the House will approve Sunday sales, but he's less sure of the bill's fate in the Senate. He noted lawmakers seem increasingly open to loosening restrictions on alcohol, including approving a law this year to allow sales of beer and wine during the Indiana State Fair. "The door just keeps going further and further open," Elliott said.

BEVERAGE RETAILERS UNHAPPY WITH CHAMBER STANCE ON SUNDAY SALES: In reply to the Indiana State Chamber briefing with media today in which they backed the legalization of Sunday alcohol sales, the Indiana Association of Beverage Retailers' CEO Patrick Tamm issued the following statement (*Howey Politics Indiana*)…"We're disappointed that the chamber didn't review or discuss the potential consideration and impact to Indiana businesses – perhaps selecting one category of

industry over another – or consider pending litigation that is still winding its way through Indiana courts and federal appellate courts. Generally, a broad change to law is much more considered and tempered. Our association would like to believe that the chamber is focused on the best long-term outcomes for all businesses. Until we know more about this specific agenda and have a meeting to review, it's difficult to speculate on its origin and ultimate goal."

SEN. ALTING COULD AGAIN BLOCK SUNDAY SALES IN SENATE: How wide the door will open for Sunday sales in the Senate remains to be seen. Sen. Ron Alting, R-Lafayette, who chairs the Public Policy Committee in the Senate, for years has steadfastly refused to give Sunday sales advocates a hearing (Sikich and Cook, *IndyStar*). Alting could not be reached Monday but reiterated his personal opposition to Sunday sales in an interview with The Star in June. At the time, he said such sales would hurt package liquor stores and increase the possibility of drunken driving and minor consumption.

CHAMBER RECOGNIZES 5 LEGISLATORS AS 'SMALL BUSINESS CHAMPIONS': Five state legislators were given the Indiana Chamber of Commerce's Small Business Champion Award today at ceremony in downtown Indianapolis (*Howey Politics Indiana*). The honorees were chosen for their dedication to bettering Indiana's business climate for small employers. The award is based on voting and advocacy during the 2014 legislative session. The 2014 Small Business Champions are: Sen. Mike Crider from Greenfield, District #28; Sen. Pete Miller from Avon, District #24; Rep. Terri Austin from Anderson; District #36; Rep. Milo Smith from Columbus, District #59; and Rep. Cindy Ziemke from Batesville, District #55. "Today we're honoring state legislators who understand and appreciate the fact that Hoosier businesses – particularly small businesses – cannot flourish with a government constantly blocking their way," says Indiana Chamber President and CEO Kevin Brinegar. "Each one has shown support for the vital economic growth and job creation tools our state needs."

BOSMA, PELATH WILL ANNOUNCE PHILANTHROPY FOR 2015 HOUSE: Every year, House Speaker Brian C. Bosma (R-Indianapolis) selects a philanthropy that the House of Representatives participates in and raises awareness for throughout the legislative session (*Howey Politics Indiana*). This year's philanthropy is the Indiana Coalition Against Domestic Violence (ICADV). In order to kick-off the campaign, an announcement will be taking place tomorrow at 10:30 a.m. on the 4th floor of the Statehouse with Speaker Bosma, Minority Leader Scott Pelath, Laura Berry, Executive Director of ICADV and Curtis McManus, Victim Advocate. Legislators, staff and state

office holders have been asked to participate by donating bedding, grocery store gift cards and other items.

TERRE HAUTE CHAMBER OF COMMERCE FORMULATING LEGISLATIVE AGENDA: The Terre Haute Chamber of Commerce will begin this week to craft its own legislative priority list, a top organization official said Monday (Foulkes, *Terre Haute Tribune-Star*). The chamber's Public Policy Council is expected to meet later this week to begin the work of drafting a legislative agenda, said David Haynes, president of the local business organization. No specific policy proposals have yet emerged; however, whatever is produced will be "home grown," representing the local membership, he said. After meeting this week, the all-volunteer Public Policy Council will likely draft a "white paper" of ideas to be discussed with other chamber members, Haynes said. Traditionally, the Terre Haute chamber's legislative priorities are aimed at influencing state policy, Haynes said, although it's possible the organization will also discuss local topics, he said. Each year, the Terre Haute chamber tries to meet with state lawmakers at the start and conclusion of the legislative session, Haynes said. Members of the organization also plan to drive to Indianapolis in mid-session to talk with officials, he said. The Indiana General Assembly meets from Jan. 13 through the end of April this year — a "long session." Historically, the Terre Haute chamber has also sponsored a trip to Washington, D.C., each year. There was no "fly in" to Washington in 2014. In 2013, local chamber members met with federal officials to discuss unmanned aerial systems, federal prisons in Terre Haute, the Rural Health Innovation Collaborative, energy policy and local infrastructure.

Congress

LANDRIEU SCRAMBLES FOR 60TH KEYSTONE VOTE: The frenzy over the Keystone pipeline has come down to Louisiana Democrat Mary Landrieu's furious search for a 60th "yes" vote in the Senate — the culmination of a desperate week of arm-twisting by a lawmaker whose political career is on the line in the lame-duck Congress (Politico). Never mind that President Barack Obama may well veto the bill, which would approve the Canada-to-Texas oil pipeline by taking the matter out of the hands of his State Department. With Keystone apparently stuck on 59 votes — one shy of the amount needed for passage — Landrieu has turned into a one-woman Senate whip, seeking a vote set for Tuesday night that would show her clout in oil-rich Louisiana ahead of her Dec. 6 runoff. In the past week, she's drawn Sens. Michael Bennet (D-Colo.) and Tom Carper (D-Del.) to her side, while a series of rumored Democratic fence-sitters came out against the bill, including New Jersey's Cory Booker, New York's

Chuck Schumer and Michigan's Carl Levin. Since all 45 Senate Republicans already support the bill, a tiny number of Democratic waverers will decide the outcome. Landrieu and a top Republican Keystone supporter, North Dakota Sen. John Hoeven, have both expressed optimism that they'll have 60 votes. "But I don't know for sure until we have the vote," Hoeven said Monday night.

DONNELLY, GROUP CALL FOR MONTHLY BIPARTISAN LUNCHES: U.S. Senator Joe Donnelly joined a bipartisan group of more than 30 senators in urging Senators Harry Reid and Mitch McConnell to schedule monthly lunches between the Democratic and Republican caucuses in the next Congressional session—which begins in January—in an effort to build stronger and more productive relationships among all members of the Senate (Howey Politics Indiana). Donnelly and the senators wrote, in a letter led by Senators Jeff Flake (R-AZ) and Martin Heinrich (D-NM), "We believe that regular bipartisan meetings…can help foster the kind of productive relationships that will be critical for the Senate to live up to its reputation as the world's most deliberative body. It is our hope that our respective leadership teams take concrete steps to broaden the relationships and deepen the rapport among members. Specifically, we believe that monthly bipartisan lunches would serve this goal."

DONNELLY SUPPORTS PASSAGE OF CHILD CARE DEVELOPMENT BLOCK GRANTS: U.S. Senator Joe Donnelly voted Monday for bipartisan legislation that would reauthorize a law designed to help working American families afford child care (*Howey Politics Indiana*). The Child Care Development Block Grant (CCDBG) Act of 2014 would make several commonsense changes to a law that has not been reauthorized since 1996. The House-passed bill advanced in the Senate by a vote of 88 to 1 and now goes to President Obama for his signature. Donnelly said, "Whether moms and dads are going to work, school, or a training program, one of the most important decisions they have to make is who will care for their children. This commonsense legislation will help improve the quality of child care for Hoosier families in need. The reauthorization of the Child Care Development Block Grant Act is an example of what Democrats and Republicans can achieve by working together. Our children deserve access to safe, quality child care services, no matter their family's income level, and this legislation will help ensure the safety and well-being of Hoosier children." In March, Donnelly helped the Senate pass a similar version of the Child Care Development Block Grant Act.

DETAILS OF CHILD CARE DEVELOPMENT BLOCK GRANT ACT: Reforms in the Child Care Development Block Grant Act compromise bill include (*Howey Politics Indiana*): Strengthening the safety of child care providers by requiring background

checks for all individuals who provide child care with the support of this grant, as well as requiring providers to meet state health, safety, and fire standards and undergo additional annual safety inspections; Enhancing parental choice for childcare options by providing information on options available from all providers, including faith-based and community-based providers. This would allow parents to choose the child care provider that best fits their family's needs; and Allowing states to train child care providers and develop more effective and safer child care services. Ann Murtlow, President & CEO of United Way of Central Indiana, said, "We applaud the bipartisan Congressional effort to reauthorize this important legislation in a way that will improve child care quality for our youngest and most vulnerable Hoosiers. This legislation will improve the ability of low-income Hoosiers to attain and maintain self-sufficiency, and we thank Senator Donnelly for his support." More than 34,200 low-income and at-risk Hoosier children are served each month through child care development funds.

LEGISLATION BEFORE THE U.S. HOUSE THIS WEEK: On Tuesday, the House will consider H.R. 1422, the EPA Science Advisory Board Reform Act (*Howey Politics Indiana*). This bill would require the EPA's Science Advisory board to modify their disclosure requirements for its members, provide for more public input on board activities (including nominations to the board), and mandate the board respond in writing to "significant comments" received from the public during public comment periods. On Wednesday, the House will consider H.R. 5681, a bill that would extend and update a nuclear security cooperation agreement between the U.S. and U.K. governments through 2024. The current agreement expires on December 31 of this year. On Wednesday, the House will consider H.Res. 754, a resolution condemning Iran for its gross human rights violations. On Wednesday, the House will consider H.R. 4012, the Secret Science Reform Act. This bill would bar the EPA from taking any regulatory action unless it makes public all scientific and technical data public so that findings could be reproduced and analyzed independently. On Thursday, the House will consider H.R. 4795, the Promoting New Manufacturing Act. This bill would require the EPA to issue guidance and regulations for manufacturing companies seeking preconstruction permits whenever it establishes new ambient air quality standards.

State

GOVERNOR: PENCE'S FULL STATEMENT ON HIP RENEWAL - The State of Indiana announced that the Centers for Medicaid and Medicare Services (CMS) have approved renewal of the Healthy Indiana Plan (HIP) *(Howey Politics Indiana)*. News of the approval came Friday evening. "This decision by the federal government to renew

our current Healthy Indiana Plan is welcome news and will bring certainty to the more than 60,000 Hoosiers who currently enjoy the benefits of this proven health care program," said Governor Mike Pence. "Since this marks the third time the Obama Administration has approved the Healthy Indiana Plan in its current form, we hope that this decision signals an openness by this Administration to move forward with approval of HIP 2.0, which is built on the same principles of personal responsibility and consumer choice." The State continues to await a decision by the federal government on covering 350,000 more uninsured Hoosiers through HIP 2.0, which was submitted for approval in July of 2014 and has been the subject of ongoing discussions between state and federal officials.

GOVERNOR: FIRST LADY HOLDS PHONE DRIVE FOR VICTIMS OF DOMESTIC VIOLENCE - First Lady Karen Pence today announced the collection of 1,200 phones for the HopeLine from Verizon initiative that serves victims of domestic violence (*Howey Politics Indiana*). This phone drive, which the First Lady sponsored throughout the month of October, collects no-longer-used cell phones and accessories and provides them to victims of domestic violence. "I'm so thankful for the generosity of State employees as they dropped off phones in HopeLine boxes around the government center campus," said First Lady Karen Pence. "HopeLine from Verizon is an incredible program, and I hope that our efforts over the past month make a noticeable difference for victims of domestic violence across the state." In addition to refurbishing the donated cell phones, HopeLine from Verizon sells some phones for reuse, which generates grant money for agencies that assist victims and survivors of domestic violence. Since 2001, HopeLine from Verizon has collected more than 10.8 million phones nationwide and has donated more than $21.4 million in cash grants to domestic violence organizations nationwide.

STATEHOUSE: ZOELLER WILL HOST HUMAN TRAFFICKING PREVENTION TRAINING - Indiana Attorney General Greg Zoeller's Office is hosting a train-the-trainer event on Tuesday, Nov. 18, focused on increasing youth awareness of human trafficking and sexual exploitation crimes (*Howey Politics Indiana*). The average age at which children in the United States first become victims of sex trafficking is 12-14, and the FBI estimates that nearly 300,000 American youths are at risk of becoming victims of commercial sexual exploitation. The "Empowering Youth to End Sexual Exploitation" training will bring together professionals from all across the state who work in fields related to anti-human trafficking, sexual violence prevention and youth education. This will include representatives from social and victim service agencies, universities and education providers statewide. "Commercial sex is dramatized and sometimes even glamorized in today's culture," Zoeller said. "The scary truth is that a growing number of young people are being forced into the sex trade, and it's happening in our country,

state and local communities. There is an urgency in making sure young people know the dangers and warning signs of these horrific crimes."

STATEHOUSE: ZOELLER SAYS ROBOCALLS ON THE RISE: The use of robocalls to solicit Hoosiers over the phone continues to rise, said Indiana Attorney General Greg Zoeller. About 60 percent of the 10,000 Do Not Call complaints filed with the Attorney General's Telephone Privacy Division in 2014 site robocalls *(Howey Politics Indiana*). Robocalling, which refers to the use of technology that automatically dials residential phone numbers and plays prerecorded messages, is illegal in Indiana under its Auto Dialer Law. The Attorney General's Office continues to crack down on telemarketers or scammers who disregard Indiana's telephone privacy statutes. In 2014 so far, the Office has taken legal action against 11 Do Not Call or robocall violators, and obtained judgments and settlements totaling more than $6 million.

EDUCATION: IUPUI CHANCELLOR TO STEP DOWN IN AUGUST - The head of Indiana University-Purdue University Indianapolis has announced he's giving up that post next year (*Associated Press*). Chancellor Charles Bantz said Monday he'll step down August 15. The 65-year-old Bantz will take a one-year leave before returning as a faculty member on the nearly 31,000-student campus. Bantz joined IUPUI as chancellor and IU vice president for long-range planning in 2003 and was named IU's executive vice president in 2006. He previously had been provost and senior vice president at Wayne State University in Detroit. During his tenure, the number of IUPUI students living on campus has increased about six-fold to more than has 2,000 and IUPUI has built new buildings for fine arts, science and engineering, informatics and neurosciences research.

ENERGY: IURC OPPOSES DUKE ENERGY UPGRADES, RATE INCREASE - The state agency that represents utility ratepayers is asking another state department to deny Duke Energy's $1.9 billion proposal to upgrade its systems (Frazee, *Indiana Public Media*). Duke Energy's seven-year plan aims to upgrade its electric grid that services more than 800,000 homes and businesses in Indiana. Before Duke Energy can implement it, the Indiana Utility Regulatory Commission must approve the plan. The Indiana Office of Utility Consumer Counselor, which reviews utility requests, is recommending the IURC not do so. Office of Utility Consumer Counselor spokesman Anthony Swinger says Duke Energy has not provided enough information. "We've been able to thoroughly look over the evidence and information that the utility company has presented," Swinger says. "But we simply are not finding the details and the information about costs that need to be there." Duke Energy says it "strongly

disagrees" with the OUCC's assessment. "This plan is about modernizing our electric grid and bringing our system into the 21st century. It also has the benefit of generating new Indiana jobs and significant economic investment over the seven-year period," Duke Energy spokesman Lew Middleton said in a prepared statement. Duke Energy has until December 5 to file a rebuttal, which Middleton says the company will do. The IURC must give its final decision on whether to approve the plan by March 27, 2015.

TRANSIT: ST. JOE, ELKHART COS. AKSED TO JOIN TOLL ROAD EFFORT - Several northern Indiana counties are being encouraged to take back the Toll Road (Peterson, *WNDU-TV).* The Spanish Australian consortium that now runs the road, finds itself in bankruptcy court—where the right to run the road in the future will be sold to the highest bidder. It has been suggested that a not-for-profit consortium of Toll Road corridor counties form and submit a bid. The bid of the Northern Indiana Toll Road Authority would be financed with tax exempt municipal bonds. "It's very similar to what we have now, it's just a not-for-profit group comprised of counties will replace the current lease holder," said Elkhart County Commissioner Mike Yoder. Yoder took part in a conference call on Monday morning, as did officials from Lake, LaPorte, and St. Joseph Counties. Officials from LaGrange and Steuben Counties were invited, but did not participate. "I think if we could generate millions of dollars to St. Joe County on an annual basis, that's something we need to take a look at," said St. Joseph County Commissioner Andy Kostielney. The Northern Indiana Toll Road Authority would hire a domestic company to run toll road operations and the member counties would split the profits. "There's a chance initially, they're talking about a $10 million annual payment to the counties who participate but I think a lot of that depends on what state the toll road currently is, and just how much work is going to need to be done there," said St. Joseph County Commissioner Kostielney. Time is of the essence if the idea of forming a county consortium is to survive. Elkhart and St. Joseph County officials are being encouraged to act this week on a resolution that amounts to the first step toward membership. Such a measure could be considered at a scheduled Thursday meeting of the St. Joseph County Board of Commissioners. In Elkhart County, commissioners met this morning, and would have to schedule a special session for later this week, providing 48 hours notice. By the end of business on Thursday, the consortium would have to file preliminary bid information with the bankruptcy court in Chicago. Counties are being asked to pay $10,000 each to join the consortium and file the preliminary bid. Another $40,000 would be charged later to cover costs associated with issuing bonds. The Lake County Board of Commissioners will considering joining at a meeting set for Wednesday morning. The LaPorte County Board of Commissioners will do the same at its meeting Wednesday evening.

Nation

WHITE HOUSE: OBAMA ENTERING UNCHARTED TERRITORY - President Obama's expected action lifting the threat of deportation from millions of undocumented immigrants, which could come as early as this week, will expand the authority of the executive branch into murky, uncharted territory (*Washington Post*). The path is built on the long-accepted principle, going at least as far back as the 1970s, that any administration should have wide discretion over how it deals with those who are in this country illegally. Obama, however, is poised to take that leeway significantly farther than before. The move is certain to bring criticism that Obama has gone too far — ignoring the intent of Congress in passing the nation's immigration statutes and violating the constitutional requirement that the president "shall take Care that the Laws be faithfully executed." But it is unclear whether the courts would be willing to intervene, given their traditional reluctance to get in the middle of disputes between the two other branches of government. That means Obama will, in essence, be daring Congress to stop him — and betting that it won't. "They have the ability, the authority, the control to supersede anything I do through my executive authority by simply carrying out their functions over there," Obama said in an interview with CBS's "Face the Nation."

ACA: APPROVAL AT 37% IN GALLUP - As the Affordable Care Act's second open enrollment period begins, 37% of Americans say they approve of the law, one percentage point below the previous low in January. Fifty-six percent disapprove, the high in disapproval by one point. Americans were slightly more positive than negative about the law around the time of the 2012 election, but they have consistently been more likely to disapprove than approve of the law in all surveys that have been conducted since then.

CLIMATE: INDIA'S COAL PUSH COULD BE DISASTROUS - Decades of strip mining have left this town in the heart of India's coal fields a fiery moonscape, with mountains of black slag, sulfurous air and sickened residents. But rather than reclaim these hills or rethink their exploitation, the government is digging deeper in a coal rush that could push the world into irreversible climate change and make India's cities, already among the world's most polluted, even more unlivable, scientists say. "If India goes deeper and deeper into coal, we're all doomed," said Veerabhadran Ramanathan, director of the Center for Atmospheric Sciences at the Scripps Institution of Oceanography and one of the world's top climate scientists. "And no place will suffer more than India." India's coal mining plans may represent the biggest obstacle to a global climate pact to be negotiated at a conference in Paris next year. While the United States and China announced a landmark agreement that includes new targets for

carbon emissions, and Europe has pledged to reduce greenhouse gas emissions by 40 percent, India, the world's third-largest emitter, has shown no appetite for such a pledge. "India's development imperatives cannot be sacrificed at the altar of potential climate changes many years in the future," India's power minister, Piyush Goyal, said at a recent conference in New Delhi in response to a question. "The West will have to recognize we have the needs of the poor."

ECONOMY: RECESSION IN JAPAN STOKES GLOBAL FEARS - A sharp slowdown in Asia and stagnation in Europe are putting the global economy at risk of a prolonged slump, economists say, marked in places by sky-high unemployment, sluggish wage growth and some of the worst economic conditions in decades (*Washington Post).* On Monday, Japan said it had entered its fourth recession in six years — this one despite aggressive efforts by Prime Minister Shinzo Abe to boost growth. Meanwhile, British Prime Minister David Cameron warned that the world's economy could be headed toward another disaster. "Six years on from the financial crash that brought the world to its knees, red warning lights are once again flashing on the dashboard of the global economy," Cameron wrote Monday in Britain's Guardian newspaper. Two of the world's economic powerhouses — Europe and Japan — are failing to bolster global growth, and their economies appear to be getting worse. With an unemployment rate of 11.5 percent, the euro zone is experiencing conditions that some economists say echo the Great Depression. Emerging markets, which helped lift the world out of the ugly downturn that followed the 2008 financial crisis, are also lagging. Russia and Brazil have been dogged by recession, and China's double-digit growth has slowed rapidly as the country has matured and a speculative real estate bubble has let out air. China is "the thousand-pound gorilla in the emerging world and a big, big question mark," said Nariman Behravesh, chief economist at the consulting firm IHS.

VATICAN: POPE WILL VISIT PHILADELPHIA IN SEPTEMBER 2015 - A pontiff who has long championed humble acts - sneaking off to break bread with the homeless as an archbishop and washing the feet of young prisoners early in his papacy - is coming to the City of Brotherly Love (*Associated Press).* Pope Francis confirmed Monday that he will make his first papal visit to the United States with a trip to Philadelphia in September for the World Meeting of Families, a conference held every three years in a different city to celebrate the importance of family. Francis' announcement at an interreligious Vatican conference on traditional family values ended months of lobbying and speculation. It will be the second papal visit to Philadelphia - John Paul II celebrated Mass in the city in 1979 - and the first papal visit to the U.S. in eight years. Philadelphia Mayor Michael Nutter, speaking at a news conference, called it a "joyous day."

MISSOURI: GOVERNOR ACTIVATES NATIONAL GUARD - Missouri Gov. Jay Nixon declared a state of emergency Monday and activated the National Guard ahead of a grand jury decision about whether a white police officer will be charged in the fatal shooting of a black 18-year-old in the St. Louis suburb of Ferguson (*Associated Press).*Nixon said the National Guard would assist state and local police in case the grand jury's decision leads to a resurgence of the civil unrest that occurred in the days immediately after the Aug. 9 shooting of Michael Brown by Ferguson Police Officer Darren Wilson. "All people in the St. Louis region deserve to feel safe in their communities and to make their voices heard without fear of violence or intimidation," Nixon said in a written statement. There is no specific date for a grand jury decision to be revealed, and Nixon gave no indication that an announcement is imminent. But St. Louis County Prosecutor Bob McCulloch has said that he expects the grand jury to reach a decision in mid-to-late November. The U.S. Justice Department, which is conducting a separate investigation, has not said when its work will be completed.

Local

CITIES: IPS 'TRANSFORMATION ZONE' WILL TRY TO WIN BACK CONTROL OF SCHOOLS - Indianapolis Public Schools has a shot at recovering some of its most struggling schools from state intervention — an opportunity borne out of renewed confidence in district leadership (Wang, *IndyStar)*. State officials are asking IPS to pitch its plan for a "transformation zone" to initiate district-led turnaround supports for its lower-performing schools, instead of having outside companies step in. It's an about-face from several years ago, when the State Board of Education chose to take action at repeatedly failing IPS schools amid a lack of faith in the district to make the needed improvements. "We believe the transformation zone model will be one that will be beneficial for the district," said IPS Superintendent Lewis Ferebee, touting the idea of "collective intervention" instead of juggling several state-contracted companies working in different schools. The transformation zone model, formed after the highly lauded proactive efforts at Evansville Vanderburgh School Corp., would encompass IPS' Arlington, Washington, Marshall and Broad Ripple high schools. With the exception of Arlington, the high schools had been working with "lead partners" — a milder form of state intervention than complete takeover. But a State Board of Education panel acknowledged that strategy didn't work well: None of those schools are still matched with their original lead partners. Instead, having the district take the lead on turnaround and voluntarily partner with a company to assist its efforts could be more likely to yield positive results, the panel said. "It's been very convoluted in terms of really digging into school turnaround," Ferebee said. "We believe having one voice, one partner, would

definitely be more beneficial." The transformation zone model could become an official form of state intervention, with schools and districts still accountable to the state board for showing improvement.

CITIES: PRIVATE CONTRACTORS BAILING FROM INDY'S NEW SNOW PLOW PLAN - With snow on the ground and more in the forecast, Eyewitness News has learned that many private plow contractors are no longer willing to work for the city (Pescovitz, *WTHR-TV).* After last year's brutal winter, the city has reorganized the way they hire contracted plows. Last year, there were more than 100 private contractors or companies. This year, three contractors will divide the city's townships and hire sub-contractors to do the work. "We're going to monitor the contractors with whom we work directly, and we're going to count on them to identify people who can get the job done in neighborhoods," said Stephanie Wilson, spokesperson for Indianapolis Department of Public Works. Some of the veteran contractors say the new plan leaves them in the dust. For two decades, Bud Wesley's company, J.L. Wesley, has stepped in to plow when Indianapolis called. "We served the city of Indianapolis for a lot of years, We tried hard to make sure everybody was ready to go for the next morning," Wesley said. Using 30-40 trucks, about 90 percent of Wesley's plow business was on residential city streets. This year, he decided not to renew. "It wasn't worth it," Wesley said.

CITIES: LAWSUIT ALLEGES IMPD DATABASE USED TO GUN DOWN EX-WIFE - A police sergeant used an Indianapolis Metropolitan Police Department database to track his ex-wife's whereabouts and gun her down, according to a lawsuit filed by the woman's son (Disis, *IndyStar)*. The son of Kimberlee Jo Carmack, an Indianapolis police officer killed by her ex-husband in April, filed a federal lawsuit Monday against the city and the IMPD, claiming the department failed to protect her and left her defenseless against her killer. Carmack was fatally shot at her Westside home April 17 by IMPD Sgt. Ryan Anders, who then shot and killed himself. They had married in 2010 and divorced in October 2013. Dustin H. Carmack, who is also an IMPD officer, filed a federal lawsuit Monday saying the department violated his mother's civil rights. "They told her they were going to protect her," said Jeffrey McQuary, Carmack's attorney. "They told her there would be guards. They told her that they were monitoring Ryan Anders and would tell her if he ever got close to her. And they didn't do any of those things." The lawsuit accuses IMPD of bungling many aspects of a domestic-violence investigation that began March 12, more than a month before Carmack was killed. Instead of firing Anders, the lawsuit says, IMPD Chief Rick Hite reassigned him to administrative duties, "thus leaving him with police powers and access to the resources and personnel of IMPD that he could use to locate Carmack." The Marion County Prosecutor's Office told The Indianapolis Star in April that it knew of no violations of that order before she was killed. The lawsuit, however, claims he continued to stalk her.

CITIES: ELKHART COUNCIL APPROVES TIF EXPANSION FOR CONSIDERATION - After more than an hour of discussion and a strong plea for support, city council voted unanimously on Monday night, Nov. 17, to support the Moore administration's plan to expand the downtown development zone that one person termed a "blueprint" for the future (Spalding, *Elkhart Truth*). Even though two council members — Brian Dickerson and David Henke — had questioned the idea of expanding the downtown tax increment finance district to the north, council voted unanimously to support the redevelopment commission plan. The vote was 8-0. Council member Mary Olson was absent. Monday night's approval represented the last major hurdle and the redevelopment commission could provide a final OK next month. Supporters appeared to go the extra mile to gain its approval. The city hosted a series of public meetings, established a website and used a promotional video to highlight past achievements that have come about from the use of TIF dollars. After the plan is finalized in December, the city would then consider seeking a bond that would provide money to begin undertaking community development projects that are part of the downtown TIF.

CITIES: RICHMOND'S FINANCIAL CONDITION "STABLE" - The numbers are in and the city, as Richmond Mayor Sally Hutton has repeatedly said, is in stable financial condition (Engle, Richmond Palladium-Item). But the final numbers might tell a different story. Richmond Common Council received financial summaries for all funds for April through September on Monday night plus a report from Dan Hedden of Umbaugh & Associates, the financial consultant who is straightening out problems in the controller's office. "I'm very pleased we receive these financials," said Councilwoman Misty Hollis, who has joined other council members in demanding an accurate financial accounting. "I'm glad to see the taxpayers' money and how it is being spent," she added. Problems arose in the spring when both the city controller and deputy controller left within two months of each other and new controller Paula Hill struggled with budget preparation and providing updates financial summaries to council.

Scott.A.Milkey

From: Hill, John (DHS)
Sent: Wednesday, November 12, 2014 5:56 PM
To: Atterholt, Jim
Subject: FW: Advice on State Agency

I'm on it. The one lady, Jan Crider, retired in October and I have told her supervisor to get me answer this week.

This is embarrassing.

From: Hill, John (DHS)
Sent: Wednesday, November 12, 2014 5:52 PM
To: Copeland, Arvin
Subject: FW: Advice on State Agency

Please provide an answer for me by close of business on Friday.

Thank you.

John

From: Czarniecki, Cary (Lani)
Sent: Wednesday, November 12, 2014 4:25 PM
To: Scott Minier
Subject: Re: Advice on State Agency

Got it Scott!

I am on the road for the remainder of today but I can run the traps on this first thing tomorrow.

Best regard,

lani

Lani Czarniecki

765-[redacted]

Lanicz@gov.in.gov

www.in.gov/gov

On Nov 12, 2014, at 12:17 PM, "Scott Minier" <SMinier@indianahistory.org> wrote:

Lani,

Thank you again for working together so well on Governor and Mrs. Pence's participation in the funeral of former Marion County Sheriff Jack L. Cottey.

When you get a chance, I'd like to seek your advice on how to approach a state agency about a major outstanding pledge the Indiana Historical Society seems to be having trouble collecting.

Nearly two years ago, Nov. 28, 2012, the Indiana Department of Homeland Security agreed in writing to fund $10,000 toward our "You Are There 1913: A City Under Water" exhibit, which opened in March of 2013. Since then, several reminders have been mailed and emailed to Jan Crider, IDHS Mitigation, who appears to have signed the funding agreement, and to Manuela Johnson, IDHS Disaster Relief Fund, who has been kind enough to at least return phone calls from IHS. Both Jan and Manuela reportedly served on an advisory panel for this impactful and popular interactive exhibit.

It is only with the support of funders that IHS is able to create educational experiences like "A City Under Water," which highlights disaster aid, relief and prevention efforts.

Your guidance on how we might best approach IDHS to successfully close this outstanding pledge would be greatly appreciated. It is a matter that continues to be discussed in many meetings involving folks in high circles. I'm sure you can appreciate my desire to prevent any further embarrassment for the administration. My hope is that either you or Jim Atterholt can help me solve this situation quietly and quickly.

Thanks, my friend.

Scott Minier

Director, Corporate Relations

Indiana Historical Society

Eugene and Marilyn Glick Indiana History Center

450 West Ohio Street

Indianapolis, Indiana 46202

317-234-8853 office

317-234-0076 fax

www.indianahistory.org

See the newest features of the Indiana Experience:

You Are There 1939: Healing Bodies, Changing Minds

You Are There 1913: A City Under Water

You Are There 1904: Picture This

Scott.A.Milkey

From: Nancy Hiltunen, III <chiltunen@[redacted]>
Sent: Friday, October 03, 2014 3:50 PM
To: Johnson, Chris (FSSA)
Cc: Keefer, Sean (GOV);Wernert, Dr. John J.;Hill, John (DHS);Miller, Eric;Willing, Kirke (GOV);Atterholt, Jim
Subject: Secure Prescription Program Information
Attachments: Program_Overview2.docx; New York Bureau of Narcotic Enforcement Prescription Program Organization and Staffing copy.pdf; PDMP best practice report 2012 copy.pdf; (edit)Winchester_Neonatal_Abstinence_and_Opiate_Prescriptions._12_13_2012_pt.pdf; Attorney General Wants Action On Prenatal Drug Exposure News - Indiana Public Media.pdf; ER_Wright_Presentation_on_Epidemiology_of_Nonmedical_Prescription_Drug_Abuse_in_Indiana_12-10-2010.pptx; PrescDr copy.pdf; ShovelingUpII copy.pdf; intercept QA session followup-Charliev1.pptx; interceptRx Overview Governor Presentation 1-9-13 copy.pdf

Chris

Please find below an updated overview of the Secure Prescription Program, with additional information based on our last conversation. Also, if you would like to speak with someone from the New York Program, the new contact (the NY Medicaid Inspector General lead has retired)is:

Ottavio Nicotina, New York Office of the Medicaid Inspector General (OMIG), Ottavio.Nicotina@omig.ny.gov phone: 518-[redacted]

I tried to break everything down into categories and appendixes so that you could digest the information a little easier; let me know if you need any more detail.

Have a GREAT weekend!

Charlie Hiltunen

(317)[redacted]

Program Overview:

Appendix to Program Overview:

Program Overview:

The PSS/interceptRx Prescription Fraud Program is a prescription fraud prevention program that stops fraud at the point-of-sale.

> The goal of the Prescription Fraud Prevention Program is to save lives and taxpayer funds by establishing an effective mechanism to prevent prescription fraud (and subsequent abuse) at the point-of-sale without a cash outlay or appropriation of State funds. Funding of the program will be accomplished through the utilization of cost avoidance savings realized through leveraging federal funding through State programs, such as Medicaid.

This proven solution **Saves Lives, Saves Taxpayer Dollars, and Stops Prescription Drug Crime at the Pharmacy Counter.** The program will be implemented in an innovative manner that produces **SUBSTANTIAL SAVINGS TO THE STATE WITH NO FINANCIAL RISK.** The Indiana Board of Pharmacy is the appropriate oversight agency, in coordination with FSSA for the funding component of the project.

The Program is ideally suited as a **PENCE ADMINIISTRATIVE INITIATIVE** through the **Governor's Roadmap to Indiana Directive.** The program**:**

> **Presents no cost to the state of Indiana.** Private investors fund the program, and are paid a fee out of savings realized by the state and leveraged with federal matching funds. (Conservative estimated first year savings to the state of $12 to $37 million.)
>
> *Invests* in strategies and systems that increase efficiency and reduce significant waste brought on by fraud, abuse, and mistakes within the largest budget expenditure categories.
>
> Avoids burdensome regulations placed upon providers and patients, cuts to essential services, and other more intrusive methods of addressing fraud while providing a positive incentive and benefit to all prescribers through free prescription pads.
>
> Once successfully executed and launched, **THE STATE OF INDIANA MODEL WILL SAVE BILLIONS NATIONWIDE.**

Background:

PSS/INTERCEPTRX Partner, Standard Register, innovated a solution to address the largest, gaping hole in prescription security: The New York State Serialized Prescription Program went into effect beginning April, 2006 and required that all prescriptions

written in New York State - for both controlled and non-controlled substances – **must** be written on an official NYS serialized prescription form in order to combat prescription fraud. Initially, hospitals and selected clinics were given exemptions from this requirement. However, as of October 2006, all providers were required to be in compliance with this requirement and an edit was implemented in the eMedNY system that denies all claims for prescriptions that are not written on an official prescription form. As a requirement of submitting a valid claim and receiving payment, all claims for such prescriptions must be printed on paper incorporating security features to prevent alteration, duplication, and forgery and contain a prescription serial number pre-printed on the official prescription form. Some valid prescriptions, such as oral prescriptions, were dispensed when not written on official prescription forms. These were identified via the use of a separately issued serial number. (See Appendix A for Reports from the New York Initiative)

As part of the NYS serialized prescription program, The Office of the Medicaid Inspector General (OMIG) sponsored claims system edits that deny all claims for prescriptions written that are not written on an official prescription form. Other system edits were developed to ensure that the serialized prescription numbers are put through a validity check to verify the authenticity of the Official NYS Serialized Prescription number. These new System edits match the serialized prescription number and Prescription Origin Code on the claim to the issued script file and verify the legitimacy of a prescription by comparing it to a database of serial numbers and the providers to whom they were assigned. Additionally, the serial numbers will be compared to a database of prescriptions reported as stolen, lost, or invalidated and alerts given to pharmacists when a match occurs. Serial numbers reported lost or stolen are front loaded to eMedNY claims system in real-time and if a serial # and prescriber ID submitted by pharmacy do not match, the transaction will be rejected at the point of service.

The Serialized Prescription Program in NYS has resulted in substantial cost-savings and has been a deterrent to prescription fraud within the NYS Medicaid program. Savings are calculated monthly. Edits are monitored for lack of a serial number and rejects for stolen/forged scripts. Claims may be resubmitted within 90 days if the situation is corrected (stolen scripts reported as found, etc. See Appendix B, New York Bureau of Narcotic Enforcement Organization and Staffing Document)

Legislative Authority:

IC 25-26-13-4, passed within the 2009 State Budget Act, states that the Governor may direct the Board of Pharmacy to develop a prescription drug program that includes the establishment of criteria to eliminate or significantly reduce prescription fraud and a standard format for an official tamper resistant prescription drug form for prescriptions (as defined in IC 16-42-19-7(1)). (Exhibit B, Appendix)

Cost to the State/ Project Funding Mechanism:

The program will be developed, implemented, and financed through private and/or foundation participation; PSS/interceptRx and benefactors will risk the capital outlays in the program with the expectation that as savings are realized, a portion of the savings will be used to recoup the capital expended, reward the risk assumed, and create funds for re-investment into the fraud prevention program. PSS/interceptRx, with State approval, will fund an independent third party evaluator to develop a benchmark formula to calculate savings/rewards for remuneration under a pay-for-performance contract with the State, based on only one aspect of savings, the Medicaid program, in order to leverage the use of federal funds and to maximize the amount of savings reverting to the State.

Benefits To The State of Indiana vs. the Cost of Doing Nothing

Applying the New York program's results to Indiana, the following is what Indiana can expect from the Prescription Fraud Prevention Program:

Estimated Fiscal Impact for Indiana:

- Program Cost: $6.5 million (provided by PSS/interceptRx) annually
- Estimated Implementation Time: 6-8 months
- Annual Estimated Indiana Medicaid Savings: $12 to $37 million (conservative)
- Private Insurers should experience similar cost savings based on their market share

Savings estimates are made by taking the known data from the New York experience and extrapolating Indiana data to develop a savings model. Based on the Savings model, PSS Partner, Standard Register, conservatively estimates the **Indiana prescription fraud prevention program to deliver between $12 and $37 million dollars of savings in the first year of operation.** This savings model does not include savings to private-sector insurance, other State insurance and health programs, or the savings from the cost of prescription drug addiction outlined below. For more detailed information, See Appendix C: - Shoveling UP and Wright Study.

Downstream Loss Prevention and Cost Savings

Estimated Costs/Allocations Attributable to Substance Use (Indiana, FY 2008)
TOTAL IMPACT: $7.3 BILLION

- ***Funding to Reduce Substance Use***
  - Prevention, Intervention and Research: $70 million
- ***Funding to Address Consequences of Substance Use***
  - Healthcare costs/Medicaid and Medicare: $4.8 billion
  - Corrections and Judiciary: $1.3 billion

- Education: $621 million
- Child welfare: $685 million
- Income support: $133 million
- Mental health: $126 million
- Developmental disabilities/FASD: $11 million
- Public safety: $60 million
- State workforce: $7 million

- ***Net Gain from Substance Use***
  - Excise taxes for alcohol, tobacco, and controlled substances: $567 million

Additionally, According to Attorney General Greg Zoeller, treating Neonatal Abstinence Syndrome (NAS) at Indiana hospitals cost an estimated $30 million in 2010, the most recent year for which data is available, and he says that is with limited tracking because hospitals are not required to report the condition. **The Secure Prescription Program will impact these costs and statistics, as well as help with one of Governor Pence's top issues – INFANT MORTALITY.**

Indicators Point to high Rx Drug Fraud Rate in Indiana

Data shows a rapidly growing Indiana Prescription drug problem, despite the state's current efforts:

- Indiana's prescriptions issued per capita is 14.2; by comparison New York's is 12.0 and the United States' is 12.0. *(2008 data; Source: www.statehealthfacts.org)*
- The number of drug-induced Indiana deaths (including deaths from all drugs) increased from 245 in 1999 to 665 in 2005—an increase of over 170%.
- The rate of past-year prescription drug abuse of Hoosiers ages 18 to 25 (17.8%) is significantly higher than rates among their U.S. counterparts (14.5%).
- Indiana's estimated rate of abuse exceeds that of the nation for prescription pain relievers and benzodiazepines. *(Indiana State Epidemiology and Outcomes Workgroup, 2006)*
- Indiana leads the nation in Pharmacy robberies in 2013
- From 1999 to 2009, unintentional poisoning, (prescription drug overdose), skyrocketed 502 % in Indiana. Over the decade, unintentional poisoning became the leading cause of injury death, outpacing unintentional motor vehicle accidents, suicide with a firearm, and homicide with a firearm
- A 2011 survey stated Indiana ranked second highest out of the 35 states where students were surveyed who said they took prescription drugs without a doctors prescription.
- Indiana neonatal abstinence syndrome cost has increased from $5 to $90 million annually

Program Mechanics/Implementation Overview

PSS/interceptRx will adhere to strict and diligent processes to monitor and execute the rollout and operation of the State system and will:

- Initiate the program by engaging its project managers to prepare all documents, waivers, and Advance Planning Documents to secure approval of enhanced FMAP funds to cover 90% of the program fees resulting from savings and cost avoidance. PSS/interceptRx will also seek other funds and federal incentives to maximize the savings that will remain with the State of Indiana.

- Work with FSSA and claims processing vendor to authorize edits for exchange of data regarding issued/rejected scripts and claims edit updates. Integrate edits into the pharmacy claims process to validate each participating prescription claim and develop an on-going reporting of fraud prevention savings in support of shared saving funding process, with on-going data mining processes to identify to identify and stop fraud, spot developing fraud trends, and sharing with other State Fraud vendors and efforts. Additionally, PSS is developing applications to work outside of the edit system to remotely verify prescriptions, such as ***Smartphone Apps for law enforcement.***

(See Edit Detail below)

- Institute sustained and effective Stakeholder Communications **-** A detailed multi phased program to inform all stakeholders on the launch of the program. PSS/interceptRx will act as the administrator and project manager of the program and will coordinate the program and communications with key State agencies, licensed prescribers, and organizations that support both prescribers and the pharmacy community. Consult with Board of Pharmacy (BOP) to plan communication/education schedule to state prescribers and develop educational collateral.

- Coordinate the development, design, production, and distribution of a secure prescription blank, including a digital track & trace system for paper, electronic and phone-in prescriptions to provide an estimated 59 million prescription blanks to licensed Indiana prescribers. The program will include:

- Providing Patent Protected fraud prevention technology and Trade Secret digital fraud prevention technology (patent numbers are available upon request):

    - **AVA *(Automated Validation & Authentication)***

prescription fraud digital detection system.

- **Material science fraud prevention**- two different patented security inks that will be part of the overt fraud prevention specifications

- **Secure design**- one patented and several trade secret design features that will be incorporated into the prescription design.

- **Software**- several patents protecting our SMARTworks™ secure order capture system along with trade secrets and pending IP protection for our AVA (Automated Validation & Authentication) system.

- Production of tamper resistant prescription blanks designed to prevent forgeries, alterations, counterfeits and capable of tracking lost and/or stolen prescriptions through a control number, which far exceed CMS minimum standards:

  - Secure manufacturing, storage and distribution
  - Personalization of prescription blanks with required prescriber information
  - Inventory management support and software
  - Annual SAS 70 level 2 third party audits of selected Standard Register facilities

- Provide secure on-line ordering through a patented order management solution system, *SMARTworks. ™* Distribution will be free to all licensed prescribers at no cost to the State of Indiana or prescribers. The system includes secure web-based order capture software and a call center to support non web-based orders and respond to order inquiries.

- Expand Secure Serialized Prescription Technology to electronic prescribing, utilizing PSS proprietary technology and encryption.

- Enable Data warehouse connectivity for the sharing of data with INSPECT, other agencies and fraud vendors.

- Work with FSSA, Board of Pharmacy, and Claims Processing Vendor to provide a monthly savings tabulation based on

fraudulent Medicaid pharmacy claims which are caught and rejected as a result of the prescription fraud prevention program.

E-Prescribing

The PSS/interceptRx technology is applicable to both paper and electronic prescriptions. The serialized prescription system provides a base platform so that individual electronic prescriptions can be tagged with a serial number to validate the authenticity of the transmission, as well as protect from unauthorized use of a prescriber's computer system. Electronic Prescription fraud has the potential of being as much or more rampant than paper fraud. Electronic fraud can be as easy as procuring a username and password or as sophisticated as "ghosting" an IP Address or hacking a system with a Trojan virus. E-prescription fraud also removes the barrier created during the time a prescription is presented to a pharmacist for validation. The perpetrator does not have to face a person and, in some cases, will receive notification that the prescription is ready for pick-up, giving the perpetrator the assurance that he/she will not be caught. PSS plans on rolling out the electronic system after the paper roll-out to ensure a smooth transition to the new system.

Serialized Prescription Edits

A key component of the Secure Prescription Program is the Serialized Prescription Edits feature, executed after the claims have been submitted and adjudicated in the claims processing system. After subjecting all claims to the various edits, they are then pended, paid or denied. The following cost-savings edits are executed for the Serialized Prescription Program:

- Prescription Serial Number Missing.

  This edit will deny incoming pharmacy claims where the prescription serial number is missing. This edit will verify that a prescription serial number is included on a pharmacy claim.

- Prescription Serial Number Reported as Missing/Stolen.

  This edit will verify that the prescription serial number has not been reported as missing or stolen.

- Prescription Serial Number cannot be Adjusted

  This edit denies any claim adjustments where the prescription serial number has been altered.

Also executed is a series of other edits for the Serialized Prescription Program:

- Validity edit for Serialized Prescription Numbers

- Validity of Prescriber License/Current Authority to Prescribe

- Match Serialized Prescriptions for Individual prescribers

- Edit to deny pharmacy claims where the same serialized prescription number is/was submitted by different providers or same provider with the same refill indicator. (Bypass for electronic prescriptions, oral prescription, faxes, etc.)

- Edit to deny pharmacy claims where the fill date is greater than the date written and there is a refill indicator greater than "00", but there are no refills indicated on the script.

- Edit to report cost savings on a monthly basis

NOTE: Out-of-state prescriptions viewed with the new Indiana Official Prescription Program- When the new program is implemented, all outside Indiana border cities and towns that have physician's written prescription but are filled in IN are still valid and will be accepted as it pertains to IN's current laws and regulations. If an IN physician writes a prescription that is filled outside of IN it must be written on the new IN script. Once implemented, Pharmacists will notice the difference in scripts as IL, MI, OH, KY will not have a barcode or an 8-digit number associated with those scripts.

Impact of Managed Care

More and more States are moving their Medicaid program away from the traditional fee-for-service (FFS) model and more toward a capitated model or Managed Care. As a result, the deployment of system claims edits may be different, depending upon the claims processing system. If the claims processing system is within the managed care vendor's system, then the edits must be worked through the vendor's claim processing system and the CMS funding mechanism must be amended to reflect tracking through those systems for reimbursement. If all pharmacy benefits are provided through a managed care vendor, the vendor will realize a significant "bonus" through reduced pharmacy claims, but the State will benefit at the time of the re-negotiation of the capitation rate and will still enjoy substantial savings from the other cost drivers impacted by the program. The managed care vendor will be incentivized through the "bonus" but also benefit from the other capabilities of the system including: verification that a prescription originated from a managed care provider's participating physician, prevention of duplicate billings, and other detected fraud and abuse. Critical fraud data can still be shared with other agencies, including INSPECT through encounter records or pharmacy reports.

Impact Upon Physicians and Pharmacists

The user experience from the provider and patient's perspective will be positive. Licensed prescribers will receive their pads for free, which is an immediate plus to their bottom line. Every new mandate and regulation seems to increase the cost of business for the provider, but this solution will have a positive impact on already-stretched office budgets. The only change will be that prescribers order from a different source, either on-line or call-in for free pads and delivery. A grace period will be given the doctors during implementation to allow them to use up any inventory and order new pads prior to the launch date. The pharmacists can scan the new pads with their existing barcode reader or input the 8-digit number on the pad within the current NCPDP software in their system. The field will be ready to populate within the current software.

The PSS/interceptRx validation and authentication process is a time-tested proven system. The Standard Register system has been operating in the State of New York without incident since 2006. The PSS/interceptRx project management team has incorporated safeguards and back up plans, in addition to Standard Register's comprehensive customer service resources to insure timely dispensing of legitimate prescriptions.

The PSS/interceptRx system will work seamlessly, invisibly, and within the normal course of prescribing…no additional mandates, equipment or effort will be required of health care providers or patients. Furthermore, performance measures related to timely dispensing of legitimate prescriptions can be covered in contract statements of work and in the SOW.

How the program works with other Fraud Systems and PDMP's

The PSS/interceptRX program is specifically designed to integrate with Prescription Drug Monitoring Programs like INSPECT. Furthermore, the Secure Prescription System is listed as a PDMP BEST PRACTICE (see Appendix D, PDMP BEST PRACTICE, Klatte PowerPoint Presentation).

- ✓ Data from INSPECT and the Professional Licensing Agency can enhance the Secure Prescription Program – Prescriptions flagged by INSPECT can be stopped at the counter through PSS/interceptRx, Medical Licensing Agency data on deceased prescribers and suspended licenses can trigger PSS/interceptRx intervention.
- ✓ Data collected from prescriptions stopped at the counter can provide insight to other data collected by INSPECT
- ✓ Enforcement can be enhanced by adding the ability to block targeted prescriptions.

- ✓ Specific Prescriptions are directly linked to Provider and Claim Data, which could enhance the INSPECT system.
- ✓ The PSS/interceptRx system data can be available to INSPECT, Agencies, and fraud vendors to enhance the comprehensive fraud prevention/enforcement efforts in the State of Indiana.
- ✓ PSS/interceptRx will operate consistently within the guidelines, goals, and objectives established by the FSSA HIT Strategic Plan.

The data collected through the PSS/interceptRx program will augment the efforts of the Fraud and Abuse Detection System (FADS) contractor, by providing another source of data for analysis, mining, algorithm development to supports FADS, Surveillance and Utilization Review Systems (SURS), Office of the Inspector General (OIG), Medicaid Fraud Control Unit (MFCU), and the Medicaid Integrity Contractor (MIC).

APPENDIX

LEGISLATIVE AUTHORITY
IC 25-26-13-4 Powers and duties of board; prescription drug form program (Relevant Sections)

Sec. 4. (a) The board may:

…

(1) promulgate rules and regulations under IC 4-22-2 for implementing and enforcing this chapter;

…

(4) regulate the sale of drugs and devices in the state of Indiana;

…

(d) The board shall adopt rules and procedures, in consultation with the medical licensing board, concerning the electronic transmission of prescriptions. The rules adopted under this subsection must address the following:

(1) Privacy protection for the practitioner and the practitioner's patient.
(2) Security of the electronic transmission.
(3) A process for approving electronic data intermediaries for the electronic transmission of prescriptions.
(4) Use of a practitioner's United States Drug Enforcement Agency registration number.
(5) Protection of the practitioner from identity theft or fraudulent use of the practitioner's prescribing authority.

(e) The governor may direct the board to develop:

(1) a prescription drug program that includes the establishment of criteria to

eliminate or significantly reduce prescription fraud; and

(2) a standard format for an official tamper resistant prescription drug form for prescriptions (as defined in IC 16-42-19-7(1)).

The board may adopt rules under IC 4-22-2 necessary to implement this subsection.

(f) The standard format for a prescription drug form described in subsection (e)(2) must include the following:

(1) A counterfeit protection bar code with human readable representation of the data in the bar code.

(2) A thermochromic mark on the front and the back of the prescription that:

(A) is at least one-fourth (1/4) of one (1) inch in height and width; and

(B) changes from blue to clear when exposed to heat.

(g) The board may contract with a supplier to implement and manage the prescription drug program described in subsection (e). The supplier must:

(1) have been audited by a third party auditor using the SAS 70 audit or an equivalent audit for at least the three (3) previous years; and

(2) be audited by a third party auditor using the SAS 70 audit or an equivalent audit throughout the duration of the contract;

in order to be considered to implement and manage the program.

As added by Acts 1977, P.L.276, SEC.1. Amended by Acts 1981, P.L.222, SEC.186; P.L.75-1992, SEC.20; P.L.2-1993, SEC.145; P.L.177-1997, SEC.5; P.L.212-2005, SEC.22; P.L.204-2005, SEC.15; P.L.182-2009(ss), SEC.371.

Prescription Fraud and the New York Experience:

State of New York Contact: Ottavio Nicotina, New York Office of the Medicaid Inspector General (OMIG), Ottavio.Nicotina@omig.ny.gov

Prescription drug abuse is a national epidemic according to the Centers for Disease Control. According to the National Center for Health Statistics, prescription painkillers have topped car accidents as the leading cause of accidental death in the U.S. Prescription fraud is big business, with the average Rx pad commanding a street value of approximately $10,000. Criminals perpetrate fraud through theft, forgery (creating their own Rx pads), alteration (changing existing information on a prescription), and false issuance (doctor shopping). In the end, states pay when the fraudulent scripts are filled at pharmacies, which are reimbursed through Medicaid or insurance claims. By utilizing a **single source** for prescription pads, **produced in a secure environment** (much like the US Mint for currency), a closed loop approach stops the fraud at the pharmacy counter before any Medicaid or insurance money is disbursed. The state will recognize real savings, as documented by the value of each fraudulent prescription that is not filled, and **avoid the traditional "pay and chase" process.**

<u>There's big money for criminals in trafficking prescription meds such as those used for pain relief, anxiety, and depression. How big? Nearly $1 billion a year, according to a June 1, 2011 CNN Money Story. Jim Butschli, Editor</u>

The State of New York's Medicaid Program has experienced the benefits of a secure prescription program, and is currently the only state to have implemented such a program. In 2006, New York invested approximately $14 million to create a single source (Standard Register's program), closed loop, secure prescription program with the hope of stopping an estimated $40 million annually in Medicaid prescription fraud.

The result was almost instantaneous. Within the first month of the program, the state earned back its investment in the program. By the end of the first year, New York's savings tallied over $140 million for the Medicaid prescription program.

"Official State Prescription Form Deters Medicaid Fraud"

"This program is a powerful tool in reducing prescription fraud, which drives up health-care costs and threatens public safety by diverting drugs from legitimate medical use," said New York State Health Commissioner Richard F. Daines, M.D.

"The medical community has embraced the notification program…"

"In addition to the Medicaid savings, the Bureau of Narcotic Enforcement estimates the program is also generating $75 million annually in private-sector savings through the reduction in fraudulent prescription claims to health-care plans…"
Source: North Country Gazette, August 1, 2007.

<u>"New Pads are Prescription for Fighting Forgeries"</u>

"[Dr. Glennell] Smith, an internist/endocrinologist for the last 28 years….said at least once a year over the last four years, he had been the victim of prescription forgeries for drugs on New York's list of controlled substances…ever since New York State rolled out its new Official Prescription Program…, forgeries from Smith's office are a thing of the past."
Source: Buffalo Business First, August 24, 2007

"New Prescription Program Saving Medicaid Millions of Dollars"

"…there's been a 7 percent reduction in the amount of Hydrocodone abuse, a painkiller also known as Lortab or Vicodin, from the first half of 2006 when compared to the first half of 2007." Said Jeffery Hammond New York State Department of Health
Source: The Business Review, August 30, 2007.

State of Indiana
Prescription Fraud Prevention Program

Matching Fund and Grant Process

100% of the "risk of return" contemplated by the outlay of funds to cover the cost of the program will be assumed by a cooperative formed by the Partnerships for State Solutions (PSS/PSS/INTERCEPTRX). Furthermore, PSS/PSS/INTERCEPTRX will endeavor to maximize the benefit to Indiana, as the PSS/PSS/INTERCEPTRX Pilot Partner, by seeking additional funds and grants to minimize or eliminate the amount of Indiana's savings that will be attributable to the "risk reward." Matching funds and other grants will be used for the purpose of establishing Indiana as the innovator for the project to be duplicated across the nation.

Once given the initial "go-ahead" from the State, Partnerships for State Solutions will deploy a Project Management Team to coordinate and provide all resources for State agencies to obtain approvals for grants and funding for the program. In cooperation with State agencies, PSS/PSS/INTERCEPTRX grant writers, HHS process specialists, and project management professionals will:

> Secure a 90/10 enhanced Federal Medical Assistance Percentage (FMAP) from HHS/CMS to include the costs of the Prescription Fraud Prevention Program in the amount of Federal matching funds for State expenditures for Medicaid assistance payments. (And/or other State medical and medical insurance expenditures covered under the FMAP).
>
> Seek to obtain Federal approval to cover the remaining 10% of Indiana's share of the FMAP. Title 45 of the Federal Code of Regulations creates incentives for the State to engage in cost savings initiatives by setting standards to be used to account for program income related to projects financed in whole or in part with Federal funds. Program income/savings earned during the project can be retained by the State and, in accordance with the terms and conditions of the award, can be used to further eligible project or program objectives or to finance the non-federal share of the project or program. (45 CFR Part 74)
>
> Attain other grant opportunities to support the fraud prevention efforts through Federal and private foundation grants in order to utilize the program technology for use with electronic prescription security and to expand operations in Indiana to implement the program in other States.

Requests to HHS from Governors or other duly constituted State authorities for programs involving Intergovernmental Cooperation (31 U.S.C. 6501-6508) will be given expeditious handling. Whenever possible, such requests will be granted. (45 CFR Part 74).

The PSS/PSS/INTERCEPTRX Funding Acquisition Team will:

Prepare and coordinate all documentation and procedures, including all necessary waivers, applications, and the Federal Advance Planning Document (APD) process to obtain approval for Federal financial participation in the cost of services and for enhanced FMAP funds.

Manage regulatory compliance requirements that apply to grants including all documentation such as narrative reports of project activities, work plans, schedule reports, and records produced from Independent Verification and Validation.

Direct and coordinate communications with HHS, CMS, and other entities to identify and secure other funding sources and opportunities, including Pilot State Project Funds and Expansion Grants to cover the State Portion of Prescription Drug Program. Included in the APD documentation will be the State's procurement strategy for sole source procurement with reference to the State's procurement policies and procedures. (§ 95.610(c))

Create a center to share data trends and findings with Medicaid and other entities engaged in fraud and abuse prevention and detection; to incorporate data trends into algorithms and enhance other's fraud efforts.

Seek and pursue other funding opportunities through programs created under:

The Affordable Care Act (provides $350 million over 10 years (FY 2011 through FY 2020) through the Health Care Fraud and Abuse Control Account (HCFAC).)

The Deficit Reduction Act of 2005 (also encourages states to focus on fraudulent activities occurring in state Medicaid programs and payments. Under the DRA, states that obtain Medicaid fraud settlements or judgments are allowed to keep 10% of the share they would normally send back to the Feds as repayment of the federal matching share of Medicaid.)

The Department of Health and Human Services Programs:

HHS Center for Program Integrity (CPI)

The Centers for Medicare and Medicaid ("CMS") Medicaid Integrity Program ("MIP") (section 1936 of the Deficit Reduction Act of 2005 ("DRA"),

HHS Office of Inspector General.

HHS Office of General Counsel.

Department of Justice/HHS Medicare Fraud Strike Force Teams.

HHS Administration on Community Living

Food and Drug Administration Pharmaceutical Fraud Program.

American Recovery and Reinvestment Act of 2009 Programs.

Private Foundations, such as The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, State Health Care Spending Project

Official Prescription Fraud Prevention Program

Q/A with OMB, FSSA, and interceptRx

April 15th, 2014

It is unclear how the proposal integrates with e-prescribing efforts.

- The interceptRx digital fraud prevention system will compliment and enhance all e/phone/paper Rx transactions through its proprietary coding and verification system to stop specific types of fraud at the point-of-sale.

  - ✓ The original interceptRx proposal was offered to the State prior to the time of e-prescribing penetration and federal electronic mandates. The core of the proposal is the proprietary coding and verification system.

  - ✓ The Indiana Initiative will commence with paper and phone-in transactions to close the current significant vulnerability in the prescription security system. Once operational and secure, coding and verification systems can be integrated into e-prescription transactions. No matter what percentage of prescriptions are filled through paper, there will always be a significant opportunity to compromise the system.

  - ✓ Best Security Practice Guidelines dictate that safeguards, such as interceptRx, work in conjunction with, but independent of, prescription systems to prevent internal fraud.

Are Current Tamper Resistant Forms Enough?

Medicaid Approval from CMS

- CMS and Indiana standards for tamper resistant forms are minimal, easily exploited, and have no practical system of verification or enforcement. interceptRx forms are produced under similar standards as the U.S. Mint and are self-enforcing, which not only prevents fraud but saves enforcement costs to the State.

- The minimum tamper resistant requirements fall considerably short of specifications of the proven Rx fraud prevention system upon which our solution is modeled and actually enable more fraud to occur.

- CMS approval of an SPC is important to the process; The agreement between interceptRx and the State will be contigent upon CMS matching fund approval.

- InterceptRx will provide the expertise and labor to facilitate the SPA/Waiver/APD process. The interceptRx objective is to achieve approval for 90/10 federal matching funds, but will make a best effort to seek other enhanced funds, such as Pilot and Center of Excellence Grants.

Impact Upon Indiana Printing Businesses

- **The successful launch of this solution will create Hoosier economic growth by bringing revenue from all over the country back to Indiana through interceptRx and Standard Register production facilities as interceptRx expands nationally.**

- Multiple and unsecure paper/printing sources are currently the single biggest threat to the security of the prescription system. There is no way to track inventory, verify that security measures are implemented, or insure that pads end up in the hands of legal prescribers.

- **98% of all printer vendors were noncompliant and in violation of the minimal 3-feature current standard during the last (and only) compliance audit.** Security paper is also readily available through these sources to criminals to print their own prescriptions and pads for resale, up to $10,000/pad. **At least one print vendor is a Pain Clinic!**

- Prescription printing revenue will naturally decline with the migration to e-Rx with or without the proposed initiative; a single, secure source will have a huge impact upon losses to the taxpayers due to fraud .

Why should Medicaid pay?

Equitable split of savings?

- ***Medicaid bears the most risk and loss of doing nothing*** and pays the largest share of prescription costs, which continues to grow.
- Hoosier lives and taxpayer funds are saved from day one of the initiative.
- interceptRx will be responsible for all program risks and costs; payments will only accrue only from savings realized by the initiative.
  - ✓ No up front cost to the State of Indiana.
  - ✓ Federal matching funds will cover the vast majority of program costs.
  - ✓ interceptRx assumes 100% of the financial risk.
- The proposed contract will provide for recovery of costs and reasonable return for significant risk investments, only if savings are realized; Indiana will receive the lion's share of all benefits, both direct and indirect.
- Savings measurements and verification will be established by a mutually agreed-upon independent entity, paid for by interceptRx. If there is no savings, there is no payment.

Should it be bid?

Should PLA / BoP manage?

- interceptRx is making an innovative and completely unique offer to invest and risk millions of dollars to build and operate a system created by interceptRx partner and the only company with proven experience implementing a program similar to the one proposed, Standard Register. Based on the fact that no other entity is operating a similar program, interceptRx should be considered a sole-source provider.

- PLA /BoP is the logical oversight agency; the program adds considerable value and efficiency to Pharmacy/Medical Board enforcement and could significantly augment the INSPECT program.

- PLA/BoP can manage prescriptions of deceased providers and those who lost prescribing privileges due to administrative action.

- The interceptRx mechanism is self-enforcing, giving relief to stretched agency resources.
-

Contract provisions re: databases and FSSA HIT strategic Plan

- Agreed
  - ✓ All database access, compatibility, and coordination issues can be addressed in contracting language.
  - ✓ InterceptRx will enhance and operate consistently within the guidelines, goals, and objectives established by the FSSA HIT Strategic Plan.

Has some merit?

Inhibit timeliness?

- The interceptRx/Standard Register validation and authentication process is a time-tested proven system. The Standard Register system has been operating in the State of New York without incident since 2006. The interceptRx project management team has incorporated safeguards and back up plans, in addition to Standard Register's comprehensive customer services resources to insure that timely dispensing of legitimate prescriptions will not be hindered.

- The interceptRx system will work seamlessly, invisibly, and within the normal course of prescribing…no additional mandates, equipment or effort will be required of health care providers or patients.

- Performance measure related to timely dispensing of legitimate prescriptions can be covered in contract statements of work and in the SOW.

Co-existence with INSPECT?

- Our program is specifically designed to integrate with Prescription Drug Monitoring Programs like INSPECT.
- Data collected from prescriptions stopped at the counter can provide insight to other data collected by INSPECT.
- Enforcement can be enhanced by adding the ability to shut off targeted prescriptions.
- Validation and authentication enhances investigation and enforcement activities.
- We have reviewed our program with INSPECT leadership and enjoy a supportive relationship with current and past leadership of PLA and BoP.
- interceptRx may be used to drive up participation of providers; if it is found that certain problems continue, providers may be required to check with INSPECT to receive authorization code for certain high risk providers.
- Oversight of the program can be covered in contracting language.

Summary

InterceptRx

- ✓ Will save significant lives and taxpayer funds
- ✓ compliments, enhances, and closes significant security gaps in the Indiana Prescription System
- ✓ Creates a system with no financial risk to the State
- ✓ Will have a positive economic impact to the State
- ✓ Is a time tested, proven system with no risk of failure
- ✓ Enhances and fits seamlessly with the FSSA HIT Strategic Plan

Overview:
interceptRx™ Official State Prescription Fraud Program

Problem: Huge Medicaid Losses; States Cannot Afford to Stop

Today, a vast majority of states are faced with crippling deficits and are struggling to find ways to drastically cut spending and balance their budgets. Many have resorted to ineffective methods that cut essential services and short-term expenditures, while ultimately raising the long-term costs to their state. States must aggressively address these issues through the *investment* in strategies and systems that increase efficiency and reduce significant losses within their largest expenditure line items.

The largest spending category in all states is the Medicaid budget. It is estimated that as much as 30% of Medicaid appropriations are spent on fraud, abuse, and waste (2011 total state Medicaid spending is estimated at $2.7 trillion, growing at an annual rate of 3.9 %). Due to financial and other resource constraints, states are being "robbed blind" and have been unable to invest in endeavors which will bring about truly significant safeguards and savings through innovation and increased efficiency. Even as the Center for Medicaid Services offers incredible incentives, such as 90/10 matches for fraud prevention activities, states still cannot afford to invest in efforts to protect taxpayer funds. To assist states and prevent future losses, almost instantaneously, **interceptRx** has developed solutions to finance cost saving initiatives, beginning with a Prescription Pad Fraud Prevention Program that will enable states to attain substantial short and long-term cost saving efficiencies in their Medicaid programs. The establishment of this program in states will build the foundation to expand services to include e-prescribing and private insurance initiatives, which will multiply savings exponentially for states, taxpayers, insurance industry, and consumers.

interceptRx's mission is to Save Lives, Save Money, and Stop Prescription Fraud Crimes

Solution:

Prescription fraud is widespread and commonly perpetrated by petty thieves, organized crime, and terrorist groups. For example, an average Rx pad commands a street value of approximately $10,000. Criminals commit fraud through theft, forgery (creating their own Rx pads), alteration (changing existing information on a prescription), and false issuance (doctor shopping). In the end, states pay when the fraudulent scripts are filled at pharmacies, which are reimbursed through Medicaid or insurance claims. By utilizing a single source for prescription pads from a secure facility and 8-digit algorithm bar code technology, our approach stops the fraud at the pharmacy counter before any Medicaid or insurance money is disbursed. Many features within this system are the same safeguards employed by the U.S. Treasury. This technology eliminates the "pay and chase" method of fraud detection currently used by states and prevents the crime from occurring, PERIOD…a much more cost effective and efficient methodology.

> While the **interceptRx** solution tackles the prescription paper fraud problem, it also establishes a substantial framework to address future e-prescription crimes. We have an exclusive right to Standard Register's SecurePlus™ technology that enables total control and tracking ability.

The solution that **interceptRx** proposes is modeled after the State of New York Official Prescription Fraud Prevention Program which currently operates as the only successful working model in the country today. The State of New York's Medicaid Program has experienced the benefits of a secure prescription program since 2006.

New York invested approximately $14 million to create a single source (Standard Register's program), closed loop, secure prescription program with the hope of stopping an estimated $40 million annually in Medicaid prescription fraud.

The result was almost instantaneous. Within the first month of the program, the state earned back its investment in the program. By the end of the first year, New York's savings tallied over $140 million for the Medicaid prescription program.

"Official State Prescription Form Deters Medicaid Fraud"

"This program is a powerful tool in reducing prescription fraud, which drives up health-care costs and threatens public safety by diverting drugs from legitimate medical use," said State Health Commissioner Richard F. Daines, M.D.

"The medical community has embraced the notification program…"

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Source: The Business Review, August 30, 2007.

Standard Register currently has 47 different security features incorporated in its paper scripts and is constantly monitoring and testing new algorithms to stay one step ahead of criminals. Key components of our technology offer a digital validation process to detect fraudulent scripts, seamless integration into the pharmacy claim adjudication process, and data mining to continue development of future technological safeguards. **interceptRx** is the only company that offers an operational, time-tested solution for States and has both the technological and state government expertise to deliver a solution that can be duplicated nationwide.

Business Strategy: Creating a Risk-Reward Partnership with State Governments

interceptRx is a private entity with a public mission: to work as an "incubator" for cost saving programs and assist states in investing in efficient systems to protect and save taxpayer funds.
interceptRx will implement a prescription fraud prevention program across the U.S. to save lives and money while stopping crime losses to state and federal budgets. Ultimately, our system protects the investment made by the taxpayer citizens. **interceptRx** will jump-start proprietary technology in states through the participation of private investors, with the specific objective of creating a program that becomes self-funding through its own fraud prevention savings. **The States will receive a fraud prevention program at no upfront cost or risk to the state or its taxpayers. interceptRx** is dedicated to working with the states to provide the capital, expertise, and management skills needed to design, implement and manage a successful program.

Much of the interceptRx infrastructure, systems, and software are already developed through an exclusive agreement with Standard Register (SR), a Fortune 500 Company, that is an established world leader in document and electronic security. SR also utilizes the expertise of Frank Abagnale (who was the basis and subject for the movie, Catch Me If You Can) to constantly test systems and stays one step ahead of the criminals.

Attorney General Wants Action On Prenatal Drug Exposure

By BRANDON SMITH, IPBS

Posted September 9, 2013

Treating babies who were exposed to addictive drugs in the womb cost Indiana hospitals $30 million in 2011.

Photo: Jim Lynch (flickr)

Newborns who are exposed to addictive drugs while in the womb often must be treated for addiction after they are born.

Correction: The $30 million the Attorney General cited as the cost of NAS treatment referred to money spent in 2010, not 2011 as originally reported.

Indiana Attorney General Greg Zoeller is calling on the legislature to help reduce the number of babies being exposed to narcotics while still in the womb.

It is called Neonatal Abstinence Syndrome, or NAS, newborns exposed to addictive illegal or prescription drugs before they are born.

Attorney General Greg Zoeller says treating NAS at Indiana hospitals cost an estimated $30 million in 2010, the most recent year for which data is available, and he says that's with limited tracking because hospitals are not required to report the condition.

Zoeller says one solution is requiring pregnant women take drug tests to identify the problem and start treatment before birth.

"You can reduce the length of stay for the newly born baby from six weeks to two weeks, the better health of the baby as well as the costs," he says.

State Senator Pat Miller, R-Indianapolis, says the legislature is exploring different options because of concerns about mandatory drug tests.

"Verbal screening as opposed to the kind of blood or urine analysis that might drive women away from getting prenatal care," she says, adding that a definitive answer has not been reached and a legislative panel will continue to investigate the issue leading up to next session.

Brandon Smith, IPBS has previously worked as a reporter and anchor for KBIA Radio in Columbia, MO, and at WSPY Radio in Plano, IL as a show host, reporter, producer and anchor. Brandon graduated from the University of Missouri-

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Problem: Huge Medicaid Losses; States Cannot Afford to Stop

Today, a vast majority of states are faced with crippling deficits and are struggling to find ways to drastically cut spending and balance their budgets. Many have resorted to ineffective methods that cut essential services and short-term expenditures, while ultimately raising the long-term costs to their state. States must aggressively address these issues through the *investment* in strategies and systems that increase efficiency and reduce significant losses within their largest expenditure line items.

The largest spending category in all states is the Medicaid budget. It is estimated that as much as 30% of Medicaid appropriations are spent on fraud, abuse, and waste (2011 total state Medicaid spending is estimated at $2.7 trillion, growing at an annual rate of 3.9 %). Due to financial and other resource constraints, states are being "robbed blind" and have been unable to invest in endeavors which will bring about truly significant safeguards and savings through innovation and increased efficiency. Even as the Center for Medicaid Services offers incredible incentives, such as 90/10 matches for fraud prevention activities, states still cannot afford to invest in efforts to protect taxpayer funds. To assist states and prevent future losses, almost instantaneously, **interceptRx** has developed solutions to finance cost saving initiatives, beginning with a Prescription Pad Fraud Prevention Program that will enable states to attain substantial short and long-term cost saving efficiencies in their Medicaid programs. The establishment of this program in states will build the foundation to expand services to include e-prescribing and private insurance initiatives, which will multiply savings exponentially for states, taxpayers, insurance industry, and consumers.

interceptRx's mission is to Save Lives, Save Money, and Stop Prescription Fraud Crimes

Solution:

Prescription fraud is widespread and commonly perpetrated by petty thieves, organized crime, and terrorist groups. For example, an average Rx pad commands a street value of approximately $10,000. Criminals commit fraud through theft, forgery (creating their own Rx pads), alteration (changing existing information on a prescription), and false issuance (doctor shopping). In the end, states pay when the fraudulent scripts are filled at pharmacies, which are reimbursed through Medicaid or insurance claims. By utilizing a single source for prescription pads from a secure facility and 8-digit algorithm bar code technology, our approach stops the fraud at the pharmacy counter before any Medicaid or insurance money is disbursed. Many features within this system are the same safeguards employed by the U.S. Treasury. This technology eliminates the "pay and chase" method of fraud detection currently used by states and prevents the crime from occurring, PERIOD…a much more cost effective and efficient methodology.

> While the **interceptRx** solution tackles the prescription paper fraud problem, it also establishes a substantial framework to address future e-prescription crimes. We have an exclusive right to Standard Register's SecurePlus™ technology that enables total control and tracking ability.

The solution that **interceptRx** proposes is modeled after the State of New York Official Prescription Fraud Prevention Program which currently operates as the only successful working model in the country today. The State of New York's Medicaid Program has experienced the benefits of a secure prescription program since 2006.

New York invested approximately $14 million to create a single source (Standard Register's program), closed loop, secure prescription program with the hope of stopping an estimated $40 million annually in Medicaid prescription fraud.

The result was almost instantaneous. Within the first month of the program, the state earned back its investment in the program. By the end of the first year, New York's savings tallied over $140 million for the Medicaid prescription program.

"Official State Prescription Form Deters Medicaid Fraud"

"This program is a powerful tool in reducing prescription fraud, which drives up health-care costs and threatens public safety by diverting drugs from legitimate medical use," said State Health Commissioner Richard F. Daines, M.D.

"The medical community has embraced the notification program…"

"In addition to the Medicaid savings, the Bureau of Narcotic Enforcement estimates the program is also generating $75 million annually in private-sector savings through the reduction in fraudulent prescription claims to health-care plans…"
Source: North Country Gazette, August 1, 2007.

"New Pads are Prescription for Fighting Forgeries"

"[Dr. Glennell] Smith, an internist/endocrinologist for the last 28 years….said at least once a year over the last four years, he had been the victim of prescription forgeries for drugs on New York's list of controlled substances…ever since New York State rolled out its new Official Prescription Program…, forgeries from Smith's office are a thing of the past."
Source: Buffalo Business First, August 24, 2007

"New Prescription Program Saving Medicaid Millions of Dollars"

"…there's been a 7 percent reduction in the amount of Hydrocodone abuse, a painkiller also known as Lortab or Vicodin, from the first half of 2006 when compared to the first half of 2007." Said Jeffery Hammond New York state Department of Health
Source: The Business Review, August 30, 2007.

Standard Register currently has 47 different security features incorporated in its paper scripts and is constantly monitoring and testing new algorithms to stay one step ahead of criminals. Key components of our technology offer a digital validation process to detect fraudulent scripts, seamless integration into the pharmacy claim adjudication process, and data mining to continue development of future technological safeguards. **interceptRx** is the only company that offers an operational, time-tested solution for States and has both the technological and state government expertise to deliver a solution that can be duplicated nationwide.

Business Strategy: Creating a Risk-Reward Partnership with State Governments

interceptRx is a private entity with a public mission: to work as an "incubator" for cost saving programs and assist states in investing in efficient systems to protect and save taxpayer funds.
interceptRx will implement a prescription fraud prevention program across the U.S. to save lives and money while stopping crime losses to state and federal budgets. Ultimately, our system protects the investment made by the taxpayer citizens. **interceptRx** will jump-start proprietary technology in states through the participation of private investors, with the specific objective of creating a program that becomes self-funding through its own fraud prevention savings. **The States will receive a fraud prevention program at no upfront cost or risk to the state or its taxpayers. interceptRx** is dedicated to working with the states to provide the capital, expertise, and management skills needed to design, implement and manage a successful program.

Much of the interceptRx infrastructure, systems, and software are already developed through an exclusive agreement with Standard Register (SR), a Fortune 500 Company, that is an established world leader in document and electronic security. SR also utilizes the expertise of Frank Abagnale (who was the basis and subject for the movie, Catch Me If You Can) to constantly test systems and stays one step ahead of the criminals.

Prescription Drug Monitoring Programs:
An Assessment of the Evidence for Best Practices

September 20, 2012

Prepared by

Thomas Clark
John Eadie
Peter Kreiner, Ph.D.
Gail Strickler, Ph.D.

The Prescription Drug Monitoring Program Center of Excellence
Heller School for Social Policy and Management, Brandeis University

Prepared for The Pew Charitable Trusts

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* A list of the members of the PDMP COE Expert Panel and their affiliations can be found at www.pdmpexcellence.org.

Table of Contents

I. Introduction

The role of state prescription drug monitoring programs (PDMPs) in facilitating appropriate prescribing of controlled prescription drugs and helping to address the prescription drug abuse epidemic has been highlighted in recent studies and in the 2011 White House Office of National Drug Control Policy's Prescription Drug Abuse Prevention Plan (GAO, 2002; Pradel et al., 2009; Baehren et al., 2010; Katz et al., 2010; Johnson et al., 2011; Office of National Drug Control Policy, 2011). A special concern for PDMPs is the diversion of opioid pain relievers into nonmedical use and abuse.

A PDMP is a statewide electronic database that gathers information from pharmacies on dispensed prescriptions for controlled substances (most states that permit practitioners to dispense also require them to submit prescription information to the PDMP). Many PDMPs now provide secure online access to this information for authorized recipients. Prescription data (usually for the past year, and including information on date dispensed, patient, prescriber, pharmacy, medicine, and dose) are made available on request from end users, typically prescribers and pharmacists, and sometimes distributed via unsolicited reports. Recipients of PDMP data may also include practitioner licensure boards, law enforcement and drug control agencies, medical examiners, drug courts and criminal diversion programs, addiction treatment programs, public and private third-party payers, and other public health and safety agencies. States vary widely in which categories of users are permitted to request and receive prescription history reports and under what conditions.

PDMPs represent a substantially underutilized resource in efforts to improve public health outcomes and address prescription drug abuse (Katz et al., 2010). Key reasons for this underutilization include differences in the data PDMPs collect, whether and how they ensure data quality, the kinds of data analyses and reports they produce, to which users and under what conditions they make data available, and differences in an array of other procedures and practices. With respect to many of these practices, there is not widespread understanding of which constitute "best practices"; that is, which practices are associated with maximizing PDMP effectiveness. The purpose of this white paper is to describe what is known about PDMP best practices, describe and assess the evidence supporting their identification as best practices, and document the extent to which PDMPs have implemented these practices.

The paper is structured as follows:

- Section II provides background on the history of PDMPs and a conceptual framework for assessing their effectiveness. The contexts in which PDMPs developed have been an important influence on the range of PDMP practices and the extent of their current adoption. Practices can be organized in terms of PDMP workflow and functions (e.g., data collection, analysis, and reporting). Their effectiveness can be assessed by observing their differential impact in achieving intermediate objectives, such as increasing the utilization of PDMPs by all appropriate end users, and ultimate goals, such as improving patient health and reducing the diversion of prescription drugs into illegal use (drug diversion) and overdose.

- Section III provides an overview of the paper's methods and discusses types of evidence for effectiveness, the relative strength of the methods and evidence, and how the current evidence base for potential PDMP best practices was assessed.
- Section IV describes candidate PDMP best practices, the extent to which they are implemented by PDMPs, and the evidence base for each practice, and identifies barriers to their adoption.
- Section V discusses conclusions and recommendations regarding PDMP best practices. It includes a table summarizing the types of evidence that currently exist for each practice and the strength and consistency of evidence within those types. This section also outlines a research agenda, suggesting the kinds of studies needed to produce a stronger evidence base for practices we believe have the greatest potential to improve PDMP effectiveness.
- Section VI provides the references we have examined in developing this white paper. These references are summarized in two tables in an appendix: one providing an overview of the peer-reviewed, published literature on PDMP practices and effectiveness, and a second providing an overview of other literature of evaluation studies and reports, case studies, anecdotal information, and expert opinion.

II. Background

A brief history of PDMPs

Through 1989, nine PDMPs had been established. Two were located in state Attorneys General offices (California, 1939 and Pennsylvania, 1972); two in Departments of Public Safety (Hawaii, 1943 and Texas, 1981); two in Departments of Health, Bureau of Narcotics Enforcement (New York, 1970 and Rhode Island, 1978); one in a Department of Substance Abuse Services (Illinois, 1961); one in a Board of Pharmacy (Idaho, 1967); and one in a Department of Consumer Affairs, Bureau of Health Professions (Michigan, 1988). All of these programs collected information about Schedule II prescriptions[1] only, and all used state-issued serialized prescription forms. The use of these multiple-page forms allowed the original prescription records to be sent to the PDMP for key-punch data entry, while the pharmacy, and in most cases the prescriber, kept a copy.

Reflecting their locations primarily in state agencies concerned with public safety and drug enforcement, these early PDMPs all provided solicited reports, and most provided unsolicited reports to law enforcement personnel and regulatory agencies or professional licensing agencies. None provided reports to prescribers or pharmacists. The reports and, where relevant, PDMP investigations focused on prescribers selling prescriptions, pharmacies selling controlled substances illegally, and organized doctor shopping rings. For example, narcotics enforcement in New York, using PDMP data, focused on Quaalude and barbiturate prescription abuse associated with sleep clinics in the late 1970s and early 1980s, and subsequently on stimulant prescription abuse associated with weight clinics (Eadie, 2010).

With support from the U.S. Drug Enforcement Administration (DEA), the existing PDMP administrators created the Alliance of States with Prescription Monitoring Programs in November 1990. The Alliance was founded to provide a forum for support and information exchange among PDMPs, states where efforts were under way to establish a PDMP, and states where creation of a PDMP was being considered. At this time, PDMPs expanded data collection beyond Schedule II prescriptions. In the context of computer-based information technologies, a second generation of PDMPs came into existence that collected prescription information electronically, without the use of serialized prescription forms. Examples included the Oklahoma PDMP in 1990, located in the Department of Public Safety, and the Massachusetts PDMP in 1992, located in the Department of Public Health.

The Nevada PDMP, implemented in 1997 and located in the state Board of Pharmacy, ushered in a new era of PDMPs by providing data directly to prescribers and pharmacists. Initially, Nevada proactively sent unsolicited reports to the health care practitioners who had issued and dispensed prescriptions to

[1] The Controlled Substances Act, passed in 1970, established the five-tiered schedule of controlled substances that is now in effect. Drugs are assigned to one of these categories, or schedules, based on the substance's medicinal value, harmfulness, and potential for abuse and diversion. Schedule II is the most restrictive of the schedules of legally available controlled substances.

possible doctor shoppers—that is, individuals receiving multiple simultaneous prescriptions of commonly abused drugs. This resulted in a rapid demand for reports upon request (Prescription Drug Monitoring Program Center of Excellence [PDMP COE], Notes from the Field [NFF] 2.5). While the reports initially were sent by fax, Nevada developed in 2001 an online system that began issuing reports based upon users' direct inquiries. Kentucky soon followed Nevada's lead, implementing a program in 1999 and developing online capabilities within a few years. In 1994, the Alliance initiated a process to help standardize electronic formats for data collection. This resulted in the publication of the American Society for Automation in Pharmacy's (ASAP) first version of guidelines for pharmacies to submit controlled substances prescription data to PDMPs. The standards have been updated frequently to incorporate enhancements in electronic system capabilities, and all PDMPs are now using a version of an ASAP standard.

Early studies in New York indicated that the state's PDMP had greatly impacted stimulant, barbiturate, and later benzodiazepine prescribing and abuse (Fisher et al., 2011). Other studies suggested that serialized prescription forms required by PDMPs had a so-called "chilling effect" on legitimate prescribing (Joranson & Dahl, 1989; Pearson et al., 2006; Fornili & Simoni-Wastila, 2011). In 1996, OxyContin was introduced, and sales of prescription opioids began to increase markedly. After a slow rise in 1984, the numbers of first-time illicit users of pain relievers doubled between 1994 and 1998. Unintentional drug overdose death rates, while increasing through the 1990s, began to increase more steeply in the early 2000s, largely attributed to increased prescription opioid prescribing and abuse (Hall et al., 2008; Bohnert et al., 2011).

An element of the federal response to the increasing death rate was the creation of the Harold Rogers Prescription Drug Monitoring Program Grant Program in the Department of Justice, Bureau of Justice Assistance (BJA) in federal fiscal year 2002. BJA also designated the National Association for Model State Drug Laws (NAMSDL) to assist states in developing PDMP legislation. At about the same time, Purdue Pharma, manufacturer of OxyContin, began to support the creation of new PDMPs with technical as well as monetary assistance, specifying PDMP characteristics that it deemed desirable. In 2005, Congress passed the National All Schedules Prescription Electronic Reporting (NASPER) Act, authorizing additional federal funding for PDMPs; the Substance Abuse and Mental Health Services Administration (SAMHSA) was designated as the lead agency for NASPER.

In 2008, in collaboration with the Alliance of States with Prescription Monitoring Programs and the Heller School of Social Policy and Management at Brandeis University, BJA formed the PDMP Training and Technical Assistance Center, charged with assisting PDMPs in planning, implementing, and enhancing their programs. Two years later, BJA funded the PDMP COE at the Heller School in order to provide practice-relevant information, evaluation, and expertise to PDMPs and their stakeholders, including the development of best practices. As the founder of these efforts and as the nation's primary public funder of PDMPs via the Harold Rogers Grant Program, BJA has maintained a consistent focus on developing PDMP best practices and encouraging innovative applications of PDMP data. As will be noted in this paper, BJA gives priority funding consideration to states proposing to implement evidence-based practices that contribute to PDMP effectiveness.

As a result of increased public and private support and the growing recognition of PDMPs' potential to address the prescription drug abuse epidemic, PDMPs proliferated rapidly. In 2001, 16 states had passed legislation authorizing the creation of a PDMP; by June 2012, 49 states and one territory had passed such legislation, and 41 states had an operating PDMP.

The environment in which the newer PDMPs were implemented differs technologically and politically from that of PDMPs implemented through the early 2000s, generating an array of newer PDMP practices and a great diversity of practices across all PDMPs. For example, PDMPs implemented since 2001 have typically included a secure online portal for authorized providers to access PDMP data about their patients. All older PDMPs, except one, have evolved to permit provider access, often requiring new legislation authorizing such access, and then a costly retrofitting of PDMP operations to accommodate online and other new technology and new user demands. In contrast to the oldest PDMPs, newer PDMPs are often prohibited by law from providing unsolicited reports on patient or health care provider activity to law enforcement agencies or providers (PDMP COE survey of PDMPs, 2010). Although the wide range of practices carried out by different PDMPs suggests the possibility of evaluating the effectiveness of individual practices, the diversity of practices itself constrains the extent to which individual practices can be isolated and assessed across PDMPs, since other practices most often cannot be held constant.

Although PDMPs currently differ in their relative emphasis on improving medical care versus reducing drug diversion and abuse, they are well positioned to serve both objectives. Indeed, these objectives substantially overlap since the appropriate prescribing of controlled substances can reduce their diversion and abuse, while law enforcement efforts can protect public health by limiting diversion. This is analogous to the collaboration of public health and law enforcement agencies in reducing automobile accidents, injuries, and fatalities. For example, criminal investigations of doctor shoppers can bring people at risk of overdose and death into drug courts, where they can be placed into drug treatment and supervised, protecting health and saving lives. Likewise, law enforcement efforts to shut down pill mills and doctor shopping rings can have substantial public health benefits by reducing the supply of prescription drugs for street trafficking.

The opportunity therefore exists in establishing PDMP best practices to bring together advocates of effective medicine, drug abuse prevention, drug control, and substance abuse treatment to address common objectives using a common tool: improving the legitimate use of controlled substances and mitigating the prescription drug abuse epidemic by utilizing PDMP data in all their diverse applications. Despite differences in operations and objectives among PDMPs, the history outlined above depicts an environment in which program modification is the norm, with the identification and adoption of new concepts, technologies, and standards as constants. This suggests that development of evidence-based best practices will be welcomed by PDMPs, and their adoption can be expected.

PDMP effectiveness

The established value of PDMPs

Before embarking on a consideration of PDMP best practices, it should be noted that evidence suggests PDMPs are effective in improving the prescribing of controlled substances and addressing the prescription drug abuse epidemic (PDMP COE, Briefing on PDMP Effectiveness, 2012). PDMP data are unique and irreplaceable in identifying questionable activity with respect to prescription drugs, such as doctor and pharmacy shopping, prescription fraud, and problematic prescribing. No other system exists that can compile all controlled substances prescriptions, regardless of who issued the prescription, which pharmacy dispensed it, or the source of payment. According to surveys of PDMP users and a study of emergency department doctors, PDMPs are an important tool in making sound clinical decisions when prescribing or dispensing controlled substances (ASPMP, 2007; Kentucky Cabinet for Health and Family Services, 2010; Baehren, 2010). Evaluations of PDMPs generally report good user satisfaction with the utility of PDMP reports (Virginia Department of Health Professions and Virginia State Police, 2004; Lambert, 2006; Rosenblatt, 2007).

PDMP data can be used to track emerging trends in legitimate prescribing; to evaluate efforts to improve prescribing practices, such as provider education initiatives (Fisher et al., 2011a); and to reduce drug abuse and diversion, such as drug abuse prevention programs and drug control policies (Carnevale & Associates and PDMP COE, 2010; PDMP COE, NFF 3.2). PDMPs currently assist in investigations of diversion of prescription drugs into illegal use (drug diversion) (PDMP COE, NFF 2.3), medical examiner practice (PDMP COE, NFF 2.6), drug courts (PDMP COE, NFF 2.4), and direct intervention with and supervision of doctor shoppers as an alternative to criminal investigation (PDMP COE, NFF 2.1**)**, substance abuse treatment programs (PDMP COE, NFF 2.2), and epidemiological surveillance and early warning systems (Carnevale & Associates and PDMP COE, 2010). Although questions have been raised about the effectiveness of PDMPs (Fornili & Simoni-Wastila, 2011), several studies suggest a connection between PDMP utilization or particular PDMP practices and positive outcomes related to improving, prescribing, and reducing prescription drug abuse (Pearson et al., 2006; Pradel et al., 2009; Reisman et al., 2009; Wang & Christo, 2009; Paulozzi & Stier, 2010; Fisher et al. 2011b; LeMire et al., 2012; Reifler et al., 2012).

Given that PDMPs have already proven their worth in many applications, the question addressed in this white paper is what program characteristics and practices are likely to enable PDMPs to become more effective in collecting, analyzing, disseminating, and utilizing their data. See McDonald et al. (2004) for an earlier compilation of PDMP practices and recommendations for research on their effectiveness.

Conceptualizing effectiveness

The effectiveness of PDMPs can be conceptualized in terms of their impact in ensuring the appropriate use of prescription-controlled substances, reducing their diversion and abuse, and improving health outcomes, both at the patient and community levels. This impact is maximized when prescription history data are, to the extent technologically feasible, complete and accurate; analyzed appropriately and expeditiously; made available in a proactive and timely manner; disseminated in ways and formats that best serve the purposes of end users; and applied in all relevant domains by all appropriate users. This suggests that PDMPs can be thought of as information systems with inputs, internal operations, outputs, and customers who make use of their products. An effective PDMP will optimize all system phases, expand its customer base to include all appropriate users, and make sure these customers are well trained in using the PDMP. Best practices need to be identified for each phase.

Considerable preliminary work has already been done in this regard, including in formulating the Alliance of States with Prescription Monitoring Programs' Prescription Monitoring Program (PMP) Model Act (ASPMP, 2010), developing and continuously updating the standards for transmission of information from pharmacies to PDMPs (standards developed with ASAP), and identifying characteristics and practices of the "next generation" of PDMPs (Eadie, 2011, May and an "ideal" PDMP (Perrone & Nelson, 2012). Although the rationale for the practices mentioned in these documents in many cases seems both logical and plausible, the evidence base supporting them is often experiential and not well documented.

PDMP effectiveness can also be understood in the context of how PDMPs can best work together and in concert with other agencies, organizations, and health information technologies. Best practices will likely include data standardization and sharing among PDMPs and other agencies, as well as cooperative arrangements that maximize the value of PDMP data in their completeness, timeliness, analysis, and dissemination. To increase their effectiveness and impact, PDMPs must be integrated with other systems, including public health, health information exchanges, electronic health records, electronic prescribing, public safety, drug abuse prevention, and drug control. This will ensure that their data are made seamlessly available to all those engaged in improving controlled substances prescribing and addressing the prescription drug abuse epidemic. An important intermediate measure of PDMP effectiveness is therefore the number and type of interorganizational linkages and information-sharing agreements between PDMPs and other agencies. Section IV of this paper covers practices that may increase such linkages.

Toward a checklist of PDMP best practices

This paper can be considered a step toward developing an evidence-based checklist of PDMP best practices that could be used to evaluate a PDMP. Each practice would be defined operationally, and where possible and appropriate, quantitative metrics indicating success in carrying out the practice would be specified. Once parameters are established for each practice's definition and metrics, annual or semiannual surveys of PDMPs could track their adoption. Some candidate practices considered below are sufficiently well-defined and arguably have enough evidential support to already warrant their inclusion in a compendium of best practices, but many need more clarification, specificity, and evidence of effectiveness to support their inclusion. For example, practices in PDMP user recruitment, enrollment, and education need to be evaluated, such as the 2012 statutes in Kentucky, New York, Tennessee, and Massachusetts mandating PDMP enrollment and use. For demonstration purposes only, a checklist of the candidate practices considered below is presented in Appendix A.

III. Methods: Assessing the Evidence Base for Practice Effectiveness

Literature search

As the first step in assessing the evidence base for practice effectiveness, we conducted a systematic review of the medical (PubMed), psychological (PsycINFO), and economics (EconLit) literature through November 2011 for articles pertaining to the effectiveness of PDMPs and PDMP best practices, using a predetermined set of search terms. Search terms included prescription drug monitoring, prescription monitoring, doctor shopping, multiple prescribers, unsolicited reporting, and proactive reporting. All articles from peer-reviewed journals, published in English, were considered for inclusion. Abstracts identified through searches were reviewed to clarify the publication's relevance, and eligible articles were retrieved and read to further verify the study's applicability. These searches were expanded by reviewing the references cited in relevant articles. Articles were excluded if the data did not include outcome measures that would allow us to report on the effectiveness of PDMPs or of the best practice examined. In later drafts of this white paper, the literature search was extended to May 2012.

Other literature was identified from a review of documents listed on the PDMP COE website (www.pmpexcellence.org), on individual states' PDMP websites, and from discussion with PDMP COE staff. We identified written ("documented") evidence of expert opinion or consensus on best practices from review of the Alliance of States with Prescription Monitoring Programs and National Alliance for Model State Drug Laws websites (www.pmpalliance.org and www.namsdl.org), particularly practices specified in the 2010 Model Act. Other potential best practices were identified from discussions with experts in the field.

Data extraction and categorization of evidence

Researchers extracted data on study characteristics from the articles and other sources of evidence identified, and summarized the combined evidence for each potential best practice in descriptive and tabular formats. The tabular summary of evidence drew upon and was adapted from guidance provided by several sources on grading scientific strength of evidence (i.e., Lohr, 2004; Owens et al., 2010). The criteria outlined by these authors include a hierarchical evaluation of the study design, the risk of bias, the quantity of the evidence (such as the number of studies), the directness of the evidence, the consistency of the evidence, and the precision and magnitude of the estimates. Due to the paucity of studies found on PDMP best practices, we focused our analysis on summarizing the type and level of evidence available, the number of research studies, and where applicable, key findings and consistency of the research evidence. Type of evidence was categorized into two major classes: published or

formally documented studies or consensus statements, and informal, anecdotally reported experience from the field and stakeholder perceptions in support of particular practices. The first category includes randomized controlled trials (RCTs) or meta-analyses of RCTs; quasi-experimental designs (e.g., observational studies with comparison groups); other observational studies without comparison groups (e.g., interrupted time series) and case studies; and written guidelines describing a consensus of expert opinion, such as the Alliance of States with Prescription Monitoring Programs' PMP Model Act (ASPMP, 2010).

The grading system for this category ranks RCTs as the strongest evidence and expert opinion as the weakest. The consistency of the evidence for any given practice refers to the extent to which reported research findings from two or more studies show the same direction of effect. The second informal category of evidence consists of accumulated field experience with practices adopted by some states that suggests their efficacy, and the sometimes convergent perceptions among PDMP administrators and stakeholders (e.g., PDMP end users and advisory boards, legislative committees, and policy experts) concerning the value of a practice, whether proposed or in use. In some cases, these experiences and perceptions may be plausible indicators of possible best practices that will need formal research and evaluation to be adequately assessed.

We recognize that since the field is rapidly evolving, additional studies on PDMPs will likely have been published and new applications of PDMP data implemented between the time of our literature search and the publication of this white paper. This speaks to the need for continued monitoring of the "moving target" that is PDMP research and practice, to which this paper aims to contribute.

IV. PDMP Practices and Evidence for Best Practices

In this section, we survey candidate PDMP best practices, the evidence for their effectiveness, the extent to which they are currently adopted by states, and barriers to their adoption. It is organized by PDMP workflow, starting with data collection, followed by data linking and analysis, user access and reporting, recruitment, utilization, and user education. The last three headings in this section consider candidate best practices to facilitate collaboration among PDMPs and agencies concerned with prescription drug abuse; best practices with respect to PDMP evaluation; and options for the sustainable funding of PDMPs. After each practice is a thumbnail summary of its rationale, evidence base, current adoption status, and barriers to adoption.

In some cases, practices adopted by some states or thought potentially effective have no current evidence in the first category mentioned above (published studies, data analyses, or consensus statements). However, these practices are included for consideration since their possible effectiveness is suggested by evidence in the second category (accumulated experience in their application and/or perceptions of key stakeholders). Note that *all* the practices considered below have at least some support from the second category of evidence; this will be described in the text. However, the thumbnail summary of evidence for a practice will mention such support only when evidence from the first category is absent.

Data collection and data quality

Best practices in data collection, quality, and timeliness will permit more complete, accurate, and up-to-date data analyses and reports to end users. Candidate practices include actions to:

A. Standardize data fields and formats across PDMPs
    1. Collect data on all schedules of controlled substances
    2. Adopt uniform and latest ASAP reporting standard
    3. Collect data on nonscheduled drugs implicated in abuse
    4. Collect positive identification for the person picking up prescriptions
    5. Collect data on method of payment, including cash transactions

B. Reduce data collection interval; move toward real-time data collection

C. Institute serialized prescription forms

D. Integrate electronic prescribing with PDMP data collection

E. Improve data quality: pharmacy compliance, error, and missing data correction

A. Standardize data fields and formats across PDMPs

Currently, PDMPs vary in the data fields and formats collected from pharmacies, limiting the comprehensiveness of data, comparability of data across states, and ease of integration with prescription information collected by potential PDMP collaborators, such as Medicaid, the Indian Health Service (IHS), Department of Veterans Affairs (VA), and Department of Defense (DoD).

1. Collect data on all schedules of controlled substances

***Rationale*:** A possible best practice in data collection, widely adopted but not universal among PDMPs, is to collect prescription history information on all classes of controlled substances (Schedules II-V). This practice is included in the Alliance of States with Prescription Monitoring Programs' PMP Model Act (ASPMP, 2010) and will permit prescribers and pharmacists to examine the full spectrum of controlled substance prescriptions when making clinical decisions about patients. Although opioids are perhaps the most widely abused and diverted drugs, drugs in all schedules have abuse potential. For example, by 2009, there were almost as many emergency department visits associated with misuse or abuse of benzodiazepines (373,200) as for opioids (393,200) (SAMHSA, 2010), and persons who are seriously abusing drugs frequently abuse multiple controlled substances (SAMHSA, 2011). Moreover, suspected questionable activity (e.g., doctor shopping) is associated with being prescribed multiple classes of drugs. PDMPs not tracking all classes will likely underestimate the prevalence of doctor shopping (Wilsey et al., 2010) and thereby fail to inform all affected providers about problematic prescribing and dispensing. BJA has designated collecting data on all schedules a priority for PDMPs seeking funding under its Harold Rogers Grant Program.

***Evidence of effectiveness*:** A preliminary evaluation of Performance Measure Reports submitted by Harold Rogers grantee PDMPs to BJA suggests that states collecting Schedules II-V have lower rates of doctor shopping than states collecting fewer schedules (PDMP COE analysis of Performance Measure Data, 2011).

***Current adoption status*:** According to the Alliance of States with Prescription Monitoring Programs, of 46 states that have established reporting requirements, only 29 require reporting of Schedules II-V; see pmpalliance.org/content/state-profiles-reports.

***Barriers to adoption*:** Tracking all drug schedules involves updating data collection systems and the need for regulation and/or legislation changes.

Summary

***Rationale*:** Prescribers need to examine all scheduled drug classes to make proper prescribing decisions; all classes are subject to abuse; collecting all schedules permits improved detection of questionable activity.

***Evidence of effectiveness*:** Unpublished PDMP COE data analysis, expert opinion (ASPMP Model Act).

***Current adoption status*:** 46 states have established reporting requirements; 29 require reporting of Schedules II-V.

***Barriers to adoption*:** Costs of updating systems, requires legislative and/or regulatory change.

2. Adopt uniform and latest ASAP reporting standard

***Rationale and evidence of effectiveness*:** Having uniform and modernized data collection standards common to all PDMPs would have many advantages, including the facilitation of cross-state data sharing, multistate data analyses, public health analyses, and collaborations with other organizations collecting and making use of prescription history data, such as the Indian Health Service, Department of Defense, VA, Medicaid, and Medicare. The Alliance of States with Prescription Monitoring Programs PMP Model Act 2010 Revision recommends that all PDMPs collect a minimum common set of data fields (ASPMP, 2010). Continuously updated standards for pharmacy data fields and formats, including those reported to PDMPs, are set by the ASAP. The more recent standards make more data fields available, simplify data correction, and permit additional data reporting functionalities, such as tracking method of payment (see **5. Collect data on method of payment**, below) (PDMP COE, NFF 3.1). Updating to more recent ASAP standards may therefore improve the performance and effectiveness of individual PDMPs. A potential best practice is for all PDMPs to move to the latest standard, 4.2, released in 2011, and then move in concert to new versions as they are released. Under its Harold Rogers Grant Program, BJA gives priority consideration to PDMPs proposing to adopt the latest ASAP standard.

***Current adoption status*:** All PDMPs use ASAP standards, but adoption of the most current version by many PDMPs has usually taken years. For example, in February 2012, of 40 operational PDMPs, 5 were using the 2005 version 3.0, 5 were using the 2007 version 4.0, 13 were using the 2010 version 4.1 (data compiled by PDMP COE), and the 17 remaining PDMPs were using older versions.

***Barriers to adoption*:** Barriers to adoption include the need to change some states' laws and/or regulations that identify a specific ASAP version, and the costs and staff time necessary to implement ASAP upgrades for state PDMPs and for pharmacy software systems. Given their cumulative experience in making system improvements, many PDMPs and pharmacies are becoming increasingly efficient in adopting new standards, so the cost of future upgrades will likely decrease.

Summary

***Rationale*:** Uniform data standard may facilitate cross-state data sharing, analyses, and inter-organizational collaboration; more recent standards provide more complete data fields, improve error correction, and provide additional reporting functionalities.

***Evidence of effectiveness*:** Case study, expert opinion.

Current adoption status: Of 40 operational PDMPs (as of February 2012), 5 were using ASAP version 3.0, 5 were using version 4.0, 13 were using version 4.1, and the 17 remaining PDMPs were using older versions.

***Barriers to adoption*:** Upgrade costs, staff resources.

3. Collect data on nonscheduled drugs implicated in abuse

***Rationale and evidence of effectiveness*:** Certain drugs not federally scheduled or scheduled by most states, such as tramadol and certain formulations of butalbital, are sometimes abused, as when mixed in "drug cocktails" with opiates and benzodiazepines. The Alliance of States with Prescription Monitoring Programs' PMP Model Act 2010 Revision suggests that states may wish to track noncontrolled substances that are judged to demonstrate "a potential for abuse" (ASPMP 2010). Some drugs used to manufacture methamphetamine, such as ephedrine and pseudoephedrine, are also unscheduled in most states. PDMPs that track these drugs will likely be better positioned to detect pill mills that specialize in drug cocktail combinations and possible hot spots of methamphetamine production. A comprehensive list of unscheduled substances that merit tracking by PDMPs could be developed. Systematic investigation of the outcomes of such tracking is needed to evaluate it as a possible best practice. No formal studies have yet been conducted.

***Current adoption status*:** Nearly a third of states with active PDMPs are tracking some of these drugs (ASPMP state profiles).

***Barriers to adoption*:** The costs of adding these drugs to PDMP data collection would likely be minimal in most cases, but objections to adding them include concerns about compromising patient privacy, adding to regulatory burdens, and restricting access to substances that are not normally subject to scheduling controls or PDMP reporting. In many states, legislation and/or regulation changes would be required to give the PDMP authority to collect this information.

Summary

***Rationale*:** Some nonscheduled drugs are implicated in abuse and illicit drug manufacture.

***Evidence of effectiveness*:** Expert opinion.

***Current adoption status*:** Approximately one-third of PDMPs.

***Barriers to adoption*:** Concerns about patient privacy, regulatory burdens, unnecessary restriction of access to nonscheduled medications, opposition by pharmaceutical manufacturers.

4. Collect positive identification for the person picking up prescriptions

***Rationale and evidence of effectiveness*:** Prescriptions are often dispensed to (picked up by) persons other than the individual for whom they are prescribed, creating an opportunity for diversion. As noted by the Massachusetts PDMP, "…in 38 percent of cases, the person dropping off or picking up the prescription is not the patient and, therefore, without the customer ID, there would be no record of who dropped off the prescription or picked up the controlled substance" (Massachusetts Department of Public Health [MADPH], request to Public Health Council, 2010). If the identification of the person picking up the prescription is not collected, prescribers and pharmacists are less able to make appropriate clinical decisions because they do not know if patients listed on PDMP prescription history reports actually received the medications. Likewise, the PDMP and other data users are unable to determine whether the patient or someone else had possession of the controlled substances. Unless

identification is obtained by the pharmacy, the pharmacies and PDMPs are missing data that would help track possible diversion. These considerations suggest that collecting customer ID would help assure the proper use of controlled substances and deter prescription fraud, while simultaneously providing information that could be used to detect fraud, especially for cash transactions (see **5. Collect data on method of payment**, below). Research is needed to confirm these hypotheses. How states actually use customer identification information, and the benefits accruing from such use, needs to be studied in order to further understand the value of collecting customer ID.

***Current adoption status*:** Some states, including Connecticut, Delaware, Hawaii, Massachusetts, Michigan, Oklahoma, South Carolina, and Texas, require that the person picking up a prescription show positive identification and that the pharmacy record this information and report it to the PDMP (PDMP COE, Positive customer identification, 2010).

***Barriers to adoption*:** Barriers to adopting positive ID requirements include the need to amend state laws and/or regulations, pharmacy concerns about increasing workload and lengthening transaction times, and patient rights groups' worries that individuals lacking standard state IDs might be denied legitimate prescriptions. Nevertheless, experience in Massachusetts, which recently adopted a positive ID requirement, suggests that these barriers can be overcome by involving pharmacies and patient rights groups in drafting regulations. Examining other states' adoption processes could help to identify model practices in how to institute positive ID requirements.

Summary

***Rationale*:** Collecting positive ID may permit better tracking of controlled substances upon dispensing.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** A few states collect positive customer ID.

***Barriers to adoption*:** Legislation and regulation changes, increases in pharmacy workload, concerns regarding potential denial of legitimate prescriptions to those without identification.

5. Collect data on method of payment, including cash transactions

Rationale and evidence of effectiveness: Collecting data on method of payment would add value to PDMP reports to end users. Method of payment, in particular cash transactions, can be an indicator of questionable activity such as doctor shopping. PDMP administrators and law enforcement investigators often cite cash payments as suggestive of doctor shopping, especially when the individual has health insurance. Pill mills usually accept only cash payments (Rigg et al., 2010). Paying with cash instead of by credit, health plan, or Medicaid/Medicare reduces the information available to identify the individual and helps to evade monitoring of prescription purchases by third-party payers. For example, cash payments enable Medicaid enrollees to avoid detection by Medicaid Drug Utilization Review systems and to avoid Medicaid patient "lock-in" programs in which patients are limited to a single prescriber and pharmacy. Provided with PDMP sources of payment information, state Medicaid programs could better detect doctor shoppers, place them in lock-in programs and monitor their compliance. According to the Coalition Against Insurance Fraud report *Prescription for Peril* (Coalition Against Insurance Fraud, 2007), persons who abuse prescription opioids incur excess health care costs totaling more than $72 billion

annually to all public and private health insurers, including Medicaid. Recording the method of payment by all PDMPs and transmitting this information to Medicaid and third-party payers would help reduce these costs. Examining the experience of PDMPs that require the reporting of method of payment, including how they use this information in analyses and reports and how they address privacy concerns, would help support such reporting as a best practice.

***Current adoption status*:** States that require reporting method of payment include Alaska, Arizona, Florida, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Michigan, Nevada, New York, North Dakota, and Oklahoma. Increasingly, states are providing data to Medicaid agencies. Six PDMPs were permitted to provide data to state Medicaid agencies in 2006; by 2010, the number had increased to 15 PDMPs (PDMP COE survey of PDMPs, 2010). In 2012, the State of Washington allowed the state workers' compensation program to examine PDMP data.

***Barriers to adoption*:** Barriers to this practice include the fact that some PDMPs do not record method of payment due to use of an older ASAP standard that does not permit transmission of this data element. Concerns also exist about compromising patient privacy.

Summary

***Rationale*:** Information on method of payment may help detect doctor shopping and pill mills, may contribute to safe and effective prescribing by identifying patients at high risk.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** Several states collect method of payment.

***Barriers to adoption*:** Using older ASAP data collection standards, concerns about patient privacy.

B. Reduce data collection interval; move toward real-time data collection

***Rationale and evidence of effectiveness*:** State PDMPs receive updated prescription dispensing data from pharmacies at varying intervals, ranging from monthly to daily, with most pharmacies reporting every one or two weeks (ASPMP state profiles, 2011). This means that even PDMPs that supply end users with immediately available online reports are delivering data that often do not include patients' most recent prescription purchases. These omissions compromise the utility of prescription history data for clinical practice and drug diversion investigations (PDMP COE, NFF 2.3).

The Alliance of States with Prescription Monitoring Programs' PMP Model Act 2010 Revision recommends that pharmacies submit prescription data "no more than seven days from the date each prescription was dispensed" (ASPMP, 2010). Ideally, PDMP data would be collected in real time, within a few minutes of a drug being dispensed. PDMPs across the country report increased demands from prescribers, particularly emergency department physicians, for prescription histories of their patients that are complete at the time of seeing a patient. The Oklahoma PDMP has implemented real-time data collection, slated to be fully functional by the end of 2012; this will serve as a pilot test of the feasibility and benefits of such a system (PDMP COE, NFF 3.1). Data will be collected on the impact of the Oklahoma initiative on PDMP data quality, utilization by providers, and other outcomes, including overdoses from prescription drugs. Meanwhile, states can take incremental steps to reduce their data

collection intervals from monthly to biweekly, weekly, or daily. States might also look to the Oklahoma experience as a guide to best practices in moving to real-time data collection.

***Current adoption status*:** States vary in their data collection interval, with most collecting every one or two weeks. While only the Oklahoma PDMP has implemented real-time data collection and reporting, 2012 legislation enacted in New York State mandates pharmacies to submit data in real time to its PDMP; this provision goes into effect in 2013.

***Barriers to adoption*:** The technical and logistical obstacles to real-time data collection and reporting are significant but can be overcome, as demonstrated recently by the Oklahoma PDMP (see **PDMP COE, NFF 3.1**). Real-time reporting will be difficult for many states to adopt soon given their limited resources.

Summary

***Rationale*:** More timely data are expected to enable more informed prescribing and improved detection of questionable activity.

***Evidence of effectiveness*:** Expert opinion.

***Current adoption status*:** States vary in data collection interval, most at one or two weeks; one state has implemented real-time data collection.

***Barriers to adoption*:** Cost, staff time, information technology hurdles.

C. Institute serialized prescription forms

***Rationale and evidence of effectiveness*:** Prescription fraud and doctor shopping using counterfeit, copied, or stolen prescription forms is a common source of diverted and abused controlled substances. New York and Texas mandate the use of state-printed serialized prescription forms (in Texas for Schedule II drugs only), each of which has a unique consecutive number; batches of forms are issued to each prescriber. The serial numbers of any stolen forms showing up in the PDMP database are flagged for investigation, as are any duplicated numbers. Experience in Texas (communication from former PDMP administrator) and New York (Eadie, 1990; Eadie, 1993) suggests that serialized forms help to reduce prescription fraud. Research indicates that three PDMP states using serialized forms (California, New York, and Texas) had lower increases in death rates from opioid overdose from 1999-2005 (Paulozzi et al., 2011). Some states require use of so-called tamperproof, but unserialized, prescription forms, but analysis of PDMP data from California suggests that these are not as effective in countering diversion as serialized forms (Gilson, 2011).

***Current adoption status*:** Only New York and Texas use state-printed serialized prescription forms (in Texas for Schedule II drugs only).

***Barriers to adoption*:** Barriers to the adoption of serialized prescription forms include concerns that they might reduce access to legitimate prescriptions (the so-called “chilling effect”), incur printing and distribution costs, and require record-checking capabilities into the PDMP and pharmacy workflow. However, prescription data from Texas indicate that the forms have had no chilling effect (the number of Schedule II prescriptions issued has increased every year since the mid-1980s); serialized forms in Texas are sold at cost to doctors and made readily available; and the forms’ serial numbers are easily

scanned into pharmacy databases, along with the prescriber's registration number, minimizing the workflow burden.

Summary

***Rationale*:** Serialized prescription forms appear to reduce prescription fraud and may be superior to unserialized tamperproof forms.

***Evidence of effectiveness*:** Published studies.

***Current adoption status*:** Texas and New York State; formerly California.

***Barriers to adoption*:** Concerns about jeopardizing legitimate prescribing (the chilling effect), incurring printing and distribution costs, implementing record-checking systems.

D. Integrate electronic prescribing with PDMP data collection

***Rationale and evidence of effectiveness*:** As states implement systems of electronic prescribing of controlled substances (EPCS), the opportunity exists to integrate electronic medical records and EPCS systems with PDMP data. PDMPs could expand their data collection fields to include data specific to EPCS issued by prescribers and thereby facilitate communication with providers using an electronic prescribing (e-prescribing) system. This would permit monitoring of prescriptions as they are being issued, prior to dispensing, and after dispensing. Matching the electronic prescription to the dispensing record would assure that the drug and dose dispensed were what was prescribed, enabling prescribers to better monitor patients' compliance with their prescription drug treatment. This issue is timely as electronic prescribing of controlled substances is now expanding. For example, in 2012 legislation, New York State mandated that by the end of 2014 all prescriptions, including controlled substances, must be prescribed electronically with but with few exceptions (the "I-Stop" Program Bill #39, introduced in June 2012).

PDMPs could be made interoperable with e-prescribing systems so that: 1) obtaining an e-prescribing certification for controlled substances would be accepted by PDMPs as authentication for access to PDMP data; 2) as prescribers enter the name of a controlled substance drug for e-prescription, the patient's controlled substances history from the PDMP would appear on their electronic device; 3) as each e-prescription is sent to a pharmacy, a copy would be routed to the PDMP database; and 4) as each e-prescription is dispensed, the PDMP would match the pharmacy's dispensing record to the corresponding e-prescription from the prescriber to identify any alterations and, if any, report them to the appropriate agency.

***Current adoption status*:** In 2012 legislation enacted in New York State, electronic prescribing of all controlled substances is mandated to begin in approximately three years, with limited exceptions. The method for integration with the state's PDMP is expected to be described in implementing regulations.

***Barriers*:** Barriers to PDMP interoperability with e-prescribing include lack of existing information technology protocols, policies, and standards to enable data exchange between systems.

Summary

***Rationale*:** Integrating PDMPs with electronic prescribing may enable more reliable, complete, and timely prescription monitoring.

***Evidence of effectiveness*:** Key stakeholder perceptions.

***Current adoption status*:** None.
***Barriers to adoption*:** Technological and regulatory hurdles.

E. Improve data quality: pharmacy compliance, error, and missing data correction

***Rationale*:** The quality of a PDMP's output—analyses and reports, whether solicited or unsolicited—depends on the timeliness, completeness, accuracy, and consistency of collected data, or inputs. Best practices need to be identified for all stages of data collection and management, but little study of PDMP data quality processes has been conducted. Goals of good data management include:

- attaining a high rate of reporting from all eligible pharmacies (high compliance rate);
- accurate data entry by pharmacy personnel (low initial error rate);
- correction of data when errors are identified (low final error rate after correction); and
- identification and completion of missing data where possible (low missing data rate).

Since no agreed-upon standards for PDMP data quality exist, quantitative benchmarks indicative of success for each of these goals need to be established. Policies and procedures that enable achieving the benchmarks need research and development.

***Evidence of effectiveness*:** Recent experience with real-time reporting of prescription information in Oklahoma (see **B. Reduce data collection interval; move toward real-time data collection**, above) suggests that the advanced information systems required for real-time reporting can play a significant role in improving error correction and detecting and completing missing data, as can moving to version 4.0 or more recent versions of the ASAP reporting standard (PDMP COE, NFF 3.1). For example, ASAP versions 4.1 and later enable pharmacy correction of data errors on a case-by-case basis. Prior versions require the PDMP to return a submitted batch of data found to have unacceptable errors to the pharmacy for correction and return of the whole batch, rendering that batch of data unavailable for provider inquiry until the errors are corrected. It is also possible that other, less technically demanding updates in PDMP data management procedures and policies could produce improvements in data quality.

A survey of a sample of PDMPs comparing approaches to improving reporting compliance and data quality, and linking these to PDMP-quantified performance measures such as data completeness and error rates, would help to identify promising practices. In evaluating a practice, the financial and practical feasibility of instituting the practice would be weighed against the data quality improvement it produced. For more on researching best practices in PDMP data quality, see **Section V. Summary and Recommendations**, below.

***Current adoption status*:** Data quality standards and policies, and procedures in support of achieving acceptable data quality, differ among PDMPs and likely produce varying degrees of success in their attainment.

***Barriers to adoption*:** Barriers to data quality improvement include the cost in staff time of surveying current practices, lack of data quality standards, and lack of resources needed to update data quality systems.

Summary

***Rationale*:** Complete and accurate data can improve reporting, are important for prescribers and pharmacists making patient care decisions, and can help in detecting questionable activity.

***Evidence of effectiveness*:** Accumulated field experience, key stakeholder perceptions.

***Current adoption status*:** States vary in data quality practices.

***Barriers to adoption*:** Cost of surveying current practices, lack of standards, resources needed to update data quality systems.

Data linking and analysis

Best practices in PDMP data linking and analysis will permit better identification of unique individuals in PDMP data, development of standard analyses comparable across states, more reliable estimates of questionable activity, more appropriate and applicable epidemiological investigations, expedited and more reliable analyses, and reports incorporating experienced user knowledge. Candidate practices include actions to:

A. Link records to permit reliable identification of individuals
B. Determine valid criteria for possible questionable activity
C. Conduct periodic analyses of possible questionable activity
D. Conduct epidemiological analyses for use in surveillance, early warning, evaluation, and prevention
E. Develop automated expert systems to expedite analyses and reports
F. Record data on prescriber disciplinary status and patient lock-ins

A. Link records to permit reliable identification of individuals

***Rationale and evidence of effectiveness*:** Reliable identification of unique individuals in PDMP databases, whether patients or prescribers, is vital for accurate analyses and reporting of questionable activity and prescribing trends. Although states have implemented a number of approaches to link patient records, to date, there has been neither a census taken of such approaches, nor an evaluation of their effectiveness.

Standard benchmarks for reliable record linking need to be identified against which different linking algorithms can be tested. Since the capability to link records belonging to an individual is critical to providing accurate prescription information to all users and is essential for analyzing the impact of PDMPs, e.g., measuring the level of questionable activity, this is an area deserving of close examination for developing evidence-based best practices. See **Section V. Summary and Recommendations**, below, for further discussion and recommendations.

***Current adoption status*:** Many states have developed electronic capabilities to link prescriptions dispensed to what is likely to be a single individual in cases where the personal identifying information varies between records, e.g., the same address and prescriber but a differently spelled first name. Such linking is accomplished through vendor proprietary software, off-the-shelf software, or in-house developed or modified software.

***Barriers to adoption*:** Barriers to adopting reliable record linking systems include lack of standard benchmarks to assess linking algorithms and lack of resources to conduct research to develop standards.

Summary
***Rationale*:** Reliable linking of records maximizes identification of unique individuals in PDMP data.

***Evidence of effectiveness*:** Key stakeholder perceptions.

***Current adoption status*:** States vary in whether and how records are linked.

***Barriers to adoption*:** Lack of resources to conduct needed research, no standard benchmarks to assess linking algorithms.

B. Determine valid criteria for possible questionable activity

***Rationale and evidence for effectiveness*:** Despite the relatively widespread use of unsolicited reporting (see **User access and report dissemination, E. Send unsolicited reports and alerts to appropriate users**, below) on individuals exhibiting possible questionable activity (e.g., doctor shopping), there is little commonality in the criteria used by PDMPs to identify them. Validated and standardized criteria are therefore needed to permit reliable identification of questionable activity within and across jurisdictions. Proactive reporting is also applicable to medical providers who, whether intentionally or not, may be engaging in risky or illegal prescribing or dispensing behavior. Alerts concerning questionable activity on the part of providers may be appropriately addressed to licensure boards, peer review committees, third-party payers, Centers for Medicare and Medicaid Services (CMS), and other bodies or agencies concerned or charged with monitoring medical practitioners. When analysis of PDMP data identifies probable criminal activity, such as prescribing by pill mills, referral to law enforcement agencies would be appropriate. To guide such alerts, reliable criteria of questionable activity by providers using PDMP and other data need research and development; see, for instance, DuBose et al. (2011).

Several studies have attempted to shed light on criteria for identifying conditions and behaviors that put patients at risk for prescription drug abuse. Patients who visit a few prescribers (two to five) in a year seem not to be more at risk for opioid abuse than those using only one (Wilsey et al., 2011). Studying a sample of insurance patients on whom they were able to obtain medical records, White et al. (2009)

found that the risk for prescription opioid abuse (over a three-month period) was associated with being age 18 to 34, being male, filling four or more opioid prescriptions, having opioid prescriptions from two or more prescribers and from two or more pharmacies, using early prescription opioid refills, and obtaining escalating dosages. When medical data were allowed to be predictors in the model of risk for prescription opioid abuse, such risk (over a 12-month period) was found to be associated with being age 18 to 34, being male, filling 12 or more opioid prescriptions, having opioid prescriptions from three or more pharmacies, using early prescription opioid refills, and obtaining escalating dosages, in addition to having hospital and outpatient visits and several diagnoses.

In a sample of users of high-dosage buprenorphine, Pauly et al. (2011) compared the patient groups identified by (1) overlapping prescriptions (early refills) and (2) outliers in a distribution of patients based on number of prescriptions, number of prescribers, and number of pharmacies. These researchers found that the two groups had an 85 percent overlap. Other studies have implicated simultaneous, or overlapping, prescriptions for different controlled substances (e.g., opioids and benzodiazepines) as being associated with multiple prescriber episodes (Wilsey et al., 2010) or opioid-related deaths (Webster et al., 2011; Rich & Webster, 2011).

Paulozzi et al. (2012) were able to link a sample of patients in New Mexico who died of an unintentional drug overdose with PDMP data to obtain their prescription histories. Comparing these histories to prescription histories of a control sample with matching exposure periods in the PDMP database, these researchers found that increased risk for overdose death was associated with being male; being older; filling a certain number of prescriptions; filling prescriptions for a sedative/hypnotic, buprenorphine, and specific opioids; and receiving a daily average of 40 or more morphine milligram equivalents. A parallel study in Washington State found that patients receiving opioid prescriptions with an average daily dosage of 100 or more morphine milligram equivalents were 8.9 times as likely to die of overdose as patients receiving an average daily dosage of 1 to 20 morphine milligram equivalents (Dunn et al., 2010). An association between doctor shopping, receiving a high daily dose, and risk of overdose death is also suggested by research conducted by Hall et al. (2008), Gomes et al. (2011) and Peirce et al. (2012).

These studies suggest the utility of including factors other than number of prescribers and number of pharmacies in a specified period of time as criteria for identifying questionable activity or likely doctor shopping behavior. Moreover, indicators of doctor shopping behavior may well vary across states and over time,[2] and it is important to distinguish between (1) criteria that most accurately identify individuals engaged in questionable activity, and (2) criteria that, if used as the basis for sending unsolicited reports, would generate the most benefit in terms of facilitating appropriate prescribing and reducing abuse and diversion.

To date, no studies have compared the effects of unsolicited reporting using different criteria within the same PDMP. Studies to refine the criteria for sending unsolicited reports would appear useful to the extent they can reduce the number of false positives (possibly creating unnecessary patient discomfort) and false negatives, thereby increasing the efficiency of PDMP resources used to generate the reports.

[2] For example, as shown in PDMP COE, Notes from the Field 1.1 and 2.5, as states issue unsolicited reports, the numbers of persons exceeding the thresholds can be expected to decline. Thus a state could lower its thresholds to identify possible doctor shoppers who are obtaining fewer prescriptions.

The purpose of an unsolicited report, however, is to provide prescribers and pharmacists with additional information that they may choose to use (or not) in their clinical decision-making. This line of reasoning suggests that, for maximum effect, unsolicited reporting ought to be coupled with efforts to educate prescribers and pharmacists about how to access and use PDMP data.

Exploratory work being done by the Massachusetts and Nevada PDMPs to automate their reporting to health providers of persons who exceed thresholds should be followed closely, as automation may provide a means by which to increase reporting capabilities while decreasing costs. To avoid bottlenecks in proactive reporting, data quality and criteria for questionable activity need development to the point where unsolicited reports and alerts do not have to be reviewed by hand before they are sent (see **Develop automated expert systems**, below).

***Current adoption status*:** To identify possible doctor shoppers, PDMPs typically use a threshold of a number of prescribers from whom a patient has obtained a controlled substance prescription, and a number of pharmacies that have dispensed the prescriptions, in a specified period of time—often six months but sometimes one month. For example, BJA's required performance measures for PDMP Harold Rogers grantees asks for the number of patients who have obtained, respectively, Schedule II, Schedule II and III, and Schedule II–IV prescriptions from five or more prescribers and had them filled at five or more pharmacies in a three-month period (a 5x5x3 threshold).[3] Some PDMPs use thresholds as high as 10 prescribers and 10 pharmacies in a one-month period (10x10x1).

Several factors appear to account for the different thresholds used across PDMPs. The earliest thresholds (e.g., Nevada's) appear to reflect the judgment of the state's Prescription Controlled Substances Abuse Prevention Task Force that patients engaged in this level of activity are very likely doctor shopping. In other cases, the thresholds used reflect the PDMP's limited resources to generate such reports: Thresholds are set high to identify the persons most significantly involved in doctor shopping and to minimize the number of unsolicited reports that would be called for.

In some cases, thresholds are augmented by the review of a PDMP administrator experienced in identifying likely cases of fraud, abuse, or diversion. Katz et al. (2010) point out that varying the threshold numbers of prescribers and pharmacies from whom a patient has obtained prescriptions enables a PDMP to trade off false positives (flagging via an unsolicited report of patients not engaged in questionable activities or doctor shopping) and false negatives (failing to flag patients actually engaged in questionable activities or doctor shopping). However, as noted above, there are currently no recommended best-practice criteria for identifying patients on whom unsolicited reports should be sent.

***Barriers to adoption*:** Barriers to determining valid criteria for possible questionable activity include lack of a coordinated research program to develop such criteria, the need for a systematic review of existing criteria and their effectiveness, and lack of agreed upon standards by which such effectiveness would be measured, for instance what constitutes an acceptable balance between false positives on the one hand and capturing the full spectrum of questionable activity on the other.

[3] Through June of 2010, these thresholds applied over a six-month period. In July 2010, the period was changed to three months.

For further discussion and recommendations for research on establishing valid criteria for questionable activity, see **Section V. Summary and Recommendations**, below.

Summary

***Rationale*:** Validated criteria for questionable activity are needed to target unsolicited reports and improve measures of doctor shopping and other questionable activity.

***Evidence of effectiveness*:** Key stakeholder perceptions.

***Current adoption status*:** Variation in thresholds and other criteria used by states.
***Barriers to adoption*:** Lack of sufficient research to validate criteria.

C. Conduct periodic analyses of possible questionable activity

***Rationale*:** PDMP data are unique in providing estimates of possible doctor shopping and other questionable activity, either on the part of patients or prescribers. Such activity is a precursor to controlled substance diversion and abuse, and so is an indicator of a contributing cause of the prescription drug abuse epidemic. Since levels of questionable activity, such as the number of individuals meeting criteria for doctor shopping (see **B. Determine valid criteria for possible questionable activity**, above), are affected by the use of PDMPs, they can also serve as indicators of the impact of the PDMP and of program improvements, possibly providing evidence for PDMP effectiveness.

***Current adoption status and evidence of effectiveness*:** The Virginia PDMP found that the number of individuals meeting thresholds for possible doctor shopping (10x10 and 15x15 in a six-month period) declined following a large increase in data queries to the PDMP, in turn likely the result of improved access to PDMP data (Virginia Prescription Monitoring Program, 2010). Declines in numbers of individuals meeting doctor shopping thresholds subsequent to issuing unsolicited reports, as well as declines in prescribers, pharmacies, and dosage units for individuals reported on, have been observed in Wyoming and Nevada (PDMP COE, NFF 1.1, 2.5). This suggests that states, if they are not already doing so, should be encouraged to conduct periodic threshold and other analyses to track trends in possible questionable activity on the part of patients and prescribers that can then be correlated with PDMP utilization and reporting. PDMPs that are Harold Rogers grantees report such analyses every three months. Such analyses may provide evidence suggesting PDMP effectiveness that could be communicated to stakeholders and funders to build support for PDMPs. Developing standard analyses common to all PDMPs, e.g., using validated thresholds and/or criteria for questionable activity (see **B. Determine valid criteria for possible questionable activity**, above), would permit cross-state comparisons to help evaluate program innovations and provide standard measures by which to gauge the impact of PDMPs over time.

***Barriers to adoption*:** Barriers to conducting periodic analyses of questionable activity include lack of program resources to carry out analyses and the need for standard criteria to permit cross-state comparisons.

Summary

***Rationale*:** Periodic analyses of rates of questionable activity track an indicator of possible substance abuse and diversion, and can help assess the impact of the PDMP and program improvements.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** Harold Rogers grantees and some other states conduct regular analyses.

***Barriers to adoption*:** Lack of program resources to conduct analyses, no standard criteria for questionable activity.

D. Conduct epidemiological analyses for use in surveillance, early warning, evaluation, and prevention

***Rationale*:** As part of their standard practice, PDMPs make reports on individual prescription histories available to end users, but some also produce and disseminate other types of data analyses relevant to public health objectives involving prescription drugs. Distributing such analyses, which ordinarily de-identify or encrypt patient and prescriber-specific information, may increase the impact of PDMPs. PDMP data can be analyzed by geographic area (county, zip code, pharmacy, town, etc.) and time period to illuminate trends in both prescribing and questionable activity relevant to drug abuse surveillance and prevention efforts. Under its Harold Rogers Grant Program, BJA gives priority consideration to PDMPs proposing to share data and partner with researchers conducting epidemiological analyses concerned with the prescription drug abuse epidemic.

***Evidence of effectiveness and current adoption status*:** Some states have conducted epidemiological analyses of PDMP data for a variety of purposes. Maine's PDMP provided data on controlled substance prescribing patterns to the National Institute on Drug Abuse's Community Epidemiological Work Group, which reports on emerging drug abuse trends at the state and city levels (personal communication), and researchers have analyzed Maine PDMP data to describe trends in prescribing and questionable activity (Payne & Thayer, 2009). The South Carolina PDMP provided data to the PDMP COE by county and by age group on the prescribing of opioids; analyses identified an unexpected level of young opioid users in two major counties. This information, along with Wyoming PDMP data on the prevalence of doctor shopping by age group, was provided to the U.S. Surgeon General's 2011 Expert Panel on Prescription Drug Abuse in Youth (Eadie, 2011, March). Similarly, the Massachusetts PDMP and Brandeis University researchers have produced geo-spatial analyses of rates of possible doctor shoppers. These analyses indicate that communities with the highest rates also tend to have the highest concentrations of opioid overdoses and deaths (Carnevale & Associates and PDMP COE, 2010; Kreiner, 2011). More recent analyses indicate that communities with high rates of questionable activity are at risk for subsequent increases in rates of fatal and non-fatal opioid overdoses (Kreiner, 2012). Had these analyses been possible in prior years, the Massachusetts PDMP could have issued warnings before the overdoses and deaths became epidemic. Warnings could be sent to all community, state, and national stakeholders, including health care practitioners, law enforcement agencies, educators, substance abuse prevention and treatment organizations, schools, parent-teacher organizations, religious organizations, and other groups.

PDMP COE analyses of de-identified data from states neighboring Georgia identified zip codes within Georgia where Georgia prescribers were issuing unusually large numbers of prescriptions for controlled substances (Carnevale & Associates and PDMP COE, 2010). This information enabled Georgia officials to identify possible pill mills within their state borders, even before their PDMP was enacted into state law. These examples suggest that PDMPs are a rich but underutilized resource for surveillance and evaluation efforts aimed at preventing prescription drug abuse and overdose. To assess the range of application of PDMP data beyond providing prescription history reports, states could be surveyed on the types of further analyses they produce and the end users receiving the prescriptions.

***Barriers to adoption*:** Barriers to further analysis and dissemination include lack of PDMP resources; PDMPs' lack of familiarity with such analytical methodologies; the absence of working relationships between PDMPs and state and community organizations that could benefit from access to the analyzed data, e.g., substance abuse prevention groups; and state restrictions on reporting to or collaborating with outside research organizations.

Summary

***Rationale*:** Epidemiological analyses can assist in drug abuse surveillance, evaluation, and prevention efforts.

***Evidence of effectiveness*:** Unpublished data analyses.

***Current adoption status*:** Several PDMPs have provided analyses for communities and state agencies.

***Barriers to adoption*:** Insufficient program resources or expertise to carry out analyses, absence of cooperative working relationships between PDMPs and other groups, and restrictions on providing data to researchers.

E. Develop automated expert systems to expedite analyses and reports

***Rationale and evidence of effectiveness*:** Reliable and valid analysis of PDMP data to identify questionable activity, track prescribing trends, and conduct other research often involves multiple steps and requires familiarity with prescription information (e.g., drug classifications, standard doses, data ambiguities) gained over years of personal hands-on experience. Automated expert systems that capture at least some of this expertise may increase the speed and accuracy of such analyses and their reporting, freeing up staff time and program resources for other initiatives. Automated systems can also generate unsolicited reports and alerts based on criteria of questionable activity (see **B. Determine valid criteria for possible questionable activity**, above). Given that those meeting such criteria sometimes number in the thousands, automated algorithms to reliably identify such individuals and generate alerts to their prescribers and pharmacists may be the only feasible means to conduct proactive reporting on the necessary scale. Research is needed to document existing PDMP expert systems, evaluate their efficiencies, and help develop software programs and standard algorithms that reliably identify probable questionable activity and accelerate other analyses. Given the wide application of expert systems in other public health and safety contexts, it seems likely that PDMPs would gain in effectiveness by adopting automated procedures in analyzing and reporting their data.

***Current adoption status*:** Some states have explored the design of automated expert systems that can expedite analyses. Massachusetts and Oklahoma are using off-the-shelf business intelligence software to track prescribing patterns and PDMP utilization. States could be surveyed on what, if any, expert systems and software are being used and their impact on improving PDMP productivity.

Barriers to adoption: These include the limited resources of PDMPs, leaving them without staff, time, or funds to explore such issues; the absence of guidance material or information that PDMP administrators could utilize; design and implementation costs for customized systems; and whether a state's software vendor (if it has one) has the capacity and flexibility to implement such a system.

Summary

***Rationale*:** Expert systems and automated analyses and reports may increase the productivity of PDMPs.

***Evidence of effectiveness*:** Accumulated field experience, key stakeholder perceptions.

***Current adoption status*:** At least a few states have explored expert systems.

***Barriers to adoption*:** Limitations of PDMP resources, absence of information or guidance documents, design and implementation costs, software vendor capacity.

F. Record data on prescriber disciplinary status and patient lock-ins

***Rationale*:** PDMPs could enhance their effectiveness if they could obtain and match to prescription records data on prescribers' deaths or disciplinary status, such as a DEA registration suspension. Upon receipt of prescription information from pharmacies, the PDMP could flag any such prescribers, prompting referral to appropriate agencies. The Government Accountability Office (GAO) found in its 2009 examination of Medicaid programs that state Medicaid agencies paid for prescriptions of controlled substances that were issued by deceased prescribers or those barred from such prescribing, or that were dispensed by pharmacies not legally authorized to do so (GAO, 2009). These forms of diversion could be effectively monitored by PDMPs were they able to link to the relevant databases.

Similarly, information from Medicaid or third-party payers on patients who are in a restricted recipient program or "lock-in" to a single prescriber and pharmacy could be recorded by the PDMP. If a check of the PDMP indicates the prescription about to be dispensed is not from the specified prescriber and pharmacy, the pharmacist could take steps to make sure that dispensing is appropriate. This would be consistent with GAO's 2011 recommendation to CMS for the Medicare program that a restricted recipient program be implemented (GAO, 2011). Even if the pharmacist does not detect this prior to dispensing, the PDMP could detect that the prescription was issued and dispensed by an unauthorized prescriber and/or pharmacy and report it to the Medicaid program. Alternatively, the PDMP could make the data available to Medicaid or other third-party payer so it could analyze the data and identify the violation of a lock-in, as has Washington State (see **User access and report dissemination, B. Optimize reporting to fit user needs**, below).

***Evidence of effectiveness*:** The potential effectiveness of giving PDMPs access to data on prescriber disciplinary status and patient lock-ins is suggested by other instances of data sharing that enable identification of problematic prescribing and dispensing, for instance Washington State's provision of PDMP data to its Medicaid program (see **User access and report dissemination, B. Optimize reporting to fit user needs**, below).

***Current adoption status*:** No PDMPs were found that record prescriber disciplinary status or patient lock-ins.

***Barriers to adoption*:** To link to the relevant databases and flag reports, PDMPs will have to implement data-sharing agreements and develop the necessary information systems. Limited program resources pose the biggest obstacle to such development.

Summary

***Rationale*:** Dispensers could check the PDMP for data on practitioner disciplinary status and patient lock-ins to ensure that the presented prescription is advisable to dispense.

***Evidence of effectiveness*:** Key stakeholder perceptions.

***Current adoption status*:** None.

***Barriers to adoption*:** Lack of resources needed to develop systems to record data and automatically flag practitioners and patients when the PDMP is queried.

User access and report dissemination

Best practices in PDMP access and reporting will maximize the availability and utility of PDMP data to the widest range of appropriate end users. Candidate practices include actions to:

A. Provide continuous online access and automated reports to authorized users

B. Optimize reporting to fit user needs

C. Integrate PDMP reports with health information exchanges, electronic health records, and pharmacy dispensing systems

D. Send unsolicited reports and alerts to appropriate users

E. Publicize use and impact of PDMP via websites, presentations, and reports

A. Provide continuous online access and automated reports to authorized users

***Rationale*:** PDMPs began as paper- or faxed-based systems, distributing custom-generated reports to limited numbers of users, mostly on request (solicited reports). Since the advent of electronic databases, many states have moved to automated online systems that make prescription history reports continuously available to authorized and authenticated users at their computer terminals. This is important since medical care is provided by emergency departments, and dispensing is provided by some pharmacies 24 hours a day, seven days a week, year-round.

***Evidence of effectiveness*:** Anecdotal reports and some observational evidence suggest that ease of access to the PDMP encourages its utilization, increasing the number of data queries far beyond what earlier systems envisioned. As its reports are made more widely available to end users, a PDMP's impact appears to increase. Data from Virginia's PDMP show a typical pattern: As the state enabled continuous online access and automated reporting beginning in 2010, data queries, mostly by prescribers, jumped from 75,432 in 2009 to 433,450 in 2010. Simultaneously, and possibly because of this increased PDMP

utilization, the number of individuals in the PDMP database meeting 10x10 and 15x15 over six-month thresholds for doctor shopping declined (Virginia Prescription Monitoring Program, 2010). Continuous online access also encouraged Virginia medical examiners to make PDMP reports a standard element of all case investigations, enabling more efficient determinations of cause of death (PDMP COE, NFF 2.6).

Another example is the new Florida PDMP, which first allowed prescribers and pharmacists to request data online on October 17, 2011. Within the first 10 weeks (as of December 31, 2011), 337,635 patient-specific controlled substance dispensing queries had been performed by prescribers and pharmacies, providing information for safe prescribing and dispensing (Florida PDMP data). Given the tremendous increase in use afforded by online access, it is a high priority for states to move to automated systems that make prescription history data continuously available to end users.

***Current adoption status*:** Currently, all but four states have established or are installing online databases with Web portals for prescriber and pharmacist inquiries. The following states implemented Web portals or online access during 2011 and early 2012: Alaska, Florida, Massachusetts, Oregon, and Washington (PDMP COE Survey of PDMPs, 2011, and communication with Washington State PDMP).

***Barriers to adoption*:** Barriers to implementing such systems include cost, concerns about data security, and information technology bottlenecks.

Summary

***Rationale*:** Continuous online access seems to increase use and impact of a PDMP.

***Evidence of effectiveness*:** Unpublished Virginia PDMP data, Florida PDMP data, case study.

***Current adoption status*:** Most PDMPs.

***Barriers to adoption*:** Cost, technological bottlenecks, data security concerns.

B. Optimize reporting to fit user needs

***Rationale*:** Besides making reports continuously available, PDMPs are beginning to explore reporting functionalities and formats that will further incentivize use of their data by meeting the needs of end users. PDMP reports can be tailored to specific types of end users, for example by highlighting or suppressing certain data fields for law enforcement investigators, or by providing reports of particular interest to licensing boards. Best practices in reporting will be those that best meet end-user requirements.

***Current adoption status and evidence of effectiveness*:** The Massachusetts PDMP plans to enable batch reporting as part of its new online system, allowing prescribers to retrieve automated summary prescription histories for all patients scheduled for upcoming appointments. A full report for any patient can then be downloaded if necessary. The Washington State PDMP has agreed to provide batch transfer of PDMP data to Medicaid for its enrollees, to the Workers' Compensation unit in the Department of Labor and Industries for workers' compensation claimants, and to the Corrections Department for inmates. A review of Washington PDMP data for Medicaid enrollees identified more than 2,000 individuals in 2012 receiving Medicaid and cash-paid prescriptions for controlled substances on the same day. It also found 478 clients for whom cash and Medicaid prescriptions for the same drug were

filled less than 10 days apart and from a different prescriber. (Presentation by Scott Best, Clinical Nurse Advisor, Washington State Health Care Authority at CDC Medicaid Patient Review and Restriction Expert Panel Meeting, August 27-28, 2012, Atlanta, GA). Without the batch transfer of PDMP data, this activity would not have come to light.

PDMPs should be surveyed to document the types of PDMP report customization they currently offer, as well as any innovative reporting functions. To gauge effectiveness, process outcome data on how changes in reporting affect utilization should be sought from PDMPs as well as survey data from end users on the usefulness of customized reports or functionalities. Such information could help determine which of these might be recommended as PDMP best practices in reporting.

***Barriers to adoption*:** Barriers to optimizing reports for end users include the costs of designing and implementing customized report types as well as the need to survey end users on what report types and functionalities would be most useful.

Summary

***Rationale*:** Meeting end-user needs by optimizing reporting helps incentivize use of PDMP data, increasing PDMP impact.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.
***Current adoption status*:** A few PDMPs.

***Barriers to adoption*:** Development and implementation costs of new reporting functions and customizations.

C. Integrate PDMP reports with health information exchanges, electronic health records, and pharmacy dispensing systems

***Rationale*:** Integrating PDMP data retrieval with health information exchanges (HIE), electronic health records (EHR), and pharmacy dispensing systems should help reduce the time and effort needed for prescribers and their staff and for pharmacists to access a patient's prescription history. The Office of the National Coordinator for Health Information Technology (ONC) at the Department of Health and Human Services, in collaboration with MITRE Corporation, is leading an effort to develop and test a methodology for seamless transfer of PDMP data to prescribers, dispensers, and emergency departments before patients are seen by physicians and to pharmacies before dispensing. This effort, called "Enhancing Access to PDMPs," plans to utilize systems in which health care providers and third-party payers confirm patients' eligibility for third-party payment prior to patients being treated. The ultimate goal is to provide secure PDMP data in real time to electronic records systems such that medical providers have continuous access to prescription history information vital to safe prescribing of controlled substances.

***Current adoption status and evidence for effectiveness*:** Two pilot projects are planned by the ONC, one in Ohio using a "drug-risk indicator" in the EHR, and one in Indiana involving emergency department staff access to prescription information via EHRs. These efforts, and other initiatives by states to incorporate PDMP data into HIE/EHR, need to be documented and evaluated to determine their feasibility and which of them show promise as models for other states. In advance of full integration

with health information systems, intermediate steps to integrate the PDMP into the provider's workflow can be explored, such as instituting batch reporting on patients scheduled for upcoming visits (see **B. Optimize reporting to fit user needs**, above) and sending unsolicited reports or alerts to prescribers and dispensers that prompt them to consult the PDMP (see **D. Send unsolicited reports and alerts to appropriate users**, below).

***Barriers to adoption*:** Barriers to integrating PDMP reports with health information exchanges and electronic medical records include the need to develop and test data systems, and concerns about data security and patient confidentiality.

Summary

***Rationale*:** Integrating PDMP data with HIEs, EHRs and pharmacy dispensing systems facilitates prescriber and dispenser access to PDMP data.

***Evidence of effectiveness*:** Key stakeholder perceptions.

***Current adoption status*:** None.

***Barriers to adoption*:** Lack of resources needed to develop and test data systems, concerns about data security, and patient confidentiality.

D. Send unsolicited reports and alerts to appropriate users

***Rationale*:** Some PDMPs, in addition to supplying reports when requested or downloaded by end users (solicited reports), also send out unsolicited reports based on PDMP data suggesting questionable activity such as doctor shopping or inappropriate prescribing such as by pill mills. Recipients of unsolicited reports sent by states include prescribers, pharmacists, investigative agencies, and licensure boards. As a minimum requirement for states to receive PDMP funding under NASPER, SAMHSA established that PDMPs must provide unsolicited reports to medical practitioners (SAMHSA, 2005). Unsolicited reports can serve several functions: inform prescribers and pharmacists that patients may be abusing or diverting controlled substances; help prescribers make better decisions about prescribing controlled substances, thus improving patient care; and inform potential end users about the PDMP and its value. Reports sent to investigative agencies and licensure boards can assist in targeting drug diversion reduction efforts and ensuring safe, effective, and legal medical practice.

***Evidence for effectiveness*:** Nevada initiated its PDMP in 1997 by sending unsolicited reports to prescribers about possible doctor shoppers. These reports quickly generated interest in the PDMP among prescribers, sparking further requests for data (solicited reports) (PDMP COE, NFF 2.5). Analyses of Nevada PDMP data from 1997 to 2002 indicate that individuals for whom unsolicited reports were sent exhibited declines in the average number of dosage units and numbers of pharmacies and prescribers visited subsequent to the reports. This suggests the reports may have influenced prescribing by providers treating these patients. Similarly, analyses of data from the Wyoming PDMP suggest that unsolicited reports helped to raise awareness of the PDMP, leading to greater requests for data, with a subsequent decline in numbers of individuals identified in the PDMP database who met doctor shopping thresholds (PDMP COE, NFF 1.1).

Preliminary data from a Massachusetts survey of prescribers receiving unsolicited reports indicate that just 8 percent were aware of all or most of the other prescribers listed on the reports, and only 9 percent judged that the prescriptions listed were medically necessary (MADPH Advisory Council Presentation, 2012). Pharmacists and prescribers in Maine who received automatic threshold reports on patients took a variety of actions in response, including discussing reports with patients, calling pharmacists who had dispensed to the patient, establishing a controlled substances agreement, conducting a substance abuse screening and brief intervention, and referring patients to substance abuse treatment (Sorg et al., 2009). These findings suggest that unsolicited reports can serve important functions in providing new information to practitioners and guiding their clinical practice. A cross-state evaluation of PDMPs by Simeone and Holland indicated that states with PDMPs that engaged in unsolicited reporting reduced sales of controlled substances by 10 percent compared to states without PDMPs, potentially reducing diversion and abuse (Simeone & Holland, 2006).

Further studies are needed to determine the impact of unsolicited reporting and the mechanisms by which such reporting influences doctor shopping and prescribing behavior, especially studies involving matched comparison groups of individuals for whom unsolicited reports are not sent. Unsolicited reports can also prompt regulatory boards to determine if providers are operating outside of accepted standards of care. Guidelines for appropriate reporting to boards need to be developed, taking into account current practices by the states that permit such reporting.

An apt model for unsolicited reports and their use is the well-established public health practice of mandated reporting to disease registries operated by state health departments. Such registries include communicable diseases like mumps, rubella, and tuberculosis; positive HIV diagnoses; cancer; and other chronic diseases. Such registries are regularly analyzed, and proactive public health interventions are initiated when outbreaks or epidemics are detected.

While some persons who obtain controlled substances from multiple prescribers and dispensers do so in order to resell the drugs on the street, others obtain excessive drugs for abuse, meeting the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV criteria for abuse or dependence. Analysis by researchers in Washington State indicates that individuals who consume 100 morphine milligram equivalents or more per day are eight times more likely to overdose than persons consuming lesser quantities (Dunn, 2010). The proactive analysis of PDMP data and distribution of unsolicited reports to help prevent such overdoses would constitute a public health intervention, just like that of other disease registries. In its 2012 Harold Rogers Grant Program solicitation, BJA stated it would give priority consideration to PDMPs proposing to carry out unsolicited reporting.

***Current adoption status*:** As of a survey of 38 states in November 2011, 30 PDMPs are authorized to provide unsolicited reports to providers, but only 16 of them were actually doing so. A smaller number were also providing such reports to law enforcement agencies (eight PDMPs) and licensing boards (seven PDMPs) (PDMP COE Survey of PDMPs, 2011). Mississippi now sends unsolicited reports to individuals whose prescription histories suggest questionable activity, then tracks their prescription behavior using PDMP data. Indiana has instituted “user-led” unsolicited reports: A practitioner who has retrieved PDMP data suggestive of a patient’s questionable activity is enabled to send notifications to

other practitioners concerning the patient. These innovative approaches to unsolicited reporting could be evaluated as possible best practices.

Instead of sending full reports containing patient data, some states send letters or alerts to providers, notifying them that one or more of their patients (identified by a coded number) might be doctor shopping, and recommending that they view PDMP data on the patient. If they are not registered with the PDMP, they can open accounts to access the data. Louisiana has instituted an automated system of generating alert letters to practitioners, minimizing costs and increasing the rate of notification, and Massachusetts is developing a similar system. Given that persons identified as possible doctor shoppers in PDMP databases can number in the thousands, depending on the thresholds or criteria used, automated methods for notifying prescribers seem indicated but are in need of evaluation.

***Barriers to adoption*:** Barriers to issuing unsolicited reports include PDMP-enabling legislation in some states that does not authorize such reporting, lack of staff and information system resources needed to analyze PDMP data to detect questionable activity and to generate and disseminate reports, and a concern expressed by some that unsolicited reports will de-incentivize prescriber-initiated access to the PDMP (even though available information cited above indicates the opposite effect).

See **Section V. Summary and Recommendations** for recommendations for research and development of best practices related to unsolicited reporting.

Summary

***Rationale*:** Unsolicited reports proactively inform end users about the PDMP and of possible doctor shopping, inappropriate prescribing, and drug diversion; help inform safe and effective prescribing and dispensing; and incentivize enrollment and use of PDMP.

***Evidence of effectiveness*:** Published study, case studies, unpublished survey data, expert opinion.

***Current adoption status*:** Thirty PDMPs are authorized to provide unsolicited reports, and 16 actually do so.

***Barriers to adoption*:** Legislative prohibitions, lack of program resources.

E. Publicize use and impact of PDMP via websites, presentations and reports, and analyses

***Rationale and evidence of effectiveness*:** A few PDMPs are proactive in publically disseminating selected findings from their analyses and end-user outcomes via websites, presentations and reports. Many, but not all, PDMPs maintain public websites that are or could be used to publicize reports and findings. Greater public outreach on the part of PDMPs could raise awareness about the prescription drug abuse epidemic and the role PDMPs can play in its mitigation, which in turn could build support for funding their operations. For example, reports making the connection between PDMP activity and declines in doctor shopping and inappropriate prescribing would likely increase the positive perception of prescription monitoring as an effective tool in mitigating drug diversion and abuse. PDMP data on prescribing patterns is also of great interest to those interested in public health, whether for personal or professional reasons, so making it available constitutes a valuable public service. In order to give PDMP stakeholders and the public a wider understanding of the prescription drug abuse epidemic and PDMPs' roles in addressing it, states' websites could link to the websites of the PDMP Training and Technical

Assistance Center and the PDMP COE. A survey of PDMP practices in this area would help identify effective approaches to public education and the sorts of reports and analyses that are appropriate for release and most influential in increasing PDMP awareness.

***Current adoption status*:** States vary to the extent to which they proactively disseminate findings and outcomes related to PDMP data and activities to the wider public. A majority of PDMPs have websites (list available at www.pmpalliance.org/content/state-pmp-websites) that give an overview of program objectives and operations but are largely configured to accommodate authorized PDMP users. However, a few programs also make data analyses available. For example, Maine offers recent PDMP news and an epidemiological evaluation of PDMP data from 2005 to 2008 (www.maine.gov/dhhs/samhs/osa/data/pmp/index.htm), and Virginia posts reports showing increased PDMP utilization and concomitant declines in doctor shopping rates (www.dhp.virginia.gov/dhp_programs/pmp/docs/ProgramStats/2010PMPStatsDec2010.pdf). Others, such as Kentucky, link to satisfaction surveys that document the valuable role PDMPs play in clinical practice, and to regular (e.g., quarterly) reports that show prescribing patterns by geographic area, for instance the mostly widely prescribed drugs in each county.

***Barriers to adoption*:** Barriers to publicizing PDMP data and activities include resource limitations in generating data analyses, disseminating reports, and in expanding, updating, and maintaining websites.

Summary

***Rationale*:** Raising awareness of PDMPs via websites, presentations, and reports may help build support and help ensure funding.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** Some PDMPs publicize findings via data summaries and reports via public websites and other outlets.

***Barriers to adoption*:** Lack of staff resources to produce and disseminate reports, maintain websites.

PDMP recruitment, utilization, and education

Best practices in recruitment, utilization, and education will maximize participation in a PDMP by all appropriate users. They will also promote understanding the value and application of PDMP data in prescribing and dispensing, drug diversion investigations, drug abuse prevention programs, planning and siting drug treatment programs and office-based opioid treatment; and other activities that address prescription drug abuse. Candidate practices include actions to:

A. Enable access to PDMP data by all appropriate users; encourage innovative applications
B. Outreach and recruitment strategies
    1. Proactively identify and conduct outreach to potential high-impact users
    2. Conduct recruitment campaigns
    3. Streamline certification and enrollment processing

4. Mandate enrollment

C. Approaches to increasing utilization

1. Conduct promotional campaigns
2. Improve data timeliness and access
3. Conduct user education
4. Mandate utilization
5. Institute financial incentives
6. Delegate access

A. Enable access to PDMP data by all appropriate users; encourage innovative applications

***Rationale and evidence of effectiveness*:** PDMPs differ in their data access policies, sometimes making it difficult for potential users to access PDMP data, such as health professional licensing boards and law enforcement investigators. Some PDMPs selectively bar access to their data altogether by not expressly authorizing access for substance abuse treatment programs and professionals, medical examiners, Medicaid and Medicare agencies, workers' compensation programs, and other third-party payers. Such restrictions can limit the effectiveness of PDMPs in helping to improve prescribing and in curtailing prescription drug abuse. PDMPs can therefore increase their effectiveness by seeking to widen access to their data by all legitimate users, making sure sufficient safeguards and training are in place to maintain confidentiality of prescription records, and prevent misuse of patient and prescriber information.

BJA gives priority consideration for funding under its Harold Rogers Grant Program to PDMPs proposing to widen data utilization. In particular, local, state, and federal law enforcement agencies and investigators should be given case-appropriate access to PDMP reports (PDMP COE, NFF 2.3). California and Texas, which have long provided both unsolicited and solicited reports to law enforcement agencies, and New York, which has provided such reports to narcotic enforcement investigators within the Department of Health, have lower than average death rates from unintentional opioid overdoses (Eadie, 2011b; Paulozzi, 2010). To help curb prescription forgeries and theft, prescribers could be encouraged to consult PDMP databases periodically to ensure that their DEA controlled substance number is not being used surreptitiously (self-lookup).

To maximize end-user participation, PDMPs first need to identify which types of potential users are overly limited or barred from using PDMP data and those who are simply unaware of the PDMP. They can then undertake initiatives to enable such use, such as legislative and/or regulatory reform or outreach to agencies or professional organizations.

In addition, PDMP stakeholders should be encouraged to promote innovative applications of PDMP data, along with evaluations of their effectiveness. New applications, perhaps involving new categories of users, may eventually become best practices that states can adopt in realizing the full potential of PDMPs.

***Current adoption status*:** Depending on the state, PDMP end users typically include prescribers, dispensers, medical licensing boards, and law enforcement investigators. Some PDMPs, however, have widened their user base to include medical examiners, drug treatment programs and treatment professionals, criminal justice diversion programs such as drug courts, "pre-criminal" intervention programs (PDMP COE, NFF, 2.1), and drug prevention initiatives (PDMP COE, NFF 3.2). Washington State's new PDMP provides data to Medicaid, the Workers' Compensation unit in the Department of Labor and Industries, and the Corrections Department (communication from PDMP administrator). A 2012 statute authorizes the New York State PDMP to provide data to local health departments for purposes of public research and education. Other categories of users could include health care systems' peer review organizations (the North Dakota PDMP is authorized to provide data to peer review organizations) and third-party payers' health care professional reviewers.

PDMPs with more inclusive data access policies can serve as models for programs seeking to expand their user base. For example, Kentucky's PDMP permits use of its data by drug diversion investigators (PDMP COE, NFF 2.3) and drug courts (PDMP COE, NFF 2.4), Virginia's by medical examiners (PDMP COE, NFF 2.6), and other states by outpatient drug treatment programs (PDMP COE, NFF 2.2). A compilation of all appropriate end users, developed in consultation with state PDMPs and the PDMP Training and Technical Assistance Center, would provide direction in maximizing appropriate use of PDMP data. Developing case studies of how data are applied by these end users and in innovative applications (see **the PDMP COE "NFF" series**) will also assist in moving this process forward.

***Barriers to adoption*:** Barriers to permitting greater access to PDMP data include the absence of specific authorization for certain users written into a state's enabling PDMP legislation and/or regulations; concerns of prescribers and pharmacies about professional licensing boards or law enforcement agencies being able to see information about their prescribing and dispensing behavior (sometimes described as fear of so-called "fishing expeditions" by investigators); concerns about revealing the identity of patients in drug treatment programs; lack of PDMP resources to undertake outreach and legislative initiatives; and lack of awareness of PDMPs on the part of potential end users.

Summary

***Rationale*:** Permitting and encouraging use of PDMP data by all appropriate users, and in innovative applications, will help to maximize PDMP utilization and impact.

***Evidence of effectiveness*:** Case studies.

***Current adoption status*:** States vary in restricting or encouraging use of PDMP by different categories of users.

***Barriers to adoption*:** Legislative prohibitions on PDMP data access by potential users, concerns about misuse of data by law enforcement and substance abuse treatment agencies, lack of awareness of PDMP.

B. Outreach and recruitment strategies

Enrollment in and use of PDMPs by medical practitioners is key to achieving their full potential in helping to ensure safe prescribing and dispensing, and in reducing diversion and abuse of controlled substances.

One of the most significant challenges facing PDMPs has been the slow increase in enrollment in and use of PDMPs by prescribers and pharmacists. Rates of enrollment among prescribers are well below 50 percent in most states.[4] Best practices, therefore, need to be identified for how PDMPs can most efficiently increase enrollment among user groups, including producing enrollments of, for example, at least 50 percent of those who wrote 10 or more controlled substance prescriptions in the past year, or of prescribers of at least 50 percent of prescriptions written.

To inform best practices in this domain, appropriate rates of enrollment need to be studied, taking into account that many providers prescribe infrequently and that a relatively small proportion of prescribers are responsible for issuing most controlled substance prescriptions. Data from the Massachusetts PDMP indicate that just 30 percent of all those who prescribed an opioid at least once in 2011 were responsible for 88 percent of all opioid prescriptions in 2011 (MADPH Advisory Council Presentation, 2012). This suggests that to maximize the effectiveness of PDMPs, recruitment strategies could profitably be focused on the most frequent prescribers of those controlled substances implicated in abuse and diversion (see immediately below).

1. Proactively identify and conduct outreach to potential high-impact users

Rationale and evidence for effectiveness: Certain categories of potential PDMP users are a high priority for enrollment given the impact their use of PDMP data would likely have in improving prescribing and dispensing, and in reducing diversion and abuse of prescription drugs. Primary among these are the most frequent prescribers of controlled substances, such as the top 10 percent in terms of prescriptions per year (Paulozzi, 2011), as well as those prescribers with relatively high proportions of suspected doctor shoppers in their practices. Such prescribers are readily identifiable using PDMP data and can be encouraged to enroll in and use the PDMP via letters and alerts, either electronically or by mail. In 2010, Utah's PDMP analyzed its data to identify top prescribers, then contacted them electronically, resulting in a rapid rise in enrollment among this group. Massachusetts is currently conducting an initiative to identify prescribers with relatively high proportions of doctor shoppers in their practices; these prescribers are receiving letters suggesting they join and use the Massachusetts PDMP. These prescribers' enrollment in and utilization of the PDMP will be monitored, along with any changes that may occur in the proportion of possible doctor shoppers in their practices.

***Current adoption status*:** Contact with other PDMPs is warranted to ascertain which are engaged in similar efforts and assess outcomes, including on enrollment, utilization, prescribing, doctor shopping rates, and proportions of doctor shoppers among identified frequent prescribers. Outreach to frequent prescribers for enrollment in the PDMP will need to be coordinated with licensure boards and investigative agencies in case any of the identified practitioners happen to be subjects of disciplinary action or investigations.

[4] According to data during the first half of 2010 from Harold Rogers PDMP Grant Program, of 12 PDMPs with operational online Web portals for prescribers to request prescription history reports, 11 reported 9 to 39 percent of prescribers who issued controlled substances prescriptions were registered. Only one state (Hawaii) reported 100 percent registration.

***Barriers to adoption*:** Barriers to adoption include the limited resources of PDMPs, leaving them with limited staff, time, or funds to conduct outreach to high-frequency prescribers and other target groups.

Summary

***Rationale*:** Recruiting high-frequency prescribers may help to maximize impact of PDMP in improving prescribing, reducing doctor shopping.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** A small number of states have targeted potential high-impact users.

***Barriers to adoption*:** Lack of program resources to identify and conduct outreach to target groups.

2. Conduct recruitment campaigns

Rationale and evidence for effectiveness: In launching and promoting their PDMPs, most states conduct recruitment campaigns to raise awareness of the PDMP and enroll participants. Virtually all PDMPs engage in one or more forms of recruitment, including a mix of presentations to professional groups, hospitals, and conferences; mail and e-mail campaigns; online training modules and webinars; and Web pages with instructional materials and FAQs. Recently, a few states have initiated targeted outreach to potential high-impact users (see 1. **Proactively identify and conduct outreach to potential high-impact users**, above). Campaigns have included disseminating end-user testimonials about the value of PDMP data, such as those gathered by surveys of PDMP users in Kentucky (Kentucky Cabinet for Health and Family Services, 2010). Some states, such as Massachusetts, take advantage of controlled substance registration requirements to notify prescribers about the PDMP and facilitate enrollment.

Little data exist on the relative effectiveness of various recruitment strategies. To help inform best practices, states' promotional activities should be examined in connection with how they affect rates of enrollment. Historical data on activities and enrollment rates are often available to PDMPs; these could provide some indication of the impact of specific promotional efforts, or types of efforts, as reflected in applications to join the PDMP.

***Current adoption status*:** States that have recently conducted outreach campaigns, or that are in the process, include Massachusetts, North Carolina, Utah, and Vermont. Surveys of both enrolled and non-enrolled practitioners could shed light on which recruitment techniques seem to achieve the most penetration, and which barriers exist to learning about and joining the PDMP. A recent survey found that a significant deterrent to enrollment among pharmacists in Ohio was the perceived time needed to access a PDMP report (Ulbrich et al., 2010). This suggests that educating prospective PDMP participants about the advantages and ease of access to PDMP data would help increase enrollment.

***Barriers to adoption*:** States' resources are limited, especially during this difficult economic period, including funding for activities to recruit participants. Moreover, little evidence exists on the relative effectiveness of recruitment strategies, so programs lack guidance on how to proceed in outreach efforts.

Summary

***Rationale*:** Well-focused recruitment campaigns may boost PDMP enrollment.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** States have undertaken a variety of recruitment campaigns.

***Barriers to adoption*:** Lack of resources, little evidence on what approaches produce best enrollment outcomes.

3. Streamline certification and enrollment processing

Rationale and evidence for effectiveness: Among the barriers to enrollment in a PDMP is the sometimes burdensome process of certifying a potential user's credentials and establishing secure system access via proper identification, including passwords and biomarkers. Evidence-based best practices in user certification and enrollment would streamline and automate these processes, while maintaining confidentiality and system security. For example, requiring notarization of prescribers' applications for PDMP accounts, although helping to validate an applicant's identity, may present an obstacle to enrollment for busy practitioners. Further investigation of notarization and alternative means of validating identity and credentials is warranted. This is especially important, since without notarization, it would not be difficult for someone to fraudulently claim to be a licensed prescriber or pharmacist, open a PDMP account, and then obtain confidential data that could be used against others, e.g., against a rival in a divorce or domestic custody suit or against an opposing candidate running for political office. Given that a few states have reported such fraudulent activity, this must be examined carefully. Experience in some states, described below, suggests that enrollment and authentication procedures can be safely automated, but long-term data on fraudulent enrollments and security breaches need to be collected to confirm this hypothesis.

***Current adoption status*:** Utah, which mandates prescriber enrollment in its PDMP (see **4. Mandate enrollment**, below), has taken advantage of its cross-agency integration of health provider information to expedite PDMP certification and enrollment. Kentucky, also in response to a utilization mandate, has developed application forms that prescribers can complete online, submit electronically, and simultaneously print for notarization and submission. Connecticut has developed a process through which applicants need not send in paper forms, even after notarization; instead, applicants submit forms by fax, and the PDMP's computers automatically convert the forms to electronic files. Florida's enrollment and authentication procedures are fully automated, involving electronic communication between an online application form and a Department of Public Health database.

Such approaches could serve as models for other states for how to incentivize and process enrollments, should evaluation confirm their security and efficacy. A survey of other PDMP enrollment procedures could help identify those that minimize the time and inconvenience for potential participants. Enrollment data from PDMPs can help validate hypotheses about which procedures are most effective in accelerating the enrollment process.

There is also a need to study the feasibility of using the federally required certification of prescribers to authorize their electronic prescribing of controlled substances prescriptions. States could potentially use

the federal certification to accept and enroll users in their PDMPs, thus saving the prescriber from duplicative authentication procedures and expediting the PDMP enrollment procedure. This kind of study is urgent as e-prescribing of controlled substances is expected to advance quickly, especially as New York State has passed a 2012 statute mandating e-prescribing of controlled substances within a few years.

Barriers to adoption: Barriers to streamlining certification and enrollment processing include lack of secure online information systems that can replace in-person notarization as a means to authenticate applicants. In particular, the need exists to explore federal certification of prescribers to issue electronic prescriptions for controlled substances, as a shortcut in state authentication systems.

Summary

***Rationale*:** Streamlined certification and enrollment processes may increase enrollment and utilization.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** A few states have explored various steps in streamlining enrollment.

***Barriers to adoption*:** Lack of information systems and validated processes that would facilitate certification and enrollment, including possible use of federal certification of prescribers for electronic prescribing.

4. Mandate enrollment

***Rationale*:** In most states with operational PDMPs, enrollment and utilization are voluntary. This makes it necessary for states to conduct recruitment campaigns to increase awareness of the PDMP and induce prescribers and pharmacists to enroll (see **2. Conduct recruitment campaigns**, above). Such campaigns can be expensive, resource-intensive, and time-consuming; PDMP administrators frequently report that campaigns fail to produce high rates of participation. Another option, not yet widely adopted but gaining in prevalence, is to make enrollment in a PDMP mandatory for certain user groups, such as prescribers and dispensers (NAMSDL, 2012a).

***Evidence of effectiveness*:** The effectiveness of prescriber- and pharmacist-mandated enrollment in producing greater utilization of PDMPs needs to be assessed, taking into account any unintended consequences, such as resistance on the part of some doctors to a perceived regulatory burden and/or infringement on their autonomy, or the inability of enrollment and certification systems to handle a surge of applications. One PDMP has expressed concern about a legislative mandate for enrollment because it may not provide funding for processing applications. Examining states' experience could shed light on whether mandates are more successful than voluntary campaigns in producing high rates of enrollment and utilization, and if so, which ancillary systems and policies enable successful mandates. Utah, with a relatively small number of prescribers, has been able to implement mandated enrollment using its advanced health management information system. How and whether larger and less technologically advanced states could carry out such a mandate are open questions needing investigation.

***Current adoption status*:** Since 2007, Arizona has required that practitioners who possess a registration under the U.S. Controlled Substances Act must also be registered with the PDMP. Utah has recently (July

2010) mandated that prescribers join its PDMP, making enrollment a prerequisite for practitioners to renew their federal or state licenses to prescribe controlled substances. More than 90 percent of those with licenses to prescribe controlled substances in Utah are now enrolled in its PDMP (personal communication from Utah PDMP administrator). Similarly, Minnesota requires PDMP enrollment for pharmacists as a precondition for license renewal, and in Louisiana, recent legislation requires the medical directors of pain clinics to enroll in and use the PDMP. Kentucky, New Hampshire, Tennessee, and Massachusetts have passed laws in 2012 mandating registration and use of the PDMP by prescribers (NAMDSL, 2012a and 2012b, communication with Massachusetts PDMP). A New York 2012 statute (the "I-Stop" Program Bill #39, introduced in June 2012) mandates use of the PDMP prior to prescribing or dispensing controlled substances, with limited exceptions—effectively mandating enrollment as well. A 2012 Massachusetts statute mandates that all prescribers of controlled substances enroll in the PDMP program over a three-year period as they establish or renew their state controlled substances registrations. Maine requires registration but not utilization.

***Barriers to adoption*:** Barriers to mandating PDMP enrollment include the need for possibly significant revisions in PDMP legislation and regulations, possible opposition from provider groups wary of state intrusion on medical practice, and lack of funding and other program resources to support implementation. A facilitating factor might include the perception that prescriber use of a PDMP is becoming a "duty of care," given its role in promoting safe prescribing, especially as online PDMP reports become available to practitioners.[5] This suggests that public and provider education about the value of PDMP data for medical practice might help build support for enrollment mandates, should a consensus emerge that they constitute a best practice for building PDMP participation. See Section V. Summary and Recommendations for further discussion of mandates to enroll in and use PDMPs.

Summary

***Rationale*:** Mandating enrollment may increase provider utilization of a PDMP.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** A few states mandate enrollment.

***Barriers to adoption*:** Need for legislative/regulatory change, provider resistance to mandates, and lack of program resources to implement mandate.

C. Approaches to increasing utilization

Like enrollment, actual use of the PDMP—such as requesting a report via fax or accessing an online database – is optional for prescribers and pharmacists in most states. This raises the question of which strategies work best to increase voluntary utilization by registered users and the further question of whether mandating the use of a PDMP might constitute a best or promising practice. Even in states with

[5] Concerns among doctors that they would become legally liable for failure to consult the PDMP could perhaps be offset by reductions in malpractice insurance premiums for physicians who integrate use of the PDMP into their practices (see **5. Institute financial incentives**, below).

comparatively well-established PDMPs, awareness of and enrollment in a PDMP do not always entail its utilization (Feldman et al., 2011).

1. Conduct promotional campaigns

***Rationale and evidence for effectiveness*:** As noted above, states have undertaken outreach initiatives to inform practitioners and the public about the benefits of consulting the PDMP to help assure safe prescribing and dispensing. They have also sought to provide reassurances about patient privacy and explain that fears about the so-called chilling effect (unwarranted reductions in prescribing pain medication as a consequence of prescription monitoring) may be overblown. Published data are scarce on the impact of consulting a PDMP on prescribing, but a recent study of emergency physicians indicated that when informed of a patient's prescription history, they prescribed more controlled substances for some patients but less for others, when compared to their not being informed of patient histories (Baehren et al., 2010). A Canadian study found no significant differences in changes in opioid dispensing rates between provinces with and without PDMPs (Fischer et al., 2011). Dissemination of these and any similar findings that eventually come to light might encourage PDMP utilization by allaying prescribers' concerns about intrusive monitoring of their medical practice and any chilling effect this might have (Barrett & Watson, 2005; Twillman, 2006; Fornili & Simoni-Wastila, 2011). Further study is needed to understand how utilization of PDMP data influences prescribing decisions.

The impact of promotional campaigns on utilization will be reflected in the number of data queries to the PDMP, comparing the periods before and after the campaigns, although controlling for confounding factors may prove difficult. Recent data analyses from Virginia suggest that a well-focused outreach campaign, along with program improvements, can increase both enrollment and utilization by prescribers and dispensers (Virginia Prescription Monitoring Program, 2010). It is likely that other states could produce similar analyses to help evaluate the effectiveness of their campaigns.

Current adoption status: As noted above (see **2. Conduct recruitment campaigns**), states have mounted a variety of promotional efforts to recruit PDMP users and educate them concerning the use and value of PDMP data. Massachusetts has mandated prescriber education for the prescribing of controlled substances; such education includes information on how to download and interpret prescription history data (communication with Massachusetts PDMP). For more on prescriber education, see **3. Conduct user education**, below.

***Barriers to adoption*:** Scarce resources for PDMPs and prescriber education limit the reach of efforts to increase PDMP utilization.

Summary

***Rationale*:** Increasing awareness of a PDMP and the value of its data by means of promotional campaigns and prescriber education may increase utilization.

***Evidence of effectiveness*:** PDMP data showing increased utilization following a campaign.

***Current adoption status*:** Many states conduct campaigns, varying in their characteristics; at least one state mandates prescriber education on prescribing controlled substances, including on use of PDMP data.

***Barriers to adoption*:** Lack of resources for outreach and prescriber education.

2. Improve data timeliness and access

***Rationale*:** Experience from states suggests that improving the timeliness and accessibility of PDMP data encourages utilization. Moving from a paper- or fax-based system to continuous online access, as all but four PDMPs have done (efforts are under way in those four states to establish online systems), dramatically increases the ease and probability of providers making voluntary queries or solicited reports to the system.

Evidence of effectiveness and current adoption status: In Virginia, initiating round-the-clock access to PDMP data with auto-response software in 2010, along with a promotional campaign (see **1. Conduct promotional campaigns**, above), resulted in a sharp rise in user registrations and data requests (Virginia Prescription Monitoring Program, 2010). It also encouraged Virginia medical examiners to include use of PDMP data in their routine practice (PDMP COE, NFF 2.6). Similarly, as Massachusetts implemented the first phase of its online PDMP starting in 2010, prescribers and dispensers joined and utilized the system in increasing numbers. Another program improvement that may spur greater utilization is shortening the required reporting interval for pharmacies.[6] Shortening the interval to daily or making it available in real time, as recently implemented in Oklahoma, makes prescription histories more up-to-date, increasing their value for end users and incentivizing utilization (PDMP COE, NFF 3.1, and see **Data collection and data quality, B. Reduce data collection interval; move toward real-time data collection**, above). Oklahoma will be tracking the user response to its real-time reporting initiative, so some quantitative measure of the impact of this program improvement on utilization will be forthcoming. A survey of other states' histories of program improvements, correlated with quantifiable changes in PDMP utilization, would identify the types of improvements that best enable and incentivize use of PDMPs.

***Barriers to adoption*:** The primary obstacle to improving data access is lack of program resources to develop an online automated response system. Resource limitations also inhibit efforts to reduce the reporting interval (and thus increase the timeliness of data), as do technological and regulatory hurdles. The Oklahoma PDMP real-time reporting project provides a case study on how these can be overcome; see PDMP COE, NFF 3.1 and **Data collection and data quality, B. Reduce data collection interval; move toward real-time data collection**, above.

[6] The median reporting interval for states is weekly, according to the Alliance of States with Prescription Monitoring Programs state profiles report, available at pmpalliance.org/content/PMP-data-collection-frequency.

Summary

***Rationale*:** Improving timeliness and accessibility of PDMP data may increase utilization and PDMP impact.

***Evidence of effectiveness*:** Case study, unpublished PDMP data on utilization.

***Current adoption status*:** Many states have implemented continuous online access; some have shortened data collection intervals.

***Barriers to adoption*:** Lack of resources to implement online systems and reduce data collection interval.

3. Conduct user education

***Rationale and evidence for effectiveness*:** A good understanding of PDMPs, how to use them, and the value of their data for prescribers, pharmacists, and other end users would likely encourage enrollment in and effective utilization of PDMPs. In its recent funding announcement under the Harold Rogers Grant Program, BJA gave priority consideration to PDMPs proposing to conduct education and outreach to enrolled and prospective PDMP users. States have experimented with various educational formats, including in-person presentations to prospective user groups, online short courses and Webinars (LeMire, 2010), and paper-based and Web page materials, such as prescriber "toolkits" on how to use PDMP data and links to Screening, Brief Intervention, and Referral to Treatment (SBIRT) resources. Two published studies suggest that provider education can influence their prescribing behavior (Cochella et al., 2011; Fisher, 2011), but comparative studies of current approaches to prescriber education, their impact on PDMP utilization, and outcomes of such utilization would help identify best practices in this domain. (add www. in footnote below for style consistency; see early pages)

Education initiatives targeted to law enforcement agencies on the value and use of PDMPs are also needed to help encourage increased utilization in diversion investigations. Current efforts by states and national organizations to educate the law enforcement community about PDMPs need to be identified, cataloged, and evaluated. Other end-user groups, such as substance abuse treatment clinicians, medical examiners, drug court professionals, and prevention workers, are also candidates for education on PDMPs. To determine best practices in education on PDMPs, field research and evaluations are needed to ascertain what educational programs exist, their costs, and their impact in assisting end users to address prescription drug abuse and diversion. Research and evaluation on education initiatives could be conducted using data from the Prescription Behavior Surveillance System under development by the PDMP COE with funding from BJA, U.S. Food and Drug Administration (FDA), and CDC.

Since many prescribers have insufficient training in the use of opioids and other prescription controlled substances, proposals for mandatory prescriber education have been discussed in the Office of National Drug Control Policy national action plan to address the prescription drug abuse epidemic (Office of National Drug Control Policy, 2011) and in the context of developing national Risk Evaluation and Mitigation Strategies (REMS). Such education could include training in not only the proper use of these drugs but also their misuse and abuse by bona fide patients; the nature and extent of doctor shopping; the extent of theft, counterfeiting, and forgery of prescriptions (Boeuf et al., 2007); and how to access

and use PDMP data. States' experience in provider education, for example in Massachusetts, which requires prescriber education on controlled substance prescribing, can serve as guides to educational mandates. The extent to which mandates are feasible and what sorts of education actually change prescriber behavior, including integrating use of PDMPs into clinical practice, are open questions in need of study (Tufts Health Care Institute Program on Opioid Risk Management, 2011).

***Current adoption status*:** To date, only a limited number of educational programs specifically on PDMPs have been developed for prescribers, for example by Connecticut, North Dakota, South Carolina, and Utah (presentations at the 2010 National PDMP Meeting in Washington, D.C.). These could be evaluated to shed light on their comparative effectiveness in terms of changing prescriber behavior and clinical outcomes. Kentucky, Louisiana, Massachusetts, and Montana statutes require education of certain users as a condition of being given access to PDMP data (NAMSDL, 2012c).

***Barriers to adoption*:** PDMPs usually have limited budgets that necessarily restrict the scope of their educational efforts. In addition, little evidence exists on what approaches to prescriber education, and the education of other potential users of PDMPs, actually work to induce greater use of PDMPs. Without such information, states may be reluctant to pursue educational initiatives.

Summary

***Rationale*:** Education of prescribers and other potential end users may encourage awareness and effective use of PDMP data.

***Evidence of effectiveness*:** Published studies.

***Current adoption status*:** Some states have fielded seminars, tutorials, Webinars, and other presentations on the value and uses of PDMP data.

***Barriers to adoption*:** Lack of resources and lack of evidence on which educational approaches produce the greatest changes in prescriber and other end-user behavior.

4. Mandate utilization

***Rationale and evidence of effectiveness*:** Mandating that providers make use of a PDMP, like mandating enrollment (see **B. Outreach and recruitment strategies, 4. Mandate enrollment**, above), may be more efficient and cost-effective in increasing PDMP utilization than encouraging optional participation. The recent move to mandate utilization by some states suggests that some PDMP stakeholders believe that requiring use of the PDMP will work better than voluntary approaches to increasing utilization. However, no research yet exists to support this claim. Because mandates are now being adopted by some states, their efficacy in increasing PDMP use needs study, as do the mechanisms for encouraging and monitoring prescriber compliance and the impact of a mandate on prescribing, patient outcomes, doctor shopping, overdoses, and drug-related deaths. Incentives for compliance need investigation; for example, PDMP stakeholders and regulatory bodies could consider, with public and private third-party payers, making the review of PDMP data when prescribing controlled substances a condition of payment. As in mandating enrollment in a PDMP, mandating utilization may have unintended consequences that experience in states with mandates might bring to light.

***Current adoption status*:** A small but growing number of states statutorily require or recommend that prescribers, pharmacists, and/or addiction treatment providers consult their PDMPs, sometimes only in specific circumstances (NAMSDL, 2012b). In Nevada, statute NRS 639.23507 states that prescribers "shall" obtain a PDMP report when first prescribing a controlled substance for a new patient who they suspect might be doctor shopping, and for patients for whom they have not prescribed controlled substances in the last year. In Oklahoma, prescribers must consult the PDMP when prescribing methadone for treating pain. Recently passed legislation in Ohio requires its medical and pharmacy licensing boards to adopt rules mandating use of its PDMP, which they have done (Ohio Administrative Code Sections 4731-11-11 and 4729-5-20). In Louisiana, medical directors of pain clinics are now responsible for joining and querying the PDMP to help ensure compliance with a patient's treatment agreement. West Virginia requires that opioid addiction treatment programs access the PDMP when beginning treatment and at 90-day intervals, and Vermont requires use of its PDMP data by physicians who treat patients for opioid dependence with buprenorphine (Office Based Opioid Treatment, or OBOT). Kentucky, Massachusetts, New York, and Tennessee have passed laws in 2012 requiring use of the PDMP by prescribers (NAMSDL, 2012b, communication with Massachusetts PDMP).

***Barriers to adoption*:** Monitoring required prescriber use of its system by a PDMP requires staff time and resources that may be unavailable to some PDMPs, presenting a barrier to assuring that prescribers adopt this practice. Other potential barriers include resistance to mandates by providers and enactment of the required legislative or regulatory changes. However, should findings from existing initiatives prove positive, other states could be encouraged to undertake the necessary legislative and regulatory changes to mandate utilization, and make resources available to implement utilization requirements.

See **Section V. Summary and Recommendations** for a recommendation to study the efficacy of mandates in comparison to voluntary approaches with regards to increasing PDMP utilization.

Summary

***Rationale*:** Mandating utilization may improve prescribing, patient safety, drug treatment, and licensing board monitoring.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** Several states mandate utilization by different categories of end users under varying circumstances.

***Barriers to adoption*:** Provider resistance to mandates, need for legislative and/or regulatory reform, lack of program resources to monitor compliance.

5. Institute financial incentives

***Rationale and evidence for effectiveness*:** Greater utilization of the PDMP by prescribers could perhaps be encouraged by financial incentives, but little data exist on such approaches. One suggestion is to make lower medical malpractice insurance premiums contingent on regular use of PDMP data. There is a need for studies examining whether prescriber use of PDMP data reduces the number of patient-initiated lawsuits stemming from alleged mis-prescribing of controlled substances; such findings could help establish the rationale for charging PDMP-using prescribers lower insurance premiums. Similarly,

health insurance carriers providing somewhat higher office visit fees to prescribers who consult the PDMP through pay for performance initiatives might also incentivize greater use. Investigation is needed to determine whether any states or agencies have implemented financial incentives to encourage PDMP use, and if they have, what impact they may have had on utilization, prescribing practices, doctor shopping, and other forms of drug diversion.

***Current adoption status*:** As of this writing, we know of no examples of financial incentive programs designed to elicit greater PDMP utilization.

***Barriers to adoption*:** No precedent exists for adopting this practice, so pilot programs should be considered.

Summary
***Rationale*:** Financial incentives may increase PDMP utilization.

***Evidence of effectiveness*:** Key stakeholder perceptions.

***Current adoption status*:** None.

***Barriers to adoption*:** Lack of evidence for effectiveness, lack of precedents.

6. Delegate access

***Rationale and evidence for effectiveness*:** Allowing prescribers to delegate access to PDMP records by office staff (sometimes called "sub-accounts"), may help increase utilization of PDMP data to detect patients at risk and improve prescribing. However, the extent to which delegate accounts increase PDMP utilization is unknown.

***Current adoption status*:** Twelve states permit prescribers to delegate access to PDMP records (NAMSDL, 2011b), and statutes adopted in 2012 in Kentucky, New York, and Tennessee authorize use of delegates. Some PDMPs permit prescribers to delegate only licensed health care professionals, e.g., nurses, while others allow non-licensed administrative staff to be delegated. New York's new statute requires the delegates to be employees of the same practice as the prescriber. Methods to allow prescribers to establish sub-accounts for delegates and to oversee and supervise their data acquisition, as well as methods to hold prescribers accountable for their delegates' activities, are not standardized. The specific policies and procedures governing delegates, their relative security, and the extent to which they increase the legitimate use of PDMP data in a practice need study. A first step would be to survey states' current policies, followed by a comparative analysis of their impact on utilization.

Barriers to adoption: Increasing staff access to PDMP data has raised concerns about maintaining patient privacy and confidentiality. Those concerns must be addressed by each state in order for delegate accounts to gain acceptance. Master account holders may find monitoring of sub-accounts for which they are responsible burdensome.

Summary

***Rationale*:** Delegating access may increase PDMP utilization.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** Twelve states allow delegated access.

***Barriers to adoption*:** Concerns about data security and patient confidentiality, the need to monitor delegate account users by master account holders.

Interorganizational best practices for PDMPs

PDMP interorganizational best practices will permit data sharing across PDMPs and integrate PDMP data into the health care system, drug abuse prevention efforts, and the work of investigative agencies. They will enable efficient collaboration among PDMPs and outside organizations engaged in improving patient health and mitigating prescription drug abuse. They will also enable linking PDMP data with other prescription and health data to permit combined analyses and facilitate data access. Candidate practices include actions to:

A. Enact and implement interstate data sharing among PDMPs
    1. Model memoranda of understanding (MOUs)
    2. Standardize data collection fields, formats, and transmissions standards
    3. Identify individuals in multistate data
    4. Standardize measures for identifying questionable activity
    5. Data encryption and de-identification

B. Collaborate with other health agencies/organizations in applying and linking PDMP data
    1. Department of Veterans Affairs
    2. Indian Health Service
    3. Department of Defense
    4. Centers for Medicare and Medicaid Services
    5. Private third-party payers

A. Enact and implement interstate data sharing among PDMPs

***Rationale*:** Since doctor shopping and other forms of prescription drug diversion often cross state lines, PDMP data from a single state are limited in their capacity to identify individuals potentially in need of intervention, whether by prescribers or investigative agencies. For example, a review of data in the Kentucky PDMP identified that the prescriptions dispensed by Kentucky pharmacies were issued by prescribers located in all 50 states, the District of Columbia and Puerto Rico; 93.2 percent were issued by Kentucky prescribers, and an additional 5.7 percent were issued by prescribers in adjoining states. Examination of Massachusetts PDMP data found similar patterns.

Combining data from neighboring states and states known to be major sources of diverted prescription drugs will help increase the capacity to identify diversion and doctor shopping for all participating states. The same advantages accrue in the discovery and investigation of pill mills and aberrant prescribing. The Alliance of States with Prescription Monitoring Programs' PMP Model Act 2010 Revision recommends that exchange of PDMP information be permitted among states (ASPMP, 2010). Under its Harold Rogers Grant Program, BJA has given priority consideration to PDMPs proposing to implement interstate data sharing.

***Current adoption status and evidence of effectiveness*:** As of 2011, 28 states have provided for data sharing between PDMPs under a variety of statutory and regulatory protocols, including the Prescription Monitoring Information Xchange (PMIX) architecture and the Rx Check Hub, the PMPi Hub, and the Health Information Design (HID) Hub for data sharing (NAMSDL, 2011a). Live data are now being exchanged between Kentucky and Alabama, and between Indiana, Ohio, and several other states to help identify cross-border doctor shopping and diversion. These states, and others soon to follow, are in effect pilot testing the various protocols, and so can help identify best practices in all aspects of data sharing. These include:

1. Model memoranda of understanding (MOUs)

   States need MOUs with their partners to ensure that data are shared fairly, securely, and in compliance with the regulations of all participating states. Existing MOUs, including master templates developed for PMIX and PMPi, can be evaluated as possible models for states considering data-sharing agreements.

2. Standardize data collection fields, formats, and transmissions standards

   States sharing their data need a minimum set of common data fields, encoded and transmitted in a shared format, such as ASAP 4.2. Different standards for these parameters may exist in current data-sharing projects, which presents the opportunity for comparison using criteria of completeness, reliability, functionality, and ease of adoption. Common data protocols also need to be developed to permit the matching and integration of PDMP data with prescription information being collected by non-PDMP organizations such as the VA, Medicaid, and third-party payers. See **Data collection and data quality**, above, for more on data collection standards; the recommendations made there can be extended to multistate standards and initiatives.

3. Identify individuals in multistate data

   The usefulness of PDMP data depends greatly on the reliable identification of particular individuals who might be engaging in questionable activity. Research is needed on the best methods for identifying and linking the records of specific individuals in multistate PDMP data. Current practices among states can be assessed in comparison to what, according to evidence and expert opinion, is considered the state of the art in identifying individuals in data sets like those of PDMPs. Work on developing best practices for linking data within individual PDMPs (see **Data linking and analysis, A. Link records to permit reliable identification of individuals**, above) should be extended to cooperative development of multistate data-linking capabilities.

4. Standardize measures for identifying questionable activity

   States sharing data with one another or non-PDMP agencies may wish to collaborate on developing reliable measures of questionable activity, such as doctor shopping, that apply across state lines or that are appropriate to certain populations. Current efforts to test such measures, should any exist, need to be identified and evaluated with respect to the current literature (e.g., Buurma, 2008; White, 2009; Katz, 2010) and other published studies relevant to this question (see **Data linking and analysis, B. Determine valid criteria for possible questionable activity**, above).

5. Data encryption and de-identification

   To conduct analyses of PDMP data for epidemiological, surveillance, and evaluation purposes, records must be de-identified to suppress patient-level information, while maintaining linked individual records in a data set. Methods of encryption appropriate for use by states need to be identified and tested. Currently, a workgroup of the Integrated Justice Information Systems (IJIS) institute is reviewing the methodologies available for linking of patient records within PDMP databases and anonymization of the data. These would enable de-identified PDMP data from multiple states to be utilized by a surveillance system (e.g., the Prescription Behavior Surveillance System mentioned in PDMP recruitment, utilization, and education, above) to track doctor shopping, pill mill prescriptions, and other diversion of prescription drugs across state lines. While the workgroup's review is not yet complete, its findings suggest that less expensive and publicly available systems for linking are not as effective as some proprietary "gold standard" products. PDMPs may need additional resources to enable optimum data encryption, while maintaining accurately linked individual records.

***Barriers to adoption*:** Interstate data-sharing agreements involve legal, regulatory, and policy changes requiring coordination between multiple stakeholders, putting demands on scarce PDMP resources. Some states do not yet have statutory or regulatory authority to share data. Some PDMPs have yet to complete the implementation of PDMP operations or other significant enhancements necessary for initiating interstate exchange of data. In addition, many data-sharing initiatives have not completed standardization to the PMIX architecture that will make sharing among all states feasible.

Summary

***Rationale*:** Practices that enable cross-state and interorganizational data sharing will increase the application and utility of PDMP data.

***Evidence of effectiveness*:** Expert opinion.

***Current adoption status*:** A few states are currently sharing data; MOUs, data standards, methods of identifying individuals, and encrypting data vary across states and data-sharing initiatives.

***Barriers to adoption*:** Need to complete PDMP implementation and enhancements in some states, completing standardization of exchange hubs to PMIX architecture, and states' statutory, regulatory, and resource limitations.

B. Collaborate with other health agencies/organizations in applying and linking PDMP data

***Rationale*:** PDMP collaboration with health agencies, such as by matching PDMP data with other medical information, promises to improve patient protection, safety, and health, and increase health data accuracy and interagency communication. It will also increase the visibility and penetration of PDMPs in multiple health contexts, while fostering development of best practices in data integration across systems. Recent experience in Washington State involving the batch transfer of PDMP data on Medicaid patients (see **User access and report dissemination, B. Optimize reporting to fit user needs**, above) strongly suggests that collaboration with public health agencies will be effective in helping to improve controlled substance prescribing, and mitigate prescription drug abuse and diversion. Below we describe the status of some current and prospective initiatives that suggest the importance of integrating major health systems with PDMPs to maximize the value of prescription data.

***Current adoption status and evidence of effectiveness*:**

1. Department of Veterans Affairs

   The VA was granted statutory authority to share its prescription data with state PDMPs in the Budget Reconciliation Act of 2011. The sharing can begin only after the VA completes regulations authorizing it. Regulations, systems, and protocols to support VA-PDMP data sharing could be documented and evaluated as models for other interorganizational collaborations in addressing prescription drug abuse and diversion. Cooperative work with the VA may also open up new and important avenues for research that could lead to improved medical care and patient safety. For example, if PDMP data can be matched to medical care treatment in VA records, a more thorough understanding of the progression of proper opioid prescribing could be gained, as well as a better understanding of iatrogenic opioid addiction.

2. Indian Health Service

   The IHS is working with BJA, IJIS Institute, the PDMP Training and Technical Assistance Center, and the PDMP COE to share its pharmacies' data with state PDMPs. The effort includes development of software enabling IHS pharmacies to put their data into the formats each state requires for pharmacy data collection and subsequent transfer of data to each PDMP. Efforts will be undertaken to establish PDMP accounts for IHS prescribers and pharmacists so they can access PDMP data for their patients, with accompanying training in use of PDMP data. In

addition, new methodologies need to be developed and authorized for IHS professional supervisors to obtain and review PDMP data as they pertain to the practices of prescribers and dispensers within the IHS system. The IHS system includes quality assurance practices in which professional supervisors oversee the work of prescribers and dispensers. PDMPs have not previously provided data to health care systems' quality control mechanisms, with the exception of North Dakota and South Dakota, which authorize peer review committees to access data.

Study of the IHS data-sharing initiative will assist PDMPs in their efforts to link with other health care systems, including the VA, DoD, and CMS. This is particularly important because VA pharmacies use the same pharmacy software system as IHS pharmacies. Successful implementation of IHS pharmacy systems for sharing data with state PDMPs will therefore expedite the VA's ability to send data to state PDMPs when their regulations are completed.

3. Department of Defense

The DoD health care system is discussing the possibility of linking its pharmacy data with PDMPs and making state PDMP data available to its prescribers and pharmacists. Given reports on the extent of controlled substances abuse and misuse among military personnel and their families, this effort is important and should be brought to fruition. Linkage is needed with the DoD health care system (for active duty personnel) and Tricare (for dependents and retired military personnel). Legislation authorizing sharing of data between DoD facilities and PDMPs may be required as a prerequisite to sharing.

4. Centers for Medicare and Medicaid Services

Sixteen states have made PDMP data available to their state Medicaid agencies and/or fraud investigation units, and the GAO has recommended increasing use of PDMPs by Medicaid agencies and Medicare. The Alliance of States with Prescription Monitoring Programs' PMP Model Act 2010 Revision also recommends providing PDMP data to Medicaid agencies and Medicare (ASPMP, 2010). However, there is no linkage of PDMPs with the Medicare program, and, as yet, very limited national level policy dialogue with the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) regarding the coordination of PDMPs with the Medicaid and Medicare programs. Such a dialogue is important because multiple potential best practices could be considered, including:

- Documenting how state Medicaid agencies have used the PDMP data they have received, and how that may have impacted the quality and cost of care for Medicaid recipients.
- Developing recommended audit procedures for state Medicaid agencies and Medicare organizations to use with PDMP data to identify and monitor persons who should be locked in to single prescribers and pharmacies, i.e., placed in restricted recipient programs.
- Developing Medicaid and Medicare policy on encouraging or mandating prescribers to obtain PDMP data prior to issuing the first controlled substance prescription to a patient and periodically thereafter.
- Developing procedures for Medicare program reviewers or auditors to access and utilize PDMP data and developing model state legislation to authorize such access.

5. Private third-party payers

> The Coalition Against Prescription Fraud has identified that private insurance payers expend in excess of $24.9 billion annually for enrollees who abuse opioid prescriptions (Coalition Against Insurance Fraud, 2007). Workers' compensation programs that pay claimants' costs for treatment and rehabilitation following work-related accidents have found opioid misuse to be a significant problem. A recent WorkCompCentral news release stated, "The use of opioids in the nation's workers' compensation systems remains a top concern of major insurers, state regulators, and third-party administrators, according to a survey conducted by the president of a consortium of pharmacy benefit managers" (WorkCompCentral, 2012)**.** The National Council on Compensation Insurance found that a single opioid product had become the highest-costing pharmaceutical for workers' compensation programs (Lipton, 2011).

One study suggests that PDMPs are associated with lower claim rates for opioid analgesics at the county level (Curtis et al., 2006), but additional research on the role PDMPs can play in reducing costs is needed. Insurers with policies limiting patients to one prescriber and pharmacy (lock-ins) could suggest or require that prescribers consult PDMP data to confirm patient compliance. The PDMP COE is planning to follow the Office of National Drug Control Policy's call for the PDMP COE to convene a meeting with PDMPs and third-party payers in order to open dialogue regarding how they may coordinate activities and work together to interdict the national prescription drug abuse epidemic (ONDCP, 2011). A major topic to be explored is the potential sharing of PDMP data with all third-party payers.

***Barriers to adoption*:** Developing collaborative data-sharing agreements and the requisite information-sharing protocols with the agencies mentioned above will involve regulatory and policy changes at the state and national levels involving multiple stakeholders. This will require sustained commitment from leaders in the PDMP community and their counterparts within each agency to ensure the allocation of adequate attention and resources.

Summary

***Rationale*:** Coordination of PDMPs with wider health systems will enable enhanced use of PDMP data to improve prescribing and patient health and, as a byproduct, to reduce excess public and private costs.

***Evidence of effectiveness*:** Expert opinion (ASPMP Model Act), accumulated experience.

***Current adoption status*:** Data sharing between IHS facilities and PDMPs is under way and between Medicaid programs and PDMPs; the VA is working on regulations to implement such sharing, and the PDMP COE is planning an initial meeting with third-party payers.

***Barriers to adoption*:** Regulatory and organizational.

Evaluation of PDMPs

Evaluation practices and use of evaluation findings for quality improvement enable PDMPs to respond to changing demands and conditions, and ensure their systems and policies permit maximum appropriate use of high-quality, timely PDMP data. Candidate practices include actions to:

A. Conduct satisfaction and utilization surveys of end users
B. Conduct audits of PDMP system utilization for appropriateness and extent of use
C. Use PDMP data as outcome measures in evaluating program and policy changes
D. Analyze other outcome data (e.g., overdoses, deaths, hospitalizations, ER visits) to evaluate the PDMP's impact

A survey of PDMP administrators conducted in 2006 found that two states out of 18 responding (and 23 PDMPs active at the time) had completed or were conducting evaluations of the public health impact of PDMP implementation (Katz et al., 2008). Currently, three states have worked with researchers to produce evaluation reports of their PDMP: Kentucky (Blumenschein et al., 2010), Maine (Lambert, 2007), and Virginia (Virginia Department of Health Professions, 2004). At least six others have contracted with researchers to conduct evaluations (Kansas, Massachusetts, North Carolina, North Dakota, Oregon, and Washington), and other states are in discussions with researchers regarding evaluations and other work (e.g., Florida and Texas). This increase appears to reflect a growing interest by PDMP administrators in addressing end-user needs (e.g., timely and accurate provision of data to prescribers, pharmacists, law enforcement agencies, regulatory agencies, and others) and in demonstrating program utilization and impact, to assure state legislators that the PDMP is a good investment in an environment of scarce resources.

A. Conduct satisfaction and utilization surveys of end users

***Rationale*:** Satisfaction and utilization surveys of PDMP users can provide important feedback for purposes of program enhancement and increasing user buy-in. Such surveys can be conducted online, by mail, or by phone, and give PDMP administrators insight into aspects of their system that are working well, areas for improvement, and barriers to greater use of the PDMP. Surveys can help build support of the PDMP by end users, who can be important allies in passing legislative changes desired by the PDMP and in securing stable funding.

***Current adoption status and evidence of effectiveness*:** Kentucky, Maine, Massachusetts, and Virginia have reported findings from satisfaction and utilization surveys of end users of their PDMPs (e.g., Rosenblatt, 2007; Sorg et al., 2009; and survey reports linked at the Kentucky PDMP website). Survey feedback from law enforcement and regulatory agencies led Massachusetts to develop an online PDMP

portal for their use in active investigations. Accentra Health, in partnership with the Oregon Health Sciences University and the Oregon PDMP, is conducting a survey of prescribers to learn how they use PDMP data in clinical decision making and how these data affect their prescribing practices.

***Barriers to adoption*:** Barriers to conducting surveys include lack of staff time and expertise to design and field surveys, and to analyze and report out data. However, states can look to other PDMPs to assist in developing survey instruments (e.g., by modifying existing instruments), and methods for data collection and analysis.

B. Conduct audits of PDMP system utilization for appropriateness and extent of use

***Rationale*:** As discussed earlier, a PDMP's usefulness is maximized if the most active prescribers make frequent use of the PDMP. PDMP utilization audits can show how often these prescribers query the database and download reports. Audits can also be conducted to gauge the impact of viewing prescription history data on prescribing practices. For example, an audit might examine a prescriber's prescriptions for a patient following a query of the PDMP on that patient, to determine whether any of the controlled substance indicators found to be associated with risk for abuse or overdose were present. An alternative audit might compare a prescriber's prescriptions for a patient prior to and following one or more queries of the PDMP about that patient. Such audits could be conducted for multiple prescribers and patients, if longitudinal data exists. Audits can also track PDMP utilization by level of prescribing, medical specialty (if this information is made available to the PDMP), and the level of suspected questionable activity within a practice. As mandates for PDMP utilization are adopted, audits will become increasingly relevant for determining prescriber and dispenser compliance.

***Current adoption status and evidence of effectiveness*:** To our knowledge, no states are systematically auditing PDMP utilization data to evaluate appropriateness of use. However, some states are taking steps prior to such evaluation. Utah, upon determining that many of the most frequent 25 percent of prescribers were not registered with the PDMP, contacted these prescribers to remind them that Utah's law requires that they register with the program. Within one day, more than 100 of these prescribers registered with the PDMP (presentation at West Regional PDMP meeting, 2010). Massachusetts is also contacting prescribers with high proportions of possible doctor shoppers in their practices, recommending that they enroll in and use the PDMP (communication with Massachusetts PDMP). Utilization data of these prescribers could be analyzed to monitor how often they query the PDMP. We expect that states instituting mandates for utilization (e.g., Kentucky, Massachusetts, New York, and Tennessee) will begin regular audits of prescriber queries to their PDMPs.

***Barriers to adoption*:** The primary barrier to auditing PDMP utilization is the staff time required to extract and examine data. States that adopt mandates for use will of necessity have to shift resources to conducting compliance audits. This may reduce resources for other activities unless additional funds and staff are made available.

C. Use PDMP data as outcome measures in evaluating program and policy changes

***Rationale*:** While PDMPs can have an impact on prescription drug overdoses and other health outcomes, many other factors not under the control of the PDMP can affect such outcomes. A more proximate outcome for PDMP activities is the number of patients possibly engaged in abuse or diversion. As discussed previously (see **Data linking and analysis, C. Conduct periodic analyses of questionable activity**, above), this outcome can be measured to an extent using PDMP data. Similarly, as valid and reliable indicators of suspected problematic prescribing on the part of individual providers become available using PDMP data, these too could serve as outcome measures to track the impact of efforts to curtail such prescribing.

***Current adoption status and evidence of effectiveness*:** Wyoming has tracked the number of patients meeting a threshold for doctor shopping following the PDMP's initiation of unsolicited reporting, and found that this number declined markedly over a two-year period, suggesting the effectiveness of unsolicited reporting. A second effect noted by the Wyoming PDMP was an increase in prescriber registration with and use of the PDMP paralleling the distribution of unsolicited reports (NFF 1.1). Nevada's PDMP noted similar trends in both the number of patients meeting the threshold for doctor shopping and in prescriber registration with the PDMP following its initiation of unsolicited reporting (NFF 2.5). Unpublished data from Oklahoma and North Carolina on trends of doctor shopping rates show similar effects: As use of the PDMP increases, numbers of individuals meeting thresholds for questionable activity as measured by PDMP data decline (communications with Oklahoma and North Carolina PDMPs).

***Barriers to adoption*:** Limited PDMP resources may affect the extent to which data analyses on outcome measures constructed using PDMP data can be designed and carried out, and then integrated with process evaluation data on program activities that might influence these measures, for instance efforts to increase utilization and send unsolicited reports.

D. Analyze other outcome data (e.g., overdoses, deaths, hospitalizations, ER visits) to evaluate the PDMP's impact

***Rationale*:** As noted, a number of factors can affect health outcomes besides PDMP operations. This fact has complicated studies of the impact of PDMPs across states (e.g., Simeone & Holland, 2006; Paulozzi et al., 2011), to the point where an effect of PDMPs or a PDMP practice (in these cases, unsolicited reporting) is difficult to detect, at best. An alternative approach, planned in several states but not yet implemented, is to examine *changes in* health outcomes such as overdose rates at the county level within a state, in relation to: (1) the proportion of prescribers in each county who have registered with the PDMP and regularly query it, and (2) specific PDMP practices, such as unsolicited reporting (e.g., the proportion of patients in a county about whom unsolicited reports have been sent, or the proportion of prescribers in a county to whom an unsolicited report has been sent).

It is important to examine changes in health outcomes in relation to these PDMP-related factors because high rates of such outcomes may well have triggered a response by the PDMP (unsolicited reports) or practitioners (registration with and use of the PDMP). A study would test for decreases in adverse health

outcomes, by county, subsequent to the presence of these factors. Sufficient time, perhaps years in some cases, may be needed to measure these impacts as persons experiencing overdoses have frequently been abusing prescription drugs for multiple years. An effective intervention may prospectively reduce the numbers of new persons from meeting DMS IV criteria for dependence on or abuse of prescription opioids or other controlled substances, but may be less protective for those already meeting those criteria.

***Current adoption status and evidence of effectiveness*:** Although a number of states have recognized the value of evaluating PDMP activities, to our knowledge no states have completed systematic empirical studies of their effectiveness using health outcome data such as described above. Nor have there been studies of the impact of a PDMP's evaluations of any sort—that is, of whether PDMPs that are conducting or have conducted evaluations are more effective than those that have not. However, with respect to PDMP impact on health outcomes, it should be noted that overdose death and prescription monitoring data from Wilkes County in North Carolina gathered by Project Lazarus (www.projectlazarus.org) suggest that an increase in use of the North Carolina PDMP by county prescribers may have contributed to a sharp decrease in their controlled substance prescribing to county resident overdose decedents. This in turn may have been a factor in the decline in the yearly number of overdose deaths among county residents from 2008 to 2011 (PDMP COE, NFF 3.2).

***Barriers to adoption*:** The level of effort required to design and field PDMP evaluations using health outcome data is considerable, requiring intensive data collection and analysis over a multiyear period. Most PDMPs will not have the trained evaluators needed to conduct such evaluations, but universities and private research institutions are often willing to form partnerships with PDMPs in such endeavors given the increased interest in PDMP studies, provided that funding can be identified for their work.

Summary

***Rationale*:** Evaluation of PDMP activities can inform and improve activities and demonstrate the value of a PDMP.

***Evidence of effectiveness*:** Accumulated experience.

***Current adoption status*:** At least 10 states have evaluated or are evaluating their PDMP using satisfaction surveys and outcome measures constructed from PDMP data; a few are planning health outcome evaluations.

***Barriers to adoption*:** Primarily resources needed to conduct or contract for an evaluation.

Funding PDMPs

Best practices in consistent, long-term funding will enable a stable platform for PDMPs to operate, implement new technologies as needed, and maintain sufficient staffing levels. Adequate funding facilitates data access for authorized users, implementation of interoperability between PDMPs, and effective analysis of prescription information. Candidate best practices in funding include efforts to:

A. Secure funding independent of economic downturns, conflicts of interest, public policy changes, and changes in PDMP policies

B. Enact legislation to maintain sufficient funding over time

C. Conduct periodic review of PDMP performance to ensure efficient operations and identify opportunities for improvement

Note: Information discussed in this section comes from a survey of state PDMPs conducted by the PDMP Training and Technical Assistance Center at Brandeis University, interviews with PDMP administrators, and analyses of data reported to BJA by PDMPs receiving funds under the Harold Rogers Prescription Drug Monitoring Program Grant Program.

A. Secure funding independent of economic downturns, conflicts of interest, public policy changes, and changes in PDMP policies

***Rationale*:** To ensure a viable and effective PDMP in a time of shrinking public revenues, prescription monitoring advocates and stakeholders must take advantage of all available funding opportunities. These fall into four general categories: grants, licensing fees, general revenue, and board funds. Other less common sources of support include settlements, insurance fees, private donations, and asset forfeiture funds.

***Current adoption status and evidence for effectiveness*:** As described below, many PDMPs employ more than one method of securing financial support, each of which has its advantages and disadvantages.

a. Grants. There are 36 PDMPs that receive funding through some type of grant (federal: 36 PDMPs; industry: 2 PDMPs; state: 1 PDMP). Grant funding can be used to start planning the establishment of a PDMP (BJA Harold Rogers grants), implement a PDMP (Harold Rogers and NASPER[7] grants), operate a PDMP (National Association of State Controlled Substances Authorities [NASCSA] grants), enhance a PDMP (Harold Rogers, NASPER, and NASCSA grants), and promote a PDMP through education (NASCSA grants). Currently, there are 18 PDMPs that have grants as their sole funding source; 14 of them passed enabling legislation or have become operational since 2007. The availability of grant funding has facilitated the creation or enhancement of the majority of PDMPs. However, there are problems in relying on grants to fund a PDMP. Funds are limited in amount, often made available only for specific purposes, subject to periodic renewal, and limited in duration; there is no guarantee that a PDMP will receive a grant award or a renewal.

b. Licensing fees. There are 15 PDMPs that receive funding through a registrant's licensing fee. A state may assess a fee for prescribing/dispensing controlled substances or to practice medicine or pharmacy; a portion of the collected fees are used to support the PDMP. There are 14 PDMPs that obtain funding from controlled substance registry license fees, and three that obtain funding from state health license fees. There are

[7] The NASPER grant program is currently unfunded but has provided support to PDMPs in earlier years.

currently five PDMPs that have licensing fees as their sole funding source; four became operational prior to 2007. Although licensing fees provide a steady source of funding, in most cases, the percentage of the licensing fee allocated to the PDMP is small. In order to increase the percentage or amount, legislative action may be required. Some licensees may have objections to supporting a program that they may not use routinely.

c. General revenue. There are 10 PDMPs that receive funding through dedicated monies from a state's general revenue fund. There are four PDMPs that have general revenue monies as their sole funding source, all of which became operational prior to 1997. Although funds from a state's general revenue fund provide a steady source of support, the amount can be influenced by economic and political conditions. In times of economic distress, a state may be forced to reduce budgets or reapportion monies. Programs that increase public and lawmakers' awareness of PDMP's contribution to addressing the prescription drug epidemic, and that demonstrate its role in reducing health-related costs, will be most successful in securing general revenues.

d. Board funds. There are six PDMPs that receive funding from monies allotted to licensing boards, most commonly boards of pharmacy; two have board funds as their sole funding source. Although board funds provide a steady source of support, in most cases the percentage of the funds allocated to the PDMP is small. Additionally, a board has several responsibilities requiring funds, so increasing funds or providing adequate funds for a PDMP may be difficult, if not impossible. Some licensees may disagree about supporting a program that they may or may not use routinely.

e. Other. This category of funding is less common, but reflects the varied funding options that can be employed:

- Settlements—Two PDMPs are funded through monies obtained from settlements: one settlement from a pharmaceutical company and one from tobacco companies. Settlements can result in a large amount of funds for a PDMP, but they are finite and, typically, the settlement money is deposited into a state's general revenue fund.

- Insurance fees—One PDMP is funded through fees on health insurance providers. Even though the insurers reap savings by utilizing a PDMP, there may be resentment that the cost of the PDMP is borne solely by those with insurance.

- Private donations—One PDMP has established a direct support organization, a 501(c)(3) corporation, to raise funds for the PDMP. This is a creative way to provide monies for a PDMP, but fundraising efforts must be maintained, could result in conflicts of interest, and do not guarantee consistent funding over time.

- Asset forfeiture funds—One PDMP receives asset forfeiture funds from sheriffs' offices and police departments, donated through its direct support organization.

The current funding mechanisms have both positive and negative aspects. Ideally, funding should be obtained from those entities that benefit from the existence of the PDMP, contribute to the prescription drug abuse problem, or profit from the sale of controlled substances.

Those that benefit from PDMPs include prescribers, dispensers, health licensing boards, law enforcement agencies, insurance providers, hospitals, medical examiners, and substance abuse treatment programs (see **PDMP recruitment, utilization and education, A. Enable access to PDMP data by all appropriate users**, above, for others).

- In many cases, some of these beneficiaries are currently funding PDMPs. As an alternative to a flat fee, fees could be determined by the number of prescriptions or dosage units prescribed and dispensed, number of patients receiving controlled substances, etc.
- A source for funding PDMPs that could be expanded is monies from contributors to the prescription abuse problem. The diversion of prescription medications is nationwide. Individuals are arrested and convicted for diversion, and law enforcement agencies are seizing assets obtained from the illegal proceeds. Law enforcement agencies could contribute such funds voluntarily (see "**Asset forfeiture funds**" above) or a "PDMP fine" could be assessed by a court, which could provide some funding for a PDMP. If a PDMP were instrumental in assisting a law enforcement agency in a diversion investigation, it arguably has a legitimate claim to share the assets obtained as a result of the investigation.

  The entities that profit from sales of controlled substances—manufacturers and distributors—are a largely untapped source for funding. Manufacturers could be assessed a fee on the volume of controlled substances produced, and distributors on the number of controlled substances sold.

***Barriers to adoption*:** Barriers to securing funding by the means described above include opposition from those wanting to limit prescription monitoring, lack of PDMP leadership to spearhead funding initiatives, failure to include all stakeholders in advocating for PDMP support, lack of public awareness of the benefits of PDMPs, and lack of resources and expertise to apply for grants or establish nonprofit corporations.

B. Enact legislation to maintain sufficient funding over time

***Rationale*:** To ensure that a PDMP is adequately funded, states could draft legislation that not only provides monies for effective operation, but also incorporates new technologies and methodologies, as needed. Legislation can specify the source of funds, for what they can be used, and other permissible funding options.

***Current adoption status*:** Below are examples of legislative language on funding, one from the Alliance of States with Prescription Monitoring Programs PMP Model Act and three from Louisiana, Texas, and Florida. Other states' legislative language (not limited to that concerning funding) is available at the Alliance of States with Prescription Monitoring Programs' website (www.pmpalliance.org/content/pmp-laws-and-rules).

The Alliance of States with Prescription Monitoring Programs' PMP Model Act 2010 Revision recommends the funding come from prescribers (ASPMP, 2010). It states, in part:

- "The [designated state agency] may charge each prescriber an amount sufficient to cover the costs of . . . operating the prescription monitoring program. [Note: States may choose to use an alternative method . . . to pay the cost of their . . . monitoring system, for example, through controlled substances registration fees.]"

Louisiana's PDMP statute allows the state's pharmacy board to obtain grant funding if the legislature does not provide full funding. It states, in part:

- "The Board shall have the authority to make application for, receive, and administer grant funding from public or private sources for the development, implementation, or enhancement of the prescription monitoring program."
- "In the event the legislature provides full funding for the prescription monitoring program, no fees shall be levied as provided in this Section."

Texas's statute requires that controlled substance registration fees be used to cover the costs of the PDMP and that the funds can be used only for administration and enforcement of the Controlled Substances Act. The statute also sets a maximum fee amount. It states, in part:

- "The director may charge a nonrefundable fee of not more than $25 before processing an application for annual registration and may charge a late fee of not more than $50 for each application for renewal the department receives after the date the registration expires. The director by rule shall set the amounts of the fees at the amounts that are necessary to cover the cost of administering and enforcing this subchapter."
- "The director shall deposit the collected fees to the credit of the operator's and chauffeur's license account in the general revenue fund. The fees may be used only by the department in the administration or enforcement of this subchapter."

Florida's statute requires that funding come from federal grants or private funding. It establishes a direct-support organization to seek those funds. It states, in part:

- "All costs incurred by the department in administering the prescription drug monitoring program shall be funded through federal grants or private funding applied for or received by the state. The department may not commit funds for the monitoring program without ensuring funding is available. The department and state government shall cooperate with the direct-support organization . . . in seeking federal grant funds, other non-state grant funds, gifts, donations, or other private moneys for the department so long as the costs of doing so are not considered material. Funds provided, directly or indirectly, by prescription drug manufacturers may not be used to implement the program."
- "The department may establish a direct-support organization that has a board consisting of at least five members to provide assistance, funding, and promotional support for the activities authorized for the prescription drug monitoring program.

***Evidence for effectiveness*:** To our knowledge, no systematic study relating legislation on funding to actual PDMP support has been conducted. However, it seems likely that language making provisions for PDMP funds tied to specific sources that will remain available, e.g., provider licensing fees, increases the probability of stable funding.

***Barriers to adoption*:** Enacting legislation to provide stable funding for PDMPs requires marshaling majorities in legislative bodies, which in turn requires building popular support for these programs. As noted above, prescription monitoring advocates may face opposition from those wanting to limit the effectiveness of PDMPs, so they must forge alliances with all concerned stakeholders to ensure sufficient support for the legislation by lawmakers and their constituents.

C. Conduct periodic review of PDMP performance to ensure efficient operations and identify opportunities for improvement

***Rationale*:** A periodic review is beneficial and recommended when a program is funded by monies from public sources or assessed fees. The purposes for the review should be to assess the overall effectiveness of the program, evaluate current performance, evaluate staffing levels, evaluate technological capabilities, and identify areas for improvement. The goals of the review are to ensure the PDMP is operating efficiently and having a positive effect on the health care of citizens, while reducing the incidence of prescription drug abuse and diversion. It also reinforces the perception (and reality) of program accountability. The review should provide specific recommendations to enhance the PDMP's effectiveness and adjust funding levels accordingly. The review should be conducted by stakeholders impacted by the PDMP, such as representatives from health care, regulatory, law enforcement agencies, and patient advocacy entities. Reviews can be coordinated with and draw from internal PDMP evaluations (see **Evaluation of PDMPs**, above).

***Current adoption status and evidence of effectiveness*:** As noted above, a few states have conducted or are in the process of conducting evaluations of their PDMPs. To date, there has been no systematic study of how such evaluations may have influenced funding decisions on the part of legislatures or other funding sources. However, since findings from PDMP satisfaction surveys of PDMP users (primarily prescribers) in states such as Kentucky and Ohio have been very positive, they have likely played a role in motivating continued funding for PDMPs in these states.

***Barriers to adoption*:** PDMPs may not have the resources or expertise to carry out comprehensive program reviews.

Summary

***Rationale*:** Stable and adequate funding of PDMPs is essential for consistent operation and optimum utilization.

***Evidence of effectiveness*:** Accumulated experience, key stakeholder perceptions.

***Current adoption status*:** States differ widely in their approaches to funding PDMPs.

***Barriers to adoption*:** Barriers include state revenue shortfalls, difficulties in negotiating legislative and regulatory changes, and the need to build sufficient constituent support to motivate stable funding.

V. Summary and Recommendations

A comprehensive range of potential PDMP best practices has been identified and discussed in this white paper. The primary objective of this review was to summarize the available scientific evidence on each potential best practice identified. The literature review drew from a number of sources, including published, peer-reviewed academic literature; unpublished evaluation reports and case studies; and written opinions and recommendations on PDMP best practices from experts in the field. A secondary objective of the paper was to identify promising areas for future research based on the findings of this review (see **Recommendations for Research and Development of PDMP Best Practices**, below).

Results

Table 1 presents a summary of the type and quality of the evidence identified for each of the 35 potential best practices identified. As described earlier, while published, peer-reviewed research on PDMP effectiveness exists, the empirical evidence is not extensive, and the research base on PDMP best practices is in an even earlier stage of development. For example, accumulated experience and key stakeholder perceptions predominantly form the basis for more than half (21 out of 35) of potential best practices. Research studies and documented expert opinion still need to be developed for these areas:

1. Collect positive ID on persons picking up prescriptions
2. Collect data on method of payment, including cash transactions
3. Integrate electronic prescribing with PDMP data collection
4. Improve data quality
5. Link records to permit reliable identification of individuals
6. Determine valid criteria for possible questionable activity
7. Conduct periodic analyses of questionable activity
8. Develop expert systems to guide analyses and reports
9. Record data on disciplinary status, patient lock-ins
10. Optimize reporting to fit user needs
11. Integrate PDMP data with health information exchanges, electronic health records
12. Publicize use and impact of PDMP
13. Proactively identify and conduct outreach to potential high-impact users
14. Conduct recruitment campaigns
15. Streamline certification and enrollment processing
16. Mandate enrollment
17. Mandate utilization
18. Institute financial incentives
19. Delegate access
20. Evaluation of PDMPs
21. Funding of PDMPs

This set of promising practices was identified through anecdotal discussions with experts in the field, but no research evidence demonstrating effectiveness or formal written documentation of expert opinions was located.

Documented expert opinions or case studies served as the highest level of evidence for an additional six potential best practices:

1. Adopt a uniform and latest ASAP reporting standard
2. Collect data on nonscheduled drugs implicated in abuse
3. Reduce data collection interval; move toward real-time data collection
4. Enable access to data by appropriate users; encourage innovative applications
5. Enact and implement interstate data sharing among PDMPs
6. Collaborate with other agencies and organizations

Thus, we found *research* evidence (excluding case studies) for approximately one-quarter (eight out of 35) of the potential best practices identified in this paper:

1. Collect data on all schedules of controlled substances
2. Institute serialized prescription forms
3. Conduct epidemiological analyses
4. Provide continuous online access to automated reports
5. Send unsolicited reports and alerts
6. Conduct promotional campaigns
7. Improve data timeliness and access
8. Conduct user education

For these eight practices, the research evidence included only observational studies; to the authors' knowledge, no RCTs or meta-analyses of PDMP best practices have been completed to date. Most of this research is unpublished. We found only three PDMP practices—serialized prescription forms, unsolicited reporting, and education—with published, peer-reviewed papers reporting on the effectiveness of the practice. Although a few analyses examined health outcomes, such as decreased prescription drug use or drug-related mortality, many were focused on intermediate or indirect outcomes (e.g., increased PDMP use).

Even among the eight practices with some type of unpublished or published research evidence, the *quantity* of research studies was minimal. Only a few had more than one source of research evidence. Results were inconsistent for the most studied practice, unsolicited reporting. In one study, unsolicited reporting was associated with lower prescription drug sales (Simeone & Holland, 2006), while case studies on Wyoming's and Nevada's PDMPs describe reduced doctor shopping after unsolicited reporting. However, no effect on drug overdoses or opioid-related mortality was found after unsolicited reporting in another study (Paulozzi et al., 2011).

In summary, this analysis identified and reviewed 35 potential PDMP best practices. Overall, the findings indicate that good research evidence is not available for the vast majority of candidate PDMP best practices, as the research in this area is scarce to nonexistent. All of the studies that have been conducted have employed nonexperimental designs. No systematic reviews, meta-analyses, or RCTs

were identified about any of the PDMP practices in either the published, peer-reviewed literature or other sources. Thus, the reviewed practices appear promising, but major gaps exist in the evidence base that should be addressed in future research. Confirmation of their effectiveness is needed using scientific techniques.

Table 1. PDMP Candidate Best Practices: Summary of Evidence

Best Practice	Evidence Hierarchy	Author(s); (Year)	Number of Research Studies	Consistency of Research Findings	Outcomes Examined	Findings
Data collection and data quality						
Collect data on all schedules of controlled substances	3; 4	PDMP COE unpublished analysis (2011); ASPMP (2010)	1	N/A	Reduced doctor-shopping rates	States collecting all schedules have lower rates of doctor shopping than other states.
Adopt a uniform reporting standard	4	ASPMP (2010)	0	N/A	N/A	N/A
Collect data on nonscheduled drugs implicated in abuse	4	ASPMP (2010)	0	N/A	N/A	N/A
Collect positive ID on person picking up Rxs	5	None	0	N/A	N/A	N/A
Collect data on method of payment	5	None	0	N/A	N/A	N/A
Reduce data collection interval; real-time data collection	4	ASPMP (2010)	0	N/A	N/A	N/A
Institute serialized prescription forms	2	Paulozzi et al. (2011)	1	N/A	N/A	Three PDMP states using serialized forms (TX, NY, CA) had lower increases in opioid overdose death rates than states not using these forms.
Integrate electronic prescribing with PDMP data collection	5	None	0	N/A	N/A	N/A
Improve data quality	5	None	0	N/A	N/A	N/A
Data linking and analysis						
Link records to permit reliable identification of individuals	5	None	0	N/A	N/A	N/A
Determine valid criteria for questionable activity	5	None	0	N/A	N/A	N/A
Conduct periodic analyses of questionable activity	5	None	0	N/A	N/A	N/A
Conduct epidemiological analyses	3	PDMP COE unpublished analysis (2010)	1	N/A	Identification of possible pill mills	Analyses of states neighboring GA allowed identification of possible pill mills in GA.
Develop expert systems to guide analyses	5	None	0	N/A	N/A	N/A
Record data on prescriber disciplinary status and patient lock-ins	5	None	0	N/A	N/A	N/A
User access and report dissemination						
Provide continuous online access to automated reports	3; 4	VA 2010 PDMP data (unpublished analysis, 2010); PDMP COE, NFF 2.6 (2011); ASPMP (2010)	2	Consistent (increased PDMP use)	Increased PDMP utilization; reduced doctor shopping	After this change in VA, the number of data queries increased and the number of individuals meeting doctor-shopping criteria decreased (VA 2010 data); increased use by VA medical examiners (NFF 2.6).
Optimize reporting to fit user needs	5	None	0	N/A	N/A	N/A
Integrate PDMP data with health information exchanges, electronic health records	5	None	0	N/A	N/A	N/A

Table 1. PDMP Candidate Best Practices: Summary of Evidence (continued)

Best Practice	Evidence Hierarchy	Author(s); (Year)	Number of Research Studies	Consistency of Research Findings	Outcomes Examined	Findings
Send unsolicited reports (URs) and alerts	2,3,4	Paulozzi et al. (2011); Simeone & Holland (2006); PDMP COE, NFF 2.5 (2011); PDMP COE, NFF 1.1 (2010); ASPMP (2010)	4	Inconsistent	Reduced Rx sales, drug overdoses, opioid-related mortality, doctor shopping	URs associated with decreased Rx sales (S & H 2006); no effect of URs on drug overdoses or opioid-related mortality but may reduce supply (Paulozzi et al., 2011); in WY, reduced doctor shopping after URs (NFF 1.1); in NV, reduced number prescribers, dispensers, and dosage units for individuals for whom URs were sent (NFF 2.5).
Publicize use and impact of PDMP	5	None	0	N/A	N/A	N/A
PDMP recruitment, utilization, and education						
Enable access to data by appropriate users	4	PDMP COE, NFF 2.2, 2.3, 2.6 (2011); ASPMP (2010)	3	Consistent (increased PDMP use)	Increased utilization	Case studies suggest that enabling access to additional categories of end users increases PDMP utilization (NFF 2.2, 2.3, 2.6).
Outreach and recruitment strategies						
Proactively identify and conduct outreach to potential high end users	5	None	0	N/A	N/A	N/A
Conduct recruitment campaigns	5	None	0	N/A	N/A	N/A
Streamline certification and enrollment processing	5	None	0	N/A	N/A	N/A
Mandate enrollment	5	None	0	N/A	N/A	N/A
Approaches to increasing utilization						
Conduct promotional campaigns	3	VA 2010 PDMP data (unpublished analysis, 2010)	1	N/A	Increased PDMP enrollment and utilization	After promotional campaign in early 2010, the number of registered users and data queries increased (VA 2010 data).
Improve data timeliness and access	3	VA 2010 PDMP data (unpublished analysis, 2010); PDMP COE, NFF 2.6 (2011)	2	Consistent (increased PDMP use)	Increased PDMP utilization; reduced doctor shopping	After this change in VA, the number of data queries increased, and the number of individuals meeting doctor-shopping criteria decreased (VA 2010 data); increased use by VA medical examiners (NFF 2.6).
Conduct user education	3	Cochella & Bateman (2011); Fisher et al. (2011a)	2	N/A	Reduced Rx opioid death rate, improved provider prescribing behaviors; reduced meperidine (MEP) use	Provider detailing associated with reduced Rx opioid death rate and improved provider prescribing behaviors; PDMP prescriber educational intervention associated with reduced MEP use (Fisher, 2011a).
Mandate utilization	5	None	0	N/A	N/A	N/A
Institute financial incentives	5	None	0	N/A	N/A	N/A
Delegate access	5	None	0	N/A	N/A	N/A

Table 1. PDMP Candidate Best Practices: Summary of Evidence (continued)

Best Practice	Evidence Hierarchy	Author(s); (Year)	Number of Research Studies	Consistency of Research Findings	Outcomes Examined	Findings
Interorganizational best practices						
Enact interstate data sharing among PDMPs	4	ASPMP (2010)	0	N/A	N/A	N/A
Collaborate with other agencies/ organizations	4	ASPMP (2010)	0	N/A	N/A	N/A
Evaluation of PDMPs	5	None	0	N/A	N/A	N/A
Funding of PDMPs	5	None	0	N/A	N/A	N/A

The evidence hierarchy focuses on study design, with the following rating scale:

Type 1: Published or formally documented studies or consensus statements:

1=Randomized controlled trial (RCT) or meta-analysis

2=Observational study with comparison groups

3=Observational study without comparison group

4=Case study or written documentation of expert opinion

Type 2: Anecdotally reported experience and perceptions:

5=Accumulated experience and/or key stakeholder perceptions

Number of research studies includes RCT or meta-analyses, observational studies with and without comparison groups, and case studies.

Consistency of findings: for any given practice, the extent to which reported research findings have the same direction of effect (Consistent, Inconsistent, N/A=Unknown or not applicable (e.g., different outcomes, single study, or no studies)

Recommendations for research and development of PDMP best practices

Our review of candidate best practices for PDMPs indicates that several practices, such as collecting prescription information on all schedules of controlled substances, shortening the data collection interval, using the most recent ASAP standard, and providing continuous online access to prescription data, are already widely adopted or constitute long-term program goals for many PDMPs. Having plausible rationales, they will likely become universal or nearly universal among PDMPs, even if documented evidence supporting their effectiveness has not yet been forthcoming. In contrast, many other candidate practices, some with a preliminary evidence base, have not thus far been widely adopted, despite having plausible rationales.

In this section, we recommend research and development focused on a subset of practices that in our judgment show the most promise in increasing the effectiveness and impact of PDMPs. This judgment incorporates the following considerations: 1) the need to assure the accuracy, completeness, and consistency of PDMP databases as a necessary underpinning for all aspects of PDMP data utilization; 2) the need to optimize all subsequent phases of PDMP operations, including data preparation, analysis, reporting, recruitment of users, and utilization of data; 3) the impact of a practice on enhancing other PDMP capacities and functions, and maximizing PDMP effectiveness, were it widely adopted; 4) the feasibility of implementing the practice; and 5) the extent to which the practice serves to integrate PDMPs into the wider public health and public safety systems.

In addition, we have focused on practices with the potential for research that can produce strong evidence in support of the practices—that is, practices that can be studied by either a randomized controlled trial or an observational study with a comparison group. This is not to suggest that candidate practices surveyed above but unmentioned here are not worthy of research, development, and adoption as best practices, should findings prove positive. We offer this simply as an informed prioritization that may need revision in light of further developments in the field and the research itself.

The recommendations for research and development are:

A. Data collection and data quality

B. Linking records to identify unique individuals

C. Unsolicited reporting and alerts

D. Valid and reliable criteria for questionable activity

E. Medical provider education, enrollment, and use of PDMP data: the question of mandates

F. Extending PDMP linkages to public health and safety

A. Data collection and data quality

The accuracy, completeness, and consistency of PDMP databases are prerequisites for the reliability and effectiveness of PDMP data analysis, reporting, and utilization. All users rely on the data they receive from PDMPs. Prescribers and pharmacists depend on the data to make good clinical care decisions; drug

treatment programs and office-based opioid treatment physicians depend on the data when making treatment decisions; state Medicaid agencies and workers' compensation depend on the data to fill in missing data regarding their enrollees' obtaining of controlled substances; medical examiners depend on the data when determining causes of death; and investigators depend on the data to determine how and what to investigate. All statistical summaries, epidemiological research and evaluation, and geospatial analyses also depend on the data.

As noted previously (see **Data collection and data quality, E. Improve data quality: pharmacy compliance, error, and missing data correction**), best practices need to be identified for all stages of data collection and management. Of necessity, PDMPs will have in place some such systems, but there is no accepted data management gold standard by which they can be assessed. Research is needed to survey current PDMP data management practices in order to determine their common objectives, characteristics, and parameters; develop consensus on achievable data quality goals (e.g., pharmacy reporting compliance rates, target error and completeness rates); determine which data management systems and procedures best achieve those goals; and develop a means to promulgate their adoption.

The results of a PDMP data quality research and development program could be modeled on the development and promulgation of ASAP reporting standards: a specification of systems and procedures that have been proven by research and field testing to produce high-quality PDMP data, as recommended by a recognized expert body. Such an initiative could recruit PDMP administrators and vendors to actively engage in data quality improvement and to collaborate with researchers with the relevant expertise. Convening a meeting of PDMP stakeholders to explore such an initiative would be a first step in the process of identifying best practices in improving and maintaining PDMP data quality. Once clearly defined benchmarks for data quality have been established, as well as the best practices for achieving them, PDMPs will be in a position to measure their effectiveness in this domain.

B. Linking records to identify unique individuals

The capability to link prescription records belonging to an individual, a PDMP data preparation function, is critical to providing accurate prescription information to all users and essential for analyzing the impact of PDMPs, e.g., measuring the level of questionable activity as correlated with program operations. This holds for individual PDMPs, PDMPs that share data, and PDMPs and other organizations that collect or use prescription history information such as IHS, the VA, Medicaid, and private third-party payers. As a discrete data processing capability, optimized record linking seems a feasible objective for most PDMPs.

Research is needed to identify standards for assessing linking algorithms, survey current PDMP practices in linking, and evaluate them in light of accepted standards. For instance, a PDMP's linking methods could be tested on a dummy data set and its output (e.g., number of uniquely identified individuals) compared to the output of a highly rated system. Both SAMHSA and the CDC have developed public domain software—Link Plus and The Link King, respectively—that can be applied for linking records within a PDMP database belonging to the same patient. These have been evaluated with respect to each other and to a basic deterministic algorithm, and both were found superior to the deterministic algorithm (Campbell et al., 2008). However, we are not aware of any PDMPs actually using this software.

Typically, an IT vendor to a PDMP will have developed its own proprietary linking software or purchased such software. To date, no standards have been put forth for comparing such proprietary linking software.

Similarly, research is needed to assess methods of identifying unique individuals across data sets, whether of PDMPs or collaborating agencies. This would permit improved integration of PDMP databases with the wider health care system. Unlike many other kinds of health data, PDMP data do not include a unique numerical patient identifier, such as Social Security number. Linking algorithms needs to incorporate multiple fields such as patient name, street address, birth date, and gender, each of which is subject to various kinds of errors. For this reason, linking algorithms typically incorporates probabilistic matching based on "fuzzy" logic. Considerable research has been done in other fields on probabilistic matching, but research is needed to identify optimal linking algorithms using data fields available in PDMP data and their typical error rates.

Besides testing linking algorithms for relative efficiency, evaluations could assess the impact of better record linking on intermediate measures such as estimates of questionable activity, which themselves depend on actual numbers of uniquely identified individuals in a database. The requirements for optimal linking may suggest which data fields PDMPs should collect and which quality controls they should use to reliably identify individuals, whether patients or prescribers. When generating unsolicited reports, improved linking will increase the identification of individuals currently in a prescriber's practice who may need help, and provide more accurate prescription histories. Better identification of individuals and more accurate prescription histories will also improve the quality of solicited reports. Obtaining end-user feedback on unsolicited and solicited reports, pre- or post- any change in record-linking practices, can help assess the extent to which improved linking on the front end improves PDMP output to end users.

C. Unsolicited reporting and alerts

Findings mentioned above suggest that proactive data analyses and reporting of PDMP data to prescribers and pharmacists serve to inform them of possible questionable activity and patients at risk, increase their awareness and utilization of PDMPs, and contribute to lower rates of questionable activity as measured by the subsequent number of individuals meeting a threshold and prescriptions obtained by suspected doctor shoppers. Proactive analyses and reporting to law enforcement and health professional licensing agencies can identify probable pill mills and doctor shopping rings, and expedite the investigation of possible criminal activity, reducing the supplies of controlled substances for abuse and street trafficking. Some, but not all, PDMPs send unsolicited reports to prescribers and pharmacists, and a smaller number send them to law enforcement investigators, regulatory agencies, and licensing boards. This suggests that unsolicited reporting is well within the capacity of PDMPs, hence a feasible best practice. However, currently, just 40 percent of PDMPs send them to prescribers and pharmacies, and only 20 percent send them to law enforcement and professional licensing agencies.

Expansion of unsolicited reporting appears to be a prudent public health measure given the rapid escalation in prescription drug-related emergency department admissions, overdose deaths, and drug

treatment admissions. The evidence currently available regarding unsolicited reporting, the CDC recommendations, and the requirements for NASPER promulgated by SAMHSA also support its expansion, even while additional scientific evidence is sought. Broader distribution of the existing evidence for the effectiveness of unsolicited reporting and education of state legislatures, agency heads, and other policy makers is needed.

In addition, research is needed to confirm scientifically the hypothesis that unsolicited reporting has the effects suggested by the evidence thus far. For example, published studies of unsolicited reporting have not controlled for possible confounding factors influencing prescription behavior, although there are some under way in Massachusetts (MA PDMP) and Nevada (with Abt Associates). The Massachusetts PDMP is conducting an evaluation of the prescription histories of patients about whom unsolicited reports were sent to prescribers, compared with a matched comparison group about whom reports were not sent. The Schedule II prescription histories of both groups are being tracked for the 12 months prior to the reports (and corresponding period for matching comparison group member) and the 12 months following the reports (MADPH presentation at National Rx Drug Abuse Summit, 2012). The CDC has reportedly funded Abt Associates to conduct a randomized controlled trial of the effects of unsolicited reporting in Nevada on the medical claims of Medicaid patients. Results from this latter study will likely not be available for two years. Further studies are needed to assess the systems and impact of unsolicited reports sent not just to prescribers, but to pharmacists, law enforcement agencies, licensing boards, health departments, diversion programs, collaborating health agencies (e.g., VA, Medicaid) and other PDMP users. Such reporting, were it to become a standard practice, would help integrate PDMPs into other health care and public safety systems.

Research could examine the criteria used in selecting individuals for reports; the means by which reports or alerts are generated, validated, and delivered; the end-user response to reports, e.g., changes in prescribing and dispensing; and how data are used in investigations. Research is also needed on the effect of reports on health outcomes and diversion, such as rates of questionable activity; individual-level PDMP data on prescription purchases; data on overdoses, drug-related deaths, and hospitalizations; and numbers and disposition of diversion investigations. Studies can be done of states' current unsolicited reporting initiatives, examining doctor shopping rates and prescription behavior in relation to reporting. Isolating the effect of reports from confounding factors will require more sophisticated studies involving collaboration between PDMPs and partners such as government and academic research institutes.

As evidence regarding the efficacy of unsolicited reporting accumulates, further investigation will be necessary to assess the relative efficiency of systems for delivering reports and alerts. For example, automated systems with the capacity to notify prescribers for all individuals in a state meeting a threshold for questionable activity, who can number in the thousands, need to be developed and tested, especially with regard to minimizing false positives. Electronic alerts, while considerably more cost-effective than sending out unsolicited reports via mail, need to be tested for relative efficacy compared to reports. If they are found to be effective, the minimal resources needed would make them feasible for any PDMP. However, electronic alerts depend on providers registering with the PDMP and providing their e-mail addresses.

D. Develop valid and reliable criteria for questionable activity

As noted above, although some published research exists, there is no science-based consensus on valid and reliable criteria for identifying questionable activity or patients at risk of prescription drug abuse. States vary in thresholds and other criteria use to generate unsolicited reports. Although some patient characteristics, diagnoses, and drug classes, especially being prescribed multiple classes (e.g., pain relievers and anti-anxiety medications), seem to be associated with being at risk, these findings are still preliminary. A PDMP best practice would be to use the "gold standard" for questionable activity. The development of such a standard would therefore significantly increase PDMP effectiveness given the importance of accurate identification of such activity for many PDMP functions and uses.[8]

However, it is possible that criteria for questionable activity vary by state or region, just as drugs of choice for abuse vary. Further research to develop valid and reliable criteria, across all states and/or by region, therefore seems indicated. For example, surveys of prescribers could help validate criteria by obtaining patient-level information: What proportion of patients meeting the criteria were judged to actually have drug-related problems in need of intervention? What proportion were "false positives"—those whose prescriptions were medically necessary? What information about the patient, had it been incorporated into the criteria, might have avoided misclassification? Is there a linear or nonlinear relationship between the extent to which individuals exceed a given threshold and the probability of being at risk? Are certain individual characteristics of doctor shoppers, e.g., gender, age, ethnicity, income, education, and urbanicity, differentially associated with different thresholds? Criteria could also be developed by retrospective analysis: What were the prescription histories, characteristics, and diagnoses of individuals judged by prescribers to have drug abuse or diversion problems in advance of consulting a PDMP database?

Research to illuminate patterns of prescription behavior leading up to meeting a threshold for questionable activity—the "natural history" of doctor shopping—could contribute to predictive models that might enable earlier identification of patients at risk. Such patterns—for instance, how long, on average, individuals stay under a given threshold before meeting it, and how long they stay at or above a threshold—may vary by patient characteristics, diagnoses, geographic area, and state policies related to prescribing and diversion, including the use of PDMPs themselves. These questions could be addressed by conducting longitudinal analyses of PDMP databases and other associated health data sets, ideally matched at the individual level but de-identified to protect patient privacy.

These are just a sampling of the questions that research on criteria for problematic prescription behavior could investigate. Consensus on a coordinated, systematic research agenda could be developed by convening a group of investigators tasked with clarifying study objectives and methods, followed by issuing a request for proposals. Since the development of criteria beyond simple thresholds will likely involve non-PDMP health data, the development process will promote relationships and data

[8] For example, when a medical provider downloads a PDMP report, this is usually to help ascertain whether the patient might have a drug-related problem. Research on thresholds and other criteria for patients potentially at risk would help inform this judgment. PDMPs could automatically flag individuals who meet validated criteria for questionable activity; this flag would show up in downloaded reports, proactively informing prescribers and pharmacists about a possible patient at risk.

linking between PDMPs and other health care systems. A similar research agenda could be developed to identify reliable indicators within PDMP data of questionable prescribing on the part of individual providers or practices.

E. Medical provider education, enrollment, and use of PDMP: the question of mandates

As PDMP data and reports become easier to access, become integrated into health care practice, and gain acceptance as a clinical tool, the question of how to increase use of PDMPs by medical providers becomes increasingly salient, including possible actions up to and including mandating prescriber education about, enrollment in, and use of a PDMP. A handful of states now require that prescribers consult the PDMP database in specific circumstances, such as when prescribing controlled substances for the first time for a new patient and periodically thereafter, or when prescribing methadone for treating pain. Other states are considering such requirements. This suggests that instituting a mandate is an attainable policy objective, should a state decide to pursue it via legislative and regulatory reform.

However, whether mandates should become a best practice depends on proving their feasibility and benefits. Many questions need study: How well, compared to voluntary approaches, do mandates increase the actual use of a PDMP? Is the requirement that all prescribers receive education in the prescribing of controlled substances and use the PDMP, whatever their level of prescribing, the most efficient use of a prescriber's time and PDMP resources? Is mandatory use associated with improvements in patient outcomes, such as lower rates of addiction, overdoses, and deaths? Do states with mandates outperform other states in such measures? Do mandates have unintended consequences, such as leading some providers to discontinue or cut back on controlled substance prescribing? If there were reductions in prescribing, are they accompanied by decreased drug-related morbidity and mortality? Can mandates be successfully enforced, and by what kinds of monitoring and penalties for noncompliance? By what legislative and regulatory means were they instituted?

Investigating these and related questions will require descriptive studies of currently existing mandates and their consequences; studies comparing provider behavior with and without mandates, controlling for other factors; studies of how mandates were instituted; and studies of the feasibility and efficacy of enforcement mechanisms, such as monitoring use of the PDMP. Since lack of participation in PDMPs by prescribers is widely cited as a factor limiting their effectiveness, settling the question of whether mandates are better than voluntary approaches to increasing participation has immediate practical significance that should figure in setting a PDMP research agenda. Moreover, obtaining answers to such questions takes on a new sense of urgency with four states enacting mandates in 2012 alone, and other states considering such legislation.

F. Extending PDMP linkages to public health and safety

A potential best practice examined above was for PDMPs to expand their scope of application to include users beyond prescribers, pharmacists, law enforcement agencies, and professional licensure boards. Case studies carried out by the PDMP COE suggest that PDMP data have additional applications that, when implemented, link PDMPs to other public health and safety systems, potentially increasing the

impact and effectiveness of PDMPs in addressing prescription drug abuse. These studies indicate that in some states, PDMP data are being made available to drug courts, medical examiners, drug treatment programs, and criminal diversion programs. Findings suggest that these data are proving valuable in their respective applications.

Case studies could be developed to document other promising uses of PDMP data and the systems supporting such use. For instance, the Washington State PDMP is making its data available to the Workers' Compensation unit in Department of Labor and Industries. Mississippi's PDMP is contacting individuals whose prescription histories suggest questionable activity. Documenting these initiatives and their outcomes would be a first step in developing an evidence base for the utility of PDMP data in these applications. Studies should be undertaken to explore the uses to which PDMP data are applied by state Medicaid agencies and the impact of such use on the quality, safety, and costs of medical care provided to Medicaid enrollees. Another area for exploration is the feasibility of health care institutional peer review organizations using PDMP data to identify and intervene to correct prescribers' deficiencies and problems. Field research is needed to identify other innovative applications of PDMP data being explored by states that could lend themselves to case studies.

Although findings from case studies serve as important preliminary assessments of novel PDMP data applications, more systematic research and evaluation are needed to establish their value, should it exist, in increasing PDMP effectiveness and impact. The case studies conducted thus far could be followed up by formal studies, for example, of how PDMP data are used in substance abuse prevention and treatment programs and the outcomes of such use, or how, in quantitative terms if possible, PDMP reports enhance the work of drug courts, criminal diversion programs, and drug enforcement investigators. Studies could also be conducted comparing different approaches to how PDMP data are used in specific applications. As the evidence base grows in support of particular uses and the practices supporting their use, their adoption will grow. This, in turn, will increase PDMPs' integration with public health and safety systems, helping to maximize their effectiveness in improving the legitimate use of controlled substances, while mitigating the prescription drug abuse epidemic.

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Appendix A. Published Empirical Studies on PDMP Effectiveness and Candidate Best Practices

Citation	Study Topic	Study Population and Data Source	Study Design	Outcome(s)	Findings
Joranson et al., 2002	Assess perspectives on the effects of PDMPs	Qualitative data from regulatory and pain management reps on PDMP from two meetings in 1998	Qualitative	Multiple	Cooperation and information between PDMPs and pain management groups and education of medical community about PDMPs are needed.
Barrett & Watson, 2005	Physician perspectives on usefulness and effectiveness of pilot PDMP in Virginia	Survey of physicians (n=275, 41 percent response rate)	Descriptive, cross-sectional study	Knowledge of and attitudes toward PDMP	Nearly 60 percent believed their prescribing was being more closely monitored due to PDMP; of these, 23 percent reported it had a negative impact on their ability to manage patients' pain; 68 percent believed PDMP useful for monitoring and decreasing doctor shopping, but only 11 percent had requested PDMP data.
Curtis et al., 2006	Assess geographic variation in opioid use in the U.S. outpatient population	Outpatient Rx drug claims database for 7.8 million subjects with one or more Rx drug claims in 2000	Quasi-experimental: controlled—states or counties with PDMPs vs. those without	Claim rates for opioid analgesics and controlled-release oxycodone	Presence of Statewide Schedule II PDMP associated with lower claim rates at county level.
Hall et al., 2008	Evaluate risk characteristics of West Virginia unintentional Rx overdoses	Medical examiner data, PDMP data and opiate treatment program records on West Virginia residents who died of unintentional Rx overdoses in 2006	Population-based, observational study	Death involving Rx diversion, doctor shopping indicators	63 percent and 21 percent, respectively, of overdose deaths were associated with diversion of Rxs and doctor shopping.
Boeuf et al., 2007	Describe patterns of drug diversion and define profiles of forged prescriptions	National cross-sectional survey on community pharmacies in France, 2001-2004	Cross-sectional study	Profiles of forged prescriptions	Two profiles were developed for suspicious prescriptions.
Katz et al., 2008	Assess current status of PDMPs re: goals, data, data sharing, training, and evaluation efforts	Web survey of PDMP directors with telephone follow-up, 2006 (n=18)	Descriptive, cross-sectional study	Multiple	State PDMPs vary greatly; development of provider guidelines, education, and training are essential.
Pradel et al., 2009	Effect of PDMP implemented in 2004 on doctor shopping for high-dose buprenorphine (HDB)	PDMP records in a French region from 2000 to 2005	Pre-post; no control group	Doctor-shopping ratio: percentage of HDB obtained from doctor shopping; doctor-shopping quantity	After four years of increases in doctor-shopping indicators, the period after PDMP started showed a decrease in indicators and no marked effect on treatment access.
Reisman et al., 2009	Effect of state PDMPs on prescription opioid drug shipments and abuse admissions	Automation of Reports and Consolidated Orders System (ARCOS) data on state prescription opioid shipments and TEDS data on inpatient admissions, 1997-2003	Retrospective ecological cohort study; PDMP states vs. non-PDMP states	Prescription opioid shipments and admissions	PDMPs appear to decrease the amount of opioid shipments and prescription opioid admission rates in states with these programs.

Appendix A. Published Empirical Studies on PDMP Effectiveness and Candidate Best Practices (continued)

Citation	Study Objective(s)	Study Population and Data Source	Study Design	Outcome(s)	Findings
Wang & Christo, 2009	Impact of PDMPs on pain management and controlled substance prescribing	Data on PDMP structure, operations, and evaluations	Comparative analysis of PDMP operations and evaluations	Investigation times, supply of prescription medications, prescribing patterns	PDMPs may reduce abuse of controlled substances.
White et al., 2009	Assess feasibility of using claims data to create models that identify patients at risk for Rx opioid use or misuse	Rx and medical claims for 632,000 privately insured patients in Maine, 2005-2006	Modeling study	Factors predicting prescription opioid abuse	Patient characteristics can be used to predict Rx abuse and misuse (e.g., number of opioid Rxs, early refills, escalating dosages, pharmacy shopping, doctor shopping).
Baehren et al., 2010	Effect of Ohio PDMP (e.g., online access to database) on emergency department prescribing	Clinical management data on 179 ED patients with painful conditions, June/July 2008	Prospective quasi-experimental study	Change in planned opioid prescribing after review of PDMP data	After review of PDMP data, providers changed their prescribing behavior for 41 percent of cases; 61 percent of these resulted in fewer or no opioids prescribed than originally planned.
Katz et al., 2010	Evaluate trends in opioid prescribing, dispensing, and use	Massachusetts PDMP Schedule II opioids Rx records, 1996-2006		Number of Rxs, doses prescribed and individuals receiving Schedule II opioids; questionable activity (QA) measures	Outcome measures all increased from 1996 to 2006; questionable activity estimated as ≥ 4 prescribers and ≥ 4 pharmacies; the percentage of outcome measures associated with QA is small and similar to that in Maine; explores threshold criteria for doctor shopping.
Paulozzi & Stier, 2010	Comparison of drug overdose death rates in New York and Pennsylvania	National Center for Health Statistics data, 2006	Observational study	Rates and rate ratios for non-suicidal drug overdose deaths	Drug overdose death rate 1.6 times higher in Pennsylvania than New York; both states had PDMPs but New York had greater funding and required tamperproof Rx forms.
Rigg et al., 2010	Role of pain clinics in Rx drug abuse and diversion	In-depth interviews with Rx drug abusers in South Florida who use pain clinics as primary source of drugs (n=30)	Qualitative	Characteristics of pain clinics	Pain clinic pill mills only accept cash as payment; method of payment, especially cash, can be indicator of questionable activity (e.g., doctor shopping).
Ulbrich et al., 2010	Factors influencing pharmacists' enrollment in Ohio's PDMP	Online survey of pharmacists in Ohio (n=2,511)	Descriptive cross-sectional study	Factors influencing enrollment	Non-PDMP pharmacists noted time available to access the PDMP report as top factor affecting decision not to enroll in PDMP.
Wilsey et al., 2010	Profiles multiple provider prescribing of opioids, benzodiazepines, stimulants, and anorectics	California PDMP data, 2007	Modeling study	Predictors of multiple provider episodes (MPEs)	MPEs associated with being prescribed different controlled substances simultaneously.

Appendix A. Published Empirical Studies on PDMP Effectiveness and Candidate Best Practices (continued)

Citation	Study Objective(s)	Study Population and Data Source	Study Design	Outcome(s)	Findings
Bohnert et al., 2011	Association between opioid prescribing patterns and opioid overdose-related deaths	Veteran's Health Administration pharmacy data and National Death Index data, 2004-2008, unintentional opioid overdose decedents (n=750) and random sample of patients who received opioid therapy for pain	Case-cohort design	Opioid dose and schedule and risk of overdose deaths	Higher maximum daily opioid doses associated with risk of overdose deaths.
Feldman et al., 2011	Awareness and use of state PDMP by physicians in Ohio	Survey of physicians (n=95, 61 percent response rate)	Cross-sectional survey	PDMP use rates	Awareness was high (84 percent), but less than 59 percent of respondents had used PDMP; medical specialty had effect on awareness and use of PDMP.
Fischer et al., 2011;	Examine impact of PDMPs on opioid use	Opioid dispensing data from representative sample of 2,700 pharmacies in 10 Canadian provinces, 2005-2010	Longitudinal; controlled (PDMP vs. non-PDMP provinces)	Changes in opioid dispensing rates (ODR) between provinces with and without PDMPs	No significant differences in changes in ODRs between PDMP provinces and non-PDMP provinces.
Fisher et al., 2011a	Effect of PDMP prescriber educational intervention on MEP use	Nova Scotia PDMP records on meperidine use, July 2005 to December 2009	Time series	Number of individuals with at least one MEP Rx filled, number of Rxs, and number of tablets dispensed	Intervention was associated with reduced MEP use, after adjusting for long-term trends in use.
Fisher et al., 2011b	Reviews literature on PDMP impact on benzodiazepine (BZD) use	32 articles on the impact of a New York PDMP for BZDs in early 1990s	Review	Use of BZDs	Suggests PDMP decreases BZD use and may help reduce doctor or pharmacy shopping or BZD diversion, though may have unintended consequences for certain subgroups.
Gilson et al., 2011	Impact of 2005 changes to California's PDMP on opioid Rx rates and associated multiple prescriber episodes (MPEs)	California's PDMP data, 2000-2006	Time series	Changes in Schedule II opioid Rx rates and MPEs associated with these drugs	Change to security form from triplicate Rx form led to rise in MPEs involving all opioids and increased prescribing of some short-acting opioids.
Gomes et al., 2011	Assess relationship between opioid dose and risk of death among nonmalignant chronic pain patients	Ontario residents, Ontario Public Drug Benefit Program (PDMP) database; death data from Office of the Chief Coroner of Ontario	Case control study	Deaths from drug exposures	Higher daily dose of opioids associated with increases in opioid-related mortality; daily doses of 200 mg or more of morphine (or equivalent) associated with very high risk.
Cochella & Bateman, 2011; Johnson et al., 2011	Effect of state-funded media/education program and physician detailing about safe opioid prescribing on overdose deaths in Utah	Medical examiner data on prescription drug-related deaths in Utah, 2007-2009	Pre-post; no control group	Opioid-related prescription drug deaths in Utah	14 percent reduction in opioid-related drug deaths in 2008 and 2009 from 2007.

Appendix A. Published Empirical Studies on PDMP Effectiveness and Candidate Best Practices (continued)

Citation	Study Objective(s)	Study Population and Data Source	Study Design	Outcome(s)	Findings
Paulozzi et al., 2011	Effect of PDMPs on death rates from drug overdose	U.S. mortality data (CDC) by state and year (1999-2005)	Observational study	Rates of drug overdose mortality, opioid mortality, opioid use by state	PDMPs not associated with lower rates of overdose, opioid mortality, or opioid use; PDMP states used more Schedule III hydrocodone, while use rates for Schedule II opioids were not significantly lower; three states (California, New York, Texas) that use special Rx forms showed lower increases in mortality rates and use rates.
Pauly et al., 2011	Compare two types of indicators to monitor Rx drug abuse among users of high-dosage buprenorphine (HDB)	French drug reimbursement database, 2006	Cluster analysis	Doctor-shopping indicator; clustering method of deviant behavior	73 percent of HDB patients had no doctor-shopping behavior, but doctor shopping was higher in patients with deviant profiles.
Wilsey et al., 2011	Analysis of number of multiple prescribers for opioids	California's PDMP data, 1997-2007	Modeling study	Predictors of use of two to five prescribers of opioids in one-year period	Individuals who used two to five providers differed from those using one provider per year, but were not more prone to opioid abuse.
Peirce et al., 2012	Assess association of doctor/pharmacy shopping and risk of drug-related death	Doctor and pharmacy shoppers from West Virginia PDMP database, decedents from drug-related death data.	Case control study	Deaths from drug exposures	Doctor and pharmacy shopping was associated with drug-related death; prescription monitoring programs may be useful in identifying potential shoppers at the point of care.

Appendix B. Unpublished Studies on PDMP Effectiveness and Candidate Best Practices

Citation	Study Objective(s)	Study Population and Data Source	Study Design	Outcome(s)	Findings
United States GAO, 2002	Examine characteristics and effectiveness of 15 state PDMPs	Review of information from DEA and National Alliance for Model State Drug Laws data; interviews with PDMP administrators and stakeholders in Kentucky, Nevada, Utah, and other national experts, 2001-2002	Review, qualitative	Time to investigate drug diversion cases, number of Rxs for controlled substances	States with PDMPs (e.g., Kentucky, Nevada) have reduced the time to investigate drug diversion cases; PDMP states had lower number of Rxs for controlled substances (e.g., OxyContin); border states showed increased Rx rates.
VA Department of Health Professions and VA State Police, 2004	Evaluation of Virginia's PDMP after first year of operation	Virginia PDMP data, 2003 and 2004; survey of physicians, state police drug diversion unit data, 2003-2004	Cross-sectional survey data; pre-post analysis of drug diversion unit data	Physician perception of impact on prescribing Schedule II drugs; time to investigate drug diversion cases	PDMP did not show a chilling effect on Schedule II substances; 36 percent of physicians reported prescribing fewer Schedule II drugs; most of these reported no impact on patient pain management; shorter investigation time for drug diversion cases from 2003 to 2004.
Simeone & Holland, 2006	Effect of PDMPs on supply and abuse of prescription drugs	Integrated data from ARCOS (drug supply) and Treatment Episode Data Set (treatment admissions) with focus on Schedule II drugs, 1997-2003	Modeling study; comparison of states with and without PDMPs	Rx drug sales for Schedule II pain relievers and stimulant drugs	Suggests PDMPs reduce supply and thus probability of abuse of these drugs; proactive Rx monitoring and dissemination of this data to doctors and pharmacists led to 10 percent decrease in Rx sales, which may result in reduced drug abuse, compared to states that did not have PDMPs; proactive states appear to reduce per capita supply of Rx pain relievers and stimulants compared to reactive states.
Twillman, 2006	Evaluate impact of PDMPs on prescribing and on substance abuse	2003 ARCOS data; 2003 TEDS and National Survey on Drug Use and Health data	Observational; controlled (PDMP states vs. non-PDMP states)	Retail distribution of Rx opioids; substance abuse treatment admissions; nonmedical use of Rx opioids in past year	PDMPs appear to result in increases in Schedule III Rxs; PDMP states have higher rates of Rx opioid abuse.
ASPMP, 2007	Assessment of state PDMPs effectiveness and results	Summary of state PDMP reports, surveys, and comments	Cross-sectional survey data	Perceptions of change in prescribing behavior and PDMP effectiveness	74 percent of California physician respondents had changed prescribing behavior due to PDMP; 91 percent rated PDMP effectiveness good to excellent.

Appendix B. Unpublished Studies on PDMP Effectiveness and Candidate Best Practices (continued)

Citation	Study Objective(s)	Study Population and Data Source	Study Design	Outcome(s)	Findings
Lambert, 2007	Impact evaluation of Maine's PDMP. Online Web portal available in 3/2006.	2006 survey of 354 prescribers and 34 pharmacies in Maine's PDMP; stakeholder interviews and PDMP data queries	Cross-sectional	Perceptions of PDMP's usefulness in reducing diversion and doctor shopping	41 percent of prescribers receiving unsolicited reports said their patient had been misusing prescriptions; more than 97 percent of prescribers and pharmacies found the PDMP useful in monitoring Rxs and controlling doctor shopping; no chilling effect; patient confidentiality maintained.
Reifler et al., 2012	Association between PDMPs and state abuse/misuse trends over time	RADARS System Poison Center Program data, 2003-2009	Observational data, controlled (PDMP states vs. non-PDMP states)	Poison center intentional exposure calls as measure of opioid abuse/misuse cases	PDMP states had higher rate of intentional exposures than non-PDMP states, but annual rate of increase in exposures was lower in PDMP states.
Blumenschein et al., 2010	Impact of KASPER on Rx drug abuse and diversion. In 2006, eKASPER created to allow online access to data and real-time receipt of reports	Surveys of prescribers, pharmacists, and law enforcement officials (2009); analysis of national datasets (ARCOS; TEDS) on distribution of controlled substances in Kentucky and nearby states, 1998-2006	Cross-sectional survey data	Perceptions of KASPER's impact on reducing abuse, diversion, and doctor shopping; rates of controlled substance diversion	KASPER users perceive KASPER PDMP as effective in reducing abuse, diversion; KASPER doesn't appear to have chilling effect; states without PDMPs are more likely to have higher rates of controlled substance diversion.
Rosenblatt, 2007	2006 KASPER Satisfaction survey to evaluate satisfaction with new eKASPER system	Survey of prescribers, dispensers, and law enforcement officials, 2006	Cross-sectional survey data	Perceptions of KASPER's usefulness and impact on identifying doctor shopping	After 2006 eKASPER change, there was increase in user belief that KASPER was useful and effective in identifying doctor shopping.
Kentucky Cabinet for Health and Family Services, 2010	2010 KASPER Satisfaction survey to evaluate opinions about the PDMP's usefulness and effectiveness	Survey of prescribers, dispensers, and law enforcement officials, 2010			
Cross-sectional survey data	Perceptions of KASPER's usefulness and impact on identifying doctor shopping	Compared to 2006 survey, KASPER user satisfaction increased and increase in opinion that KASPER was useful and effective in identifying doctor shopping and controlling substance abuse and diversion			
PDMP COE, NFF 1.1, September 2010	Trends in Wyoming PDMP prescription history reporting	Wyoming PDMP data, October 2008-2009	Case study	Number of solicited and unsolicited prescription histories per month, doctor shopping indicators	Reductions in patient doctor shopping reported after proactive reporting.

Appendix B. Unpublished Studies on PDMP Effectiveness and Candidate Best Practices (continued)

Citation	Study Objective(s)	Study Population and Data Source	Study Design	Outcome(s)	Findings
LeMire, 2010	Evaluation of efficacy of North Dakota's PDMP Online Training	Interviews with random sample of prescribers and dispensers who completed training (n=30)	Qualitative	Satisfaction with online training	High level of satisfaction with the training.
DuBose et al., 2011	Develop model for predicting prescriber questionable activity	Physician and patient prescription data	Predictive modeling	Probability of questionable prescribing	Model correctly classified 83 percent of prescribers with disciplinary actions.
PDMP COE, 2011	Briefing on PDMP effectiveness	Published articles, unpublished reports, PDMP COE Notes from the Field, personal communication	Review of published and unpublished literature	Diversion, clinical decision making, doctor shopping, others	Accumulating evidence that PDMPs reduce diversion of controlled substances and improve clinical decision-making.
PDMP COE, NFF 2.1, January 2011	Description of Nevada PDMP's Pre-Criminal Intervention Program (PCIP)	11 closed cases from PCIP	Case study	Number of prescribers, dispensers, and prescriptions post-PCIP	Post-PCIP, the average number of prescribers, dispensers, and prescriptions fell to 4, 4.5, and 34, from 13, 13, and 56 pre-PCIP, respectively.
PDMP COE, NFF 2.2, March, 2011	Using PDMP data in outpatient methadone clinic	Clinic medical director's report on PDMP prescription history data of patients in treatment setting	Case study	Percentage of patients prescribed controlled substances outside of clinic	23 percent of patients were prescribed controlled substances outside of clinic unbeknownst to clinic; anecdotal evidence that use of this data reduced diversion and illicit sale of controlled drugs.
PDMP COE, NFF 2.4, August, 2011	Role of PDMP data in Kentucky drug courts	Interview with Regional Circuit Judge for one drug court in Kentucky	Case study	Drug court participants' diversion or nonmedical use of controlled substances	PDMP data considered a valuable addition to court's monitoring capabilities.
PDMP COE, NFF 2.5, October 2011	Impact of unsolicited reports in Nevada's PDMP	Nevada PDMP data, 1997-2002	Case study	Number of prescribers, dispensers, and dosage units	The average number of prescribers, dispensers, and dosage units decreased for individuals for whom unsolicited reports were sent.
PDMP COE, NFF 2.6, December 2011	Drug-related deaths in Virginia; medical examiner (ME) use of PDMP data	Interview with one Virginia medical examiner	Case study	Impact of PDMP data on ME practice and forensic investigations	Since continuous online access to PDMP data became available in 2009, Virginia medical examiners use PDMP data in their routine practice.
PDMP COE, NFF 3.1, January 2012	Real-time reporting: Oklahoma's pioneering PDMP	Interview with PDMP administrator	Case study	Process and impact of instituting real-time reporting	Oklahoma's PDMP demonstrates the feasibility of real-time reporting, improvements in data quality, and timeliness.

Appendix C. Demonstration Checklist of Candidate PDMP Best Practices

To be used by states to track progress in adopting best practices

Practice	Adoption Status		
	Planned	In progress	Achieved
Data Collection and Data Quality			
Collect data on all schedules of controlled substances			
Adopt latest ASAP reporting standard			
Collect data on nonscheduled drugs implicated in abuse			
Collect positive identification for the person picking up prescriptions			
Collect data on method of payment, including cash transactions			
Reduce data collection interval; move toward real-time data collection			
Institute serialized prescription forms			
Integrate electronic prescribing with PDMP data collection			
Improve data quality:			
Target pharmacy reporting compliance rate			
Target initial data error rate			
Target corrected data error rate			
Target missing data rate			
Data Linking and Analysis			
Link records to permit reliable identification of individuals			
Determine valid criteria for questionable activity:			
Patients			
Prescribers			
Conduct periodic analyses of questionable activity			
Conduct epidemiological analyses for use in surveillance, early warning, evaluation, and prevention			
Develop automated expert systems to expedite analyses and reports			
Record data on disciplinary status and patient lock-ins			
User Access and Report Dissemination			
Provide continuous online access and automated reports to authorized users			
Optimize reporting to fit user needs:			
Batch reporting			
Customized reports			
Integrate PDMP reports:			
Health information exchanges			
Electronic health records			
Pharmacy dispensing systems			
Send unsolicited reports and alerts to appropriate users:			
Prescribers			
Dispensers			
Law enforcement agencies			
Licensure boards			
Patients			
Publicize use and impact of PDMP via websites, presentations, and reports			

Appendix C. Demonstration Checklist of Candidate PDMP Best Practices (continued)

To be used by states to track progress in adopting best practices

Practice	Adoption Status		
	Planned	In progress	Achieved
PDMP Recruitment, Utilization and Education			
Enable access to PDMP data by all appropriate users, encourage innovative applications:			
Prescribers, including monitoring of prescriptions attributed to their own DEA numbers			
Dispensers			
Law enforcement agencies			
Licensure boards			
Patients			
Medicare and Medicaid			
Private third-party payers			
Workers' compensation programs			
Substance abuse treatment clinicians			
Medical examiners			
Drug courts			
Proactively identify and conduct outreach to potential high impact users			
Conduct recruitment campaigns			
Streamline certification and enrollment processing			
Mandate enrollment			
Conduct promotional campaigns			
Improve data timeliness and access			
Conduct user education			
Mandate utilization			
Institute financial incentives			
Delegate access			
Inter-organization Best Practices for PDMPs			
Enact interstate data sharing:			
Model memoranda of understanding			
Standardize data collection fields, formats and transmissions standards			
Identify individuals in multistate data			
Standardize measures for identifying questionable activity			
Data encryption and de-identification			
Collaborate with other health agencies/organizations in applying and linking PDMP data:			
Veterans Affairs			
Indian Health Service			
Department of Defense			
Medicare and Medicaid			
Private third-party payers			

Appendix C. Demonstration Checklist of Candidate PDMP Best Practices (continued)

To be used by states to track progress in adopting best practices

Practice	Adoption Status		
	Planned	In progress	Achieved
Evaluation of PDMPs			
Conduct satisfaction and utilization surveys of end users			
Conduct audits of PDMP system utilization for appropriateness and extent of use			
Use PDMP data as outcome measures in evaluating program and policy changes			
Analyze other outcome data (e.g., overdoses, deaths, hospitalizations, ER visits) to evaluate the PDMP's impact			
Funding PDMPs			
Secure funding that is independent of economic downturns, conflicts of interest, and changes in PDMP policies			
Enact legislation to maintain sufficient funding over time			
Conduct periodic review of PDMP performance to ensure efficient operations and identify opportunities for improvement			

Appendix D: List of Abbreviations

ASAP — American Society for Automation in Pharmacy

ASPMP — Alliance of States with Prescription Monitoring Program

BJA — Bureau of Justice Assistance

BZD — Benzodiazepine

CDC — Centers for Disease Control and Prevention

CMS — Centers for Medicare and Medicaid Services

DAWN — Drug Abuse Warning Network

DEA — Drug Enforcement Administration

DoD —Department of Defense

DSM — Diagnostic and Statistical Manual of Mental Disorders

EHR — Electronic health record

EPCS — Electronic prescribing of controlled substances

FDA — Food and Drug Administration

GAO — Government Accountability Office

HDB — High-dose buprenorphine

HID — Health Information Designs

HIE — Health information exchange

IHS — Indian Health Service, U.S. Department of Health and Human Services

MADPH — Massachusetts Department of Public Health

ME — Medical examiner

MEP — Meperidine

MOU — Memorandum of understanding

MPE — Multiple-provider episodes (being prescribed controlled substances by multiple providers as identified in PDMP data)

NAMSDL — National Association of Model State Drug Laws

NASCSA — National Association of State Controlled Substance Authorities

NASPER — National All Schedules Prescription Electronic Reporting Act

NFF — Notes from the Field

OBOT — Office-based opioid treatment

ODR — Opioid dispensing rate

ONC — Office of the National Coordinator for Health Information Technology

ONDCP — Office of National Drug Control Policy

PDMP — Prescription drug monitoring program

PDMP COE — Prescription Drug Monitoring Program Center of Excellence

PDMP TTAC — Prescription Drug Monitoring Program Training and Technical Assistance Center

PMIX — Prescription Monitoring Information Xchange (RxCheck)

RCT — Randomized controlled trial

SAMHSA — Substance Abuse and Mental Health Services Administration

SBIRT — Screening, brief Intervention, and referral to treatment

TEDS — Treatment episode data set (data collected by SAMHSA on substance abuse treatment admissions)

UR — Unsolicited Reports

VA — Department of Veterans Affairs

Bureau of Narcotic Enforcement

Official Prescription Program

Organization and Staffing

Overview

New Public Health Law

Legislation has recently been enacted that will effectively combat prescription fraud. The new law, section 21 of the Public Health Law, requires that by April, 2006 all prescriptions written in New York be issued on an official New York State prescription form, the same form that has previously been required for prescribing and dispensing schedule II and benzodiazepine controlled substances.

The dramatic expansion of New York's Official Prescription Program necessary to implement the new law will require a corresponding increase in staffing for the Bureau of Narcotic Enforcement (BNE). Because the new law is the first of its kind in the U.S., the additional staff is essential to operate the expanded program as well as to subject the program to intensive monitoring and evaluation and for modifications of policies and procedures needed for optimum efficiency.

Prescription Fraud

Prescription fraud is an ever-increasing problem that drives up healthcare costs and diverts drugs from legitimate medical use. It is estimated that up to 20% of all prescriptions written and dispensed are fraudulent. Practitioners' prescriptions are increasingly being photocopied, scanned, forged, and altered in order to divert drugs for sale on the black market. These contaminated drugs often end up in the medicine cabinets of unsuspecting patients. The billing of fraudulent prescriptions to insurance providers also costs New York's Medicaid program and private insurers tens of millions of dollars in illegal claims. Such criminal activities are dangerous to the public health and affect all New Yorkers by driving up healthcare expenses.

Requiring the use of an official prescription for all prescribing will protect the health of New York's citizens and save the Medicaid program and private insurers, respectively, an estimated 27 million and 100 million dollars annually in fraudulent claims. Because official prescriptions are serialized and can be individually tracked—from vendor to prescriber to pharmacy—lost or stolen prescriptions can be readily detected, reported, and prevented from being dispensed. Data analysis of official prescription serial numbers will also detect submission of duplicate or fraudulent serial numbers and prevent multiple payments.

Prescription fraud occurs in both the controlled substance and non-controlled substance arenas. Abuse has become a national crisis. The Drug Abuse Warning Network (DAWN) records indicate that Emergency Department drug mentions involving the prescription narcotic hydrocodone have increased an estimated 130% between 1994 and 2001. Nationally benzodiazepine and narcotic pain relievers were mentioned as often as heroin and marijuana in 2002 in emergency room over dose episodes. Emergency Department mentions of narcotic pain medications increased 20% in 2002 and 45% between 2000 and 2002. The National Survey on Drug Use and Health (NSDUH) concluded that prescription narcotics are abused more than cocaine and heroin combined and are second only to marijuana in overall abuse. NSDUH also concluded that, in substance abusers over the age of 12, hydrocodone is the most abused narcotic pain reliever. It is important to note that the number one abused pain reliever (hydrocodone) did not require an Official Prescription, prior to this new law.

Official Prescription Program

The Department of Health's most valuable means of combating prescription fraud is its Official Prescription Program, which is widely regarded as one of the premier prescription monitoring programs of its kind in the U.S. Official prescriptions contain state-of-the-art security features specifically designed to deter counterfeiting, alterations, photocopying and forgeries, all of which are fraudulent activities used to traffic in diverted medications. Since 1972, New York's program has effectively monitored the prescribing and dispensing of schedule II controlled substances and benzodiazepines; drugs highly prone to diversion, abuse, and trafficking. Such monitoring has successfully curtailed illegal activities involving such substances.

For example, a report from the U.S. Drug Enforcement Administration regarding OxyContin, a schedule II drug reported to be diverted in a number of states, details that New York's consumption of the drug ranked 50th nationwide per 100,000 population in 2000, 2002, and 2003 and 49th nationwide in 2001. Conversely, New York's consumption of hydrocodone, a narcotic drug that does not require an official prescription and is the most diverted and abused controlled substance in the country, rose from 9th to 4th by weight nationwide from 1997 to 2001.

Also, when benzodiazepines were added to the Official Prescription Program, prescriptions decreased for participants decreased for participants in Medicaid (55%), the Empire Plan (27%), and the Elderly Pharmaceutical Insurance Coverage Program (41%). Studies clearly showed that these reductions in prescribing curtailed only fraudulent activities and not legitimate use.

These facts prove that the oversight afforded by the Official Prescription Program curtails prescription fraud involving these drugs. Expanding the Official Program to include all drugs, both controlled substances and non-controlled medications, will effectively curtail prescription fraud across the entire spectrum of prescribing.

Nature of Diversion

1. **Prescribing Practitioner Diversion**

Prescribing practitioners can engage in intentional diversion for profit by selling medications or prescriptions to individuals where there is no medical need. This type of diversion is most frequently seen in relatively young practitioners unable to establish legitimate practice and in older practitioners who are maintaining income and life-style after their practice begins to decline.

Prescribing practitioners can also intentionally divert drugs to support their own addiction of for so-called "recreational use." The Commissioner of Health has stated, and other experts have confirmed, that as many as 10% of physicians may have substance abuse problems over the course of their professional practice.

Prescribing practitioners can unintentionally divert controlled substances by carelessly prescribing them and acceding to pressure to satisfy perceived patient needs. Practitioners are frequently manipulated by their patients. Patients often view a successful practitioner-patient encounter or office visit in terms of the prescriptions received or drugs provided. A practitioner who prescribes conservatively and only when medically indicated may lose patients to other more liberal practitioners. A great many prescribing practitioners contribute, each a little, to this problem making it broad in scope, difficult to resolve and perhaps best addressed through educational efforts.

2. **Pharmacist and Pharmacy Diversion**

Pharmacists and pharmacies can intentionally divert controlled substances, as well as non-controlled substances, for profit through illegal sales and by knowingly filling improper forged prescriptions.

Pharmacists also intentionally divert by providing controlled substances for their own addiction or to satisfy a customer, friend of relative who does not have a legal prescription.

Pharmacists unintentionally divert medication through laxity in drug inventory control and more importantly by not exercising professional judgement and prerogatives in the filling of apparently legally issued prescriptions.

3. **Health Care and Other Institutional Diverison**

Health care institutions unintentionally divert medication by failing to enforce or develop adequate drug control systems and procedures for medications utilized on their premises or by lack of oversight of dispensing and prescribing for off-premises uses. Health professionals within institutions, particularly doctors and nurses, may intentionally divert controlled substances for their own dependence of for that of others.

While large volume, profit motivated diversion is not usually associated with institutions for their employees, the self-abuse and diversion occurring within institutions is an important problem as it has the potential for seriously affecting the quality of care provided to patients in addition to the harm done the self-abuser.

4. **Diversion by the Public**

There are many individuals who manipulate the health care system to obtain controlled substances for abuse by themselves of for sale to others. Such individuals typically forge prescriptions by photocopying or reproducing blank prescriptions, them completing the prescription for their drug of choice. Another popular diversion method used by the public is referred to as "doctor shopping". This popular method of fraud involves patients seeking the same medications from multiple doctors. The new "doctor shopping" program allowed by this new law is addressed later in this document.

Public Health Significance

While the public perception of "drug diversion" usually focuses upon the criminal activities associated with illegal importation, clandestine manufacture and street sales, the reality is that drug diversion as a whole is not primarily a criminal problem.

It is clear that the results of drug abuse, regardless of source, are a major public health concern because of the quantifiable morbidity and mortality directly associated with it. In addition we can only speculate about the additional numbers of lives lost, or otherwise ruined by the less direct effects of drug abuse. We do not have counts of the incidence of domestic violence, suicide, child abuse, unemployment or numbers of other social evils which owe their existence in part to drug abuse.

Since the primary source of most abused drugs is the health care system, and the effects are so widespread and destructive, it is an issue of urgent public health concern.

The Legislature in recognizing this has placed the responsibility for implementation of the Controlled Substance Act and the new Official Prescription Program within the Public Health Law under the authority of the Commissioner of Health.

Since, by definition, prescription drug diversion or abuse is the obtaining or use of medications in a manner inconsistent with accepted medical practice, it is an important public health issue to define legitimate use, assure utilization in conformance with this definition and, to the extent possible, prevent misuse and diversion.

Distribution of Official Prescriptions

BNE currently distributes some 8 million official prescriptions annually to approximately 27,000 licensed practitioners and 1,300 institutional dispensers. The new law will require the Department to increase its distribution of official prescriptions for prescribing all medications nearly 30 fold, to approximately 200 million official prescriptions. Under the new program, official prescriptions will be provided free of cost to approximately 120,000 practitioners and institutions.

Because the vast majority of practitioners receiving official prescriptions have never been involved in the ordering and use of official prescriptions, an extensive outreach and educational effort will be necessary to inform them of the program.

Official prescriptions will be distributed through a contracted vendor. Additional staff is necessary to ensure contract compliance through vigilant monitoring and oversight. Such monitoring will guarantee that there is a constant supply of official prescriptions to practitioners that is sufficient for all their prescribing needs. Such oversight will also guarantee that the official prescription security features remain consistent with contract specifications in order to detect and prevent the alterations and forgeries and preserve the overriding purpose of the new legislation to reduce prescription fraud.

Registration

New regulations require practitioners and institutions to be registered with the Bureau in order to be issued official prescriptions. The registration process ensures that only authorized practitioners and institutions receive official prescriptions. Developing and implementing process of registering 120,000 practitioners and facilities is an undertaking that is both complex and labor intensive, requiring the addition of qualified staff personnel.

Currently Official New York State Prescriptions are required for the prescribing and dispensing of Schedule II controlled substances and benzodiazepines. With the new law official prescriptions will be required for **all** prescription medications. It is important that orders from practitioners and institutions for official prescriptions be filled properly in order to insure that no patient is deprived of needed medication. At the same time, the abuse potential of these drugs requires that the systems of official prescription sales be secure from fraud and be accurate in its assignments of uniquely serialized prescriptions to individual practitioners and institutions.

The Bureau utilizes numerous systems for the detection of abuse. The official prescription sales process is an important system for detecting abuse before it occurs. Orders for prescriptions must be carefully reviewed to detect fraud and to identify shifts in purchasing patterns which may signal the start of prescribing abuse. The staff associated with the process will undertake a very important responsibility and must develop an expertise in reviewing prescription purchase orders and purchasing patterns.

Pharmacy Data Analysis

The new law requires pharmacies to submit data to the Department from all prescriptions dispensed for controlled substances, which represents 20% of prescriptions for all medications. Currently the Bureau receives approximately 4,000,000 prescription records annually. With this new program the Bureau will receive over 12,000,000 prescription records from pharmacies and prescribers, representing a 300% increase. Analyses of such data will be applied to BNE investigations to curtail illegal prescribing and dispensing, resulting in a diminished supply of diverted drugs available for illegal repackaging, trafficking and abuse and maximizes patient safety.

Data analyses will enable investigators to conduct remote pharmacy audits to detect illegal dispensing. Currently, investigators must physically obtain prescription data from the pharmacy and analyze it by manual means, a time consuming process with less than optimum efficiency. Data analyses will also identify and curtail fraudulent insurance billing by pharmacies. All such data analyses will be thorough and intensive, requiring additional staff to perform.

'Doctor Shopping' Program

The new law also will enhance the prevention of prescription fraud by authorizing the Department to notify practitioners when analyses of official prescription information reveals that their patients are obtaining controlled substances from multiple practitioners, an illegal activity known as 'doctor shopping'.

Providing practitioners with selective prescription information obtained though its investigations and analyses of official prescription data will allow the Department to effectively combat this major method of prescription fraud and drug diversion. Practitioners who are provided with this information will gain an increased level of vigilance to this method of prescription fraud, thereby contributing to prevention. Similar programs in other states have reduced 'doctor shopping' by as much as 63%.

The magnitude of this fraudulent activity is revealed by a detailed analysis of official prescription data for the month of January 2002. The BNE identified over 12,000 individuals who obtained a prescription for a controlled substance from 2 or more practitioners. One individual obtained prescriptions from 8 different practitioners. In August 2001, this same individual obtained 15 controlled substance prescriptions from 13 practitioners and had these prescriptions filled at 14 separate pharmacies.

Since 1997, the state of Nevada has notified its practitioners of instances of 'doctor shopping'. Such notifications are overwhelmingly supported by the Nevada State Medical Association and the Nevada State Board of Medical Examiners. Statistics provided to BCS by the Nevada Pharmacy Board demonstrate just how successful these notifications are in curtailing prescription fraud in that state. Between 1997 and 2000:

- The average number of practitioners seen by each profiled patient dropped from 22 to 12 per year.
- The average number of prescriptions for controlled substances received by each profiled patient dropped from 159 to 56 per year.
- The average number of doses of controlled substances received by each profiled patient dropped from 9,351 to 3,314 per year.

The Department fully expects the 'doctor shopping' component of the new Section 21 of the Public Health Law to result in similar dramatic reductions in prescription fraud in New York State. Additional staffing is needed to analyze data to detect 'doctor shopping' and to provide notifications to practitioners.

Help Desk

Additional staffing is necessary to operate a Help Desk that will be established to address inquiries from New York's approximately 120,000 practitioners, 4,000 pharmacies and 5,000 hospitals and healthcare facilities to obtain information regarding the new law and the expanded Official Prescription Program. BNE anticipates a very high volume of telephone inquiries regarding the issuance and use of official prescription forms and other relevant issues. The Bureau estimates that the volume of inquiries will be approximately 500 to 1000 telephone calls per day for the first 6 months.

Population Dynamics

Increased investigative responsibilities for BNE as a result of the new law also will require the addition of investigative staff. Since the population of the New York metropolitan area comprises some 60% of the population of the state as a whole, BNE finds it necessary to delegate a corresponding percentage of investigative staff and resources to the Department's Metropolitan Area Regional Office.

Bureau Reorganization

Currently the Official Prescription Program is located in the Diversion Prevention Section. The Bureau has two major sections. The Narcotic Investigation Section is responsible for investigating cases involving the diversion of controlled substances. The Diversion Prevention Section is responsible for the Official Prescription Program and the controlled substance licensing program. However with the major increase in workflow and responsibilities, it is necessary to render the Official Prescription Program its own section in the Bureau.

Program Management

The Official Prescription Program will be divided into three units: The Registration and Order Processing Unit, The Data Analysis and Education Unit, and The Administration Unit. The Official Prescription Program will be managed by an HPA 2 (G-25).

- **Health Program Administrator (HPA) 2**

The Health Program Administrator (HPA) 2 that currently is responsible for the Diversion Prevention Section will manage the expanded Official Prescription Program including program planning, implementation, monitoring and evaluation. The HPA 2 will provide oversight of all three units within the Official Prescription.

Duties for the HPA 2 include:

- Provide through leadership and direction within the Bureau to ensure the Official Prescription Program operates effectively and develop accountability protocols.
- Establish and maintain a means for over 200 million official prescriptions to be issued to practitioners and institutions ensuring no disruption of patient care, security in their distribution and accountability of issued prescriptions.
- Assure the development and use of the official prescription and other data systems, to target investigations and define the nature, scope, and impact of controlled substances abuse and diversion in the state.
- Establish and lead an initiative that encourages prescribers and facilities to convert to an electronic prescribing system, which will decrease medical errors and curtail prescription drug diversion.
- Provide for the coordination and cooperation of the Official Prescription Program with other related agencies and organizations at the Federal, state and local levels.
- Foster the development of legislative and regulatory changes, which will increase the availability of controlled substances for medical, need while curtailing the illegal trafficking of controlled substances.
- Conduct or oversee the performance of the Bureau's $20,000,000 budget expenditure plan and $15,000,000 in contractual payments, as well as other fiscal and budgeting aspects of the program including vendor payments and billing.
- Provide opportunities and programs for staff development and training.
- Protect the health and safety of the public through a comprehensive drug monitoring program.

The HPA 2 will be responsible for ensuring that the overall mission of the Official Prescription Program is met. The Official Prescription Program is charged with decreasing prescription fraud. It's projected that the State Medicaid program will save at least $27,000,000 per year. The HPA 2 will be responsible for ensuring that such savings are achieved. The HPA 2 will be responsible for developing and implementing program modifications as needed to ensure maximum savings are achieved.

- **Keyboard Specialist 2 (G-9)**

A Keyboard Specialist 2 will provide secretarial support for the HPA 2, as well as the other professional staff within the program. The position will be charged with the responsibilities of maintaining schedules, ordering office supplies, preparing typed memos and letters, fielding telephone inquiries, and recording notes of Bureau staff meetings.

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Administration Unit

The Administration Unit will perform three primary functions; overseeing all contracts associated with the Official Prescription Program, obtaining and utilizing existing federal grants related to the Official Prescription Program, and personnel issues associated with the Official Prescription Program. The Official Prescription Program currently utilizes a vendor for the registration of prescribers and printing of official prescriptions, as well as a vendor for help desk and data entry staff. The Official Prescription Program has received at total of $650,000 in federal grant money to enhance the Official Prescription Program. This unit will continue to seek federal grant money for this purpose. The Administration Unit will be managed by a Health Program Administrator (HPA G-23).

- **Health Program Administrator (HPA G-23)**

The Health Program Administrator (HPA), g-23, serves as the supervisor of the Administration Unit and coordinates the unit's functions with those of the Registration/Order Processing Unit and the Data Analytical Unit. One of the primary functions of the HPA is managing the contract for the printing and shipping of Official Prescriptions. Due to the fact that all prescribers are required to utilize the state issued official prescriptions; precise contract compliance is vital. A breach in security at the print plant or in the distribution of the official prescriptions could result in massive counterfeiting of the official prescriptions. A counterfeiting situation could cost the State millions of dollars in prescription fraud and flood the streets prescription drugs obtained by fraudulent means. Official prescription forms contain state-of-the-art security features specifically designed to prevent counterfeiting through photocopying and computer reproduction, as well as alterations through chemical tampering.

The bid document for the official prescription program is quite complex in nature. The document consists of the requirements for the prescription form design, delivery requirements for the prescription, security features on the prescription, complex database requirements for registration of prescribers and healthcare facilities, database requirements for the web based ordering of the official prescription forms, and projected prescription volume usage.

Applying for a new grant to be utilized to encourage electronic prescribing. Electronic prescribing involves the secure transmission of a prescription from a prescriber's office to a pharmacy. Currently Only 2% of all prescriptions are transmitted electronically. As a goal, the department would this number to exceed 50% in the next two years. Electronic prescribing has numerous benefits including drastically reducing medical errors and decreasing drug diversion. Because the start-up costs to convert to electronic prescribing can be high, the department is seeking to obtain considerable federal grant money to defray costs to prescribers. The HPA will be responsible for taking the lead on this important initiative.

Duties of the Health Program Administrator (HPA) 2 include:

- Ensures that the vendor complies with contract specifications regarding the security, quality assurance and timely processing of orders for the official prescriptions.
- Ensures the vendor compliance with the quality specifications in the prescription contract, as well as with contractual help desk.
- Ensures that the numerous security features of the official prescription are adhered to according to contract specifications.
- Responsible for ensuring that the vendor processes the official prescription orders within three days of receipt and that emergency orders are overnighted to the prescriber. Prompt delivery of official prescription is vital as a delay could result in patients not being able to obtain necessary prescription medications.
- Prepares the bid document for official prescription registration order processing and print contract every two years when the contract is up for re-bid and coordinating the bid opening, bid document materials and contract award with the Office of General Services (OGS).
- Processes the monthly payments to the vendor and ensuring that proper billing has occurred. Such processing includes co-ordination with the Bureau of Budget Management and other fiscal units in the Department.
- Perform program planning, program implementation, program monitoring and the development of policy and procedures related to the Official Prescription Program.

This is the first official prescription program of it's nature in the country therefore it is anticipated that the HPA will be continuously be involved in program and policy development and modification.

- Prepare new grants regarding the official prescription program. Currently the bureau has received $650,000 from the federal government to enhance the official prescription program.
- Manage existing grants including preparation of progress reports, financial usage reports, and grant planning.
- Prepare grant request to encourage electronic prescribing.

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Registration/Order Processing Unit

The registration and order processing unit is responsible for the registration of 125,000 practitioners and health care facilities to be authorized to purchase official prescription forms under the new law. The unit is responsible for the issuance of over 200 million official prescription forms a year to registered practitioners.

Responsibilities of the Registration/Order Processing Unit include:

- Issuance of Official New York State Prescriptions to authorized practitioners and institution.
- Registration of 125,000 practitioners and healthcare facilities to obtain Official Prescription forms.
- Design and implement a more efficient and productive prescription order system.
- Develop processes and systems to assess the effectiveness of the Official State Prescription Program.

- **Health Program Administrator (HPA G-23)**

A Health Program Administrator G-23 will serve as the manager of the Registration/Order Processing Unit. This newly created unit will ensure the distribution of approximately 200 million official prescriptions annually to authorized healthcare practitioners and facilities.

This unit will be responsible for the required registration of prescribers and healthcare facilities to order official prescription forms. This unit will also be responsible for the oversight of the Official Prescription Help Desk The HPA G-23 will oversee all unit functions and supervise the two HPA G-18 staff in the unit.

The new law creates a new requirement that all 125,000 prescribers in New York State must become registered with the department before they may receive official prescriptions. The registration process consists of the completion of either a manual application form or an on-line application form. The registration process ensures that the prescribers are authorized to prescribe medication and also serves as a means of prescribers to indicate what information they would like to appear on their official prescriptions. The registration also allows prescribers and healthcare facilities to designate specific individuals that may order official prescriptions on their behalf.

Duties for the HPA G-23 include:

- Manage the registration process for 125,000 prescribers and health care facilities.
- Perform program planning, implementation, monitoring, and the development of related policy and procedures regarding the registration of prescribers and facilities, as well as the issuance of official prescriptions.
- Partner with the analytical unit to establish policies related to the maximum number of prescriptions a prescriber may order in a given time period. This will be a difficult policy to establish as the HPA also must ensure that the program does not deny needed medication to legitimate patients by setting too strict of limitations.
- Perform supervision of the unit's two HPA's (G-18) and provide oversight of the official prescription help desk and a health program aide (G-13).
- Develop an ordering system that detects fraud and ensures accuracies in the issuance of the serialized prescriptions.
- Develop a system which reviews prescription purchase orders and identifies suspicious purchasing patterns.
- Liaison with ISHS and prescription vendor to maintain the processing of the Official New York State Prescription data.
- Develop reports of Official New York State Prescription data to be used for enforcement, educational, epidemiological and peer review purposes.

Health Program Administrator (HPA G-18)

Management of this unit requires two Health Program Administrators, G-18. One HPA, G-18, will supervise the official prescription Help Desk. The Help Desk will field thousands of inquiries on a weekly basis from healthcare professionals and healthcare facilities regarding the expanded Official Prescription Program. Prescribers and facilities will call the help desk when they need assistance registering for the official prescription program, as well as when they need assistance ordering official prescriptions. Because only 27,000 out of the 125,000 prescribers in New York State are familiar with ordering official prescriptions, the call volume is expected to be extremely high during the first two years of this program. The bureau is contracting for five help desk staff that will handle the majority of the inquiries.

The bureau has established a 1-800 phone number for such inquiries and will publicize the number to all prescribers, pharmacies and healthcare facilities.

Duties for the HPA G-18 include:

- Developing a manual and other written materials for the Help Desk staff, to be updated on a continual basis as program changes occur.
- Supervise contractual help desk staff, hire help desk staff and perform disciplinary measures as necessary.
- Ensure help desk staff answer phone inquiries accurately and in a courteous manner.
- Act at Department liaison to contractors help desk with regard to tracking prescription orders.

A second HPA, G-18 will be needed to manage the registration and prescription ordering process. The process will consist of both a manual process as well as an on-line process. All 125,000 prescribers and healthcare facilities must become registered before they may order official prescriptions.

This registration is a new process therefore continuous quality improvement and modifications will be necessary. Duties of the HPA G-18 include:

- Ensuring prompt and accurate data entry of 125,000 registration applications.
- Overseeing data entry of official prescription orders to ensure quality.
- Establish process by which registrations and orders for official prescriptions can be rushed in an emergency situation.
- Assure the development and use of the official prescription and other data systems, to target investigations and define the nature, scope, and impact of controlled substances abuse and diversion in the state.
- Improve the manner in which official prescription forms are issued to practitioners and institutions to ensure no disruption of patient care, security in their distribution and accountability of issued prescriptions.
- Act as a Department liaison to contractor with regard to processing of registrations and prescription ordering.

- **Health Program Aide**

A Health Program Aide is needed to perform verification of prescribers and facilities. The regulations require that only authorized prescribers may obtain official prescriptions. Quite frequently a prescriber changes location and fails to change their registration address with the Drug Enforcement Administration (DEA).

Duties for the Health Program Aide include:

- Verification of current DEA registration status and ensuring that the updated information is properly entered into the registration database.
- Establish process by which DEA addresses can be verified in large batches.
- Contact DEA regarding incorrect or changed address. This is estimated to be needed for approximately one hundred prescribers per day.
- Receive e-mail messages from the bureau's prescription vendor concerning prescribers that have attempted to order official prescription research and resolve such issues.
- Provide support for the HPA positions and will assist in a day-to-day basis with operating the newly created Bureau Help Desk.
- Provide back-up for supervision of the Help Desk.

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Data Analysis/Education Unit

The Data Analysis and Education Unit will collect, review and analyze data for all official prescriptions for controlled substances submitted to the Department by dispensing practitioners and the state's 4,500 pharmacies.

The unit will perform data analysis of official prescription data received by pharmacies, as well as analysis of ordering patterns and utilization of official prescriptions. Data will be reviewed by the pharmacy consultant staff for potential fraudulent activity. The data will also be reviewed for drug trends from a public health perspective for the example, the usage of stimulants in infants and preschool aged children may be analyzed from a public health perspective. Identified trends may be discussed with the related regulatory body within the Department. Currently the Department receives approximately 4 million controlled substance prescription records on an annual basis. With this new program, the department will be receiving over 12 million prescription records on an annual basis.

The Unit will also be responsible for analyzing order patterns of official prescriptions. Currently the bureau receives orders from approximately 27,000 prescribers annually. Because the new program will affect all prescription drugs, it is likely that the bureau will receive orders from all 120,000 registered prescribers in New York State. The unit will review ordering patterns for excessive or suspicious activity. The unit will also analyze ordering patterns to establish order limits. Due to the fact that the State will be proving official prescriptions free of charge with the new program, it is prudent that prescribers are only issued the quantity of prescriptions that they will actually utilize.

Excessive ordering of official prescriptions could inadvertently cost the State millions of dollars and decrease the projected savings of this initiative. This unit will provide recommendations to the HPA 2 on what limitations should be established for the maximum number of prescriptions to be issued to a prescriber at a given time.

This unit will also be responsible for developing and overseeing the new Doctor Shopper Program established by the new law. This unit will be responsible for identifying potential doctor shoppers and referring such individuals to the narcotic enforcement section. Prescribers will be notified when their patients are obtaining controlled substances from multiple other prescribers. Such notification will provide prescribers with the information they need to utilize their professional judgment on whether they wish to continue prescribing to such an individual. Doctor shopper programs are typically embraced by the medical community as and have decreased the prevalence of this illegal activity by as much as 65% in other states.

Because this program is the first of its nature in the country; proper education is vital to ensure program success. Because this is a mandatory prescription program, all 125,000 prescribers and facilities must be contacted regarding the new program. Extensive outreach materials must be developed. The HPA will be responsible for proving education and outreach through written materials, posters, and presentations. Presentations to all affected parties will be necessary statewide. The HPA will ensure staff of the unit perform such presentations and that all written materials are accurate and consist and provided to affected parties in a timely manner.

Duties of the HPA G-23 include:

- Perform program planning, implementation, maintenance, monitoring, and the development of policy and procedures for the Unit.
- Coordinate the Data Analysis Unit's activities with the Administration Unit and the Registration/Order Processing Unit to ensure maximum efficiency in operation of the overall Official Prescription Program.
- Establish a doctor shopper program designed to identify individuals seeking controlled substances fraudulently from multiple prescribers.
- Develop peer review with health care professionals and institutions and means by which drug utilization information is disseminated.
- Create education/prevention training programs regarding the new program for practitioners, pharmacists, other health care professionals and schools, as well as the general public.
- Develop and implement official prescription data systems to identify controlled substance abuse and illegal trafficking.
- Develop and administer an analysis process that uses the official prescription information to target investigations toward practitioners with a high probability for self abuse or misprescribing of drugs for use by the Bureau, OPMC or OPD

- **Computer Programmer Analyst**

The Computer Programmer Analyst is responsible for establishing and maintaining computer programmer applications involving the Official Prescription Program. The Analyst is also responsible for developing and maintaining the database for the collection of Official Prescription information from New York State pharmacies and practitioner dispensers.

Duties for the Computer Programmer Analyst include:

- Develop, test and maintain all data bases associated with the Official Prescription Program. Currently the Bureau received approximately four million prescription records electronically from pharmacies.
- Respond to inquiries of the technical nature from pharmacies and pharmacy software vendors regarding the new law. With this new program pharmacists will have to modify their pharmacy software to transmit all controlled substances data. Pharmacist will increase the number of records to transmit from four to twelve million per year.
- Provide technical assistance with regard to the new requirements that all dispensing data be transmitted to the department electronically. Approximately two hundred small pharmacies and veterinarians manually submit such data and will be required to change to a means of electronic transmission.
- Establish a web based system by which pharmacies and veterinarians can data enter such information to be in compliance with the new regulations.
- Establish a program that strongly encourages pharmacies to convert from diskette submission to submitting on the Departments secure web site. The Bureau currently received hundreds of diskettes on a monthly basis. Bureau staff spends numerous hours per month downloading the diskettes into our prescription database. By encouraging pharmacies to instead directly download the data onto Departments secure web site, numerous staff hours can be saved.
- Develop and maintain the linkage of the database for this program with the database of the contracted vendor.
- Provide training for all staff on the computer systems associated with the Official Prescription Program and developing new applications to meet program needs.

Program Research Specialist (G-18)

2 Program Research Specialist (PRS G-18) positions will be needed to collect official prescription dispensing data and analyze that data for managerial and programmatic purposes.

The PRS staff will also be responsible for analyzing the data regarding the ordering of official prescriptions. Such analysis will be a vital managerial tool for proper program planning, implementation, and maintenance. The PRS staff will ensure the collection of over 12,000,000 controlled substance prescription records from pharmacies, health care facilities and dispensing practitioners. Currently BNE staff collect data on approximately 4 million prescription records per year. Because pharmacies will have to modify their software to include all controlled substance data, the PRS staff will be responsible for ensuring the collection of the newly required data.

Duties for the Program Research Specialists include:

- Collect and analyze over 12 million controlled substance prescriptions per year and prepare reports to be used for peer review by health care professionals.
- Identify non-submitting pharmacies and dispensers and referring such cases to the Enforcement Section.
- Analyze the data regarding orders placed for official prescriptions. Due to the fact that official prescriptions will be provided without charge to practitioners and health care facilities, program management will need to establish policies that limit the number of prescriptions that may be ordered at a given time.
- Analyze ordering data to make recommendations to program management so that limits regarding the number of prescriptions ordered at one time may be established. The PRS staff will analyze that prescription ordering data by prescriber profession type. PRS staff will perform analysis utilizing technique that will assist program management in determining the average number of prescriptions ordered per profession type. The PRS staff will perform analysis to convey recommendations to management staff regarding establishing appropriate order limits. The PRS staff will determine what limits should be established for the maximum number of prescriptions ordered by a certain profession type and health care facility.
- Analyze Official Prescription data, as well as orders placed for official prescriptions, for identifying trends, which may result in program modification

Due to the fact that this is an exponential change to an existing program, there are many unknowns with regards to prescription utilization and ordering prescribers. The PRS staff will keep a constant pulse on those patterns for managerial purposes as this program evolves.

- **Pharmacy Consultant (G-20)**

Three new Pharmacy Consultants will be needed to perform pharmacological analysis of official prescription data and vital education to 125,000 healthcare professionals and facilities regarding this new program. The Pharmacy Consultants will be part of the Policy Drug Evaluation Unit, under the oversight of the Bureau Director. The Pharmacy Consultants will also be responsible for educating prescribers, pharmacists, and institutions statewide on the expanded Official Prescription Program through the presentation of educational seminars and the development and distribution of materials for mass mailings to healthcare practitioners.

The Pharmacy Consultant staff will utilize the Bureau's specialized prescription analysis computer software to detect suspected controlled substance diversion. Pharmacy Consultants through their specialized training as pharmacists, possess the pharmacological background necessary to detect inappropriate or suspicious utilization of medication. Currently the Bureau only receives four million prescription records on a limited group of narcotics. With the new program the Bureau will receive over twelve million prescription records. This data will reflect thousands of controlled substances never before analyzed by the Bureau. The Pharmacy Consultants serve as the Bureau experts in the performance of such analysis.

Duties for the pharmacy consultants include:

- Addressing telephone and written inquiries regarding the Official Prescription Program from healthcare and law enforcement professionals.
- Analyze prescription data submitted by pharmacies to detect diversion of controlled substances and 'doctor shopping', an illegal drug-seeking activity whereby individuals obtain controlled substances from multiple prescribers. It is anticipated that the pharmacy consultants will provide pharmacological analysis of approximately 12,000,000 prescriptions on an annual basis. When such activity is detected, the analyses will be provided to Bureau investigational staff.
- Conduct research and review of controlled substances utilization from a public health perspective and recommend solutions to the public health issues identified.
- Conduct epidemiological research of drug use patterns geographically, by professions, specialties, and disease entity.
- Assess current research in the area of controlled substance utilization and conduct literature review in order to keep the section chief informed of current controlled substance issues.
- Research and analyze existing health care systems to identify new and better ways of addressing the legitimate access to controlled substances.
- Identify regulatory and legislative barriers in the abilities of practitioners and health care facilities to provide appropriate controlled substance therapies to patients.

Narcotic Investigator (G-18)

The Narcotic Investigation Section of the Bureau can expect a significant continuing challenge to the accomplishment of the Bureau's mission to eliminate the flow of manufactured controlled substances into illicit channels and to empower heath care professionals as well as the public to utilize the controlled substances safely and therapeutically. To meet this challenge and to maximize the benefits of the new fraud prevention program the Bureau is adding seven (7) new Narcotic enforcement investigator positions. Grade (18).

Current investigators work cases based in part on the data collected from 4 million prescription records. The new Official Prescription Program will increase that work data to 12-15 million prescriptions. In addition new bureau data analysis positions will concentrate on identifying indicators of prescription drug abuser and diversion both professional and non-professional and forward those to the investigation section for appropriate civil or criminal action. In the current system the data of 27,000 ordering practitioners is recorded from this hundreds of loss or stolen scripts reports are received and only a small percentage can result in an investigation. The new system will receive reports from 125,000 practitioners and institutions and the investigative need can be expected to correspond accordingly. The above factors necessitate the need for additional investigators.

The Duties of the Narcotic Enforcement Investigators (GR 18) include:

- Conduct investigations of reported or suspected violations of Article 33 and Part 80.
- Reviews prescriptions, purchase orders, medical records and other documents to determine non-compliance or diversion.
- Conducts audits of controlled substances received, administered, or delivered.
- Prepares case reports
- Initiates investigations, inspections, and other assignments in compliance with case tracking system.
- Secures and gather evidence. Follows policy and procedure for handling, transporting tagging and securing as well as documents chain of custody.
- Conduct surveillance in accordance with law and policy.
- Establishes working relationships with other law enforcement and regulatory agencies.
- Conduct licensure inspections to determine compliance and suitability.
- Performs duties as a peace officer complying with provisions of manual
- Complies with state Law and Bureau policy regarding issued weapon and safeguarding.

Supervising Narcotic Investigator (G-23)

It is critical for successful implementation of the investigation responsibilities under the new program to have appropriate operational supervision over the newly assigned as well as current narcotic enforcement investigators. Regional administrative supervision is currently done by OPMC program managers with oversight and input form central office. It is imperative that newly assigned investigators be directly field operationally supervised by persons experienced in applying the New York State Penal Law, New York State Criminal Procedure Law, Rule as well as the techniques of surveillance, arrest and evidence gathering.

The Bureau is increasing the number of Supervisory Narcotic Enforcement investigators by 2. (Gr. 23). This will ensure that each region has this level of field supervision in order to best carry out the Program goals.

The Duties of the Supervising Narcotic Investigator (Grade 23) include the duties listed for Narcotic Investigator (Grade 18). In addition, reporting directly to the Narcotic Enforcement Section Chief the Supervising Narcotic Enforcement Investigator will:

- Review current investigation caseloads of regional office to identify trends and areas of improvement.
- Supervise established standardized investigative practices and procedures and ensure staff compliance.
- Prepare required reports on licensing and enforcement activities of the specific region.
- Establish mentoring and training programs for investigative staff in accordance with Bureau's policy and procedures.
- Review submitted work product of subordinate investigators to insure quality and standards of efficacy.
- Establish cooperative relationships with federal, state and local investigative law enforcement and regulatory agencies.
- Assist Bureau management in designing, implementing and revising internal audit procedures to ensure staff compliance with Department, Division, and Bureau policies, practices and procedures.

The Official Prescription Program helps combat the growing problem of prescription fraud. Official New York State Prescription Forms contain security features specifically designed to prevent alterations and forgeries that lead to abuse and diversion of drugs for sale on the black market. By preventing fraudulent claims, the program also saves New York's Medicaid program and private insurers many millions of dollars every year. Recent estimated savings to the NYS Medicaid program alone was $1.5 million per month in 2011.

6/2/11

New York State Official Prescription Program - $16,400,000

Fees collected from insurance companies support the State Insurance Department (SID) Special Revenue Account that funds this program.

The Official Prescription Program helps combat the growing problem of prescription fraud. Official prescriptions contain security features specifically designed to prevent alterations and forgeries that lead to abuse and diversion of drugs for sale on the black market. By preventing fraudulent claims, the program also saves New York's Medicaid program and private insurers many millions of dollars every year. In 2009, New York State was one of 33 states to have a drug-monitoring program, enhanced by the Official Prescription Program.

Prescription drug payments to 5 states, New York, California, Illinois, North Carolina, and Texas, constituted over 40% of all Medicaid payments for prescription drugs in 2006 and 2007. In 2006 (the latest year for which data are available) the Coalition Against Insurance Fraud (CAIF) reported that diversion of controlled prescription drugs (CPDs) collectively cost insurance companies up to $72.5 billion annually. Individual insurance plans lose an estimated $9 million to $850 million annually, depending on each plan's size, much of that cost is passed on to consumers through higher annual premiums.

Of the approximately 255.8 million prescriptions dispensed in New York State in 2009, (7.0% of national total- 2009 Kaiser Family State Health Facts) Medicaid pays for 56.1 million, or 21.9% . The remaining prescriptions, or 199.6 million, are paid for by other than Medicaid insurers.

Private insurance payments and prescriptions paid in cash in New York State represent approximately $13.9 billion for prescription drugs in FY 2009. Medicaid expenditures for prescription drugs for the same period were $4.0 billion.

The Centers for Medicare and Medicaid estimates that $48 billion (9.4%) of estimated Medicare outlays of $509 billion in fiscal 2010 went to improper payments, including fraudulent ones. This total does not include improper payments in the Medicare Part D drug benefit, for which the agency (CMS) has not yet estimated a total amount.

Assuming a conservative estimate of prescription fraud at between 1.0% to 3.0%, the Official Prescription Program could save between $179 million and $537 million annually for both Medicaid and private insurers. The estimated savings in decreased prescription fraud more than pays for the cost of the program.

Estimated Prescription Fraud Savings				
Calendar Year 2009		**Estimated Percent of Fraud Related to Prescriptions**		
New York State Prescription Claims		**3.00%**	**2.00%**	**1.00%**
Private Insuance Payments and Cash	$13,987,331,616	$419,619,948	$279,746,632	$139,873,316
Medicaid	$3,933,848,184	$118,015,446	$78,676,964	$39,338,482
Total Prescription Claims/Est. Savings	$17,921,179,800	$537,635,394	$358,423,596	$179,211,798

Note: The U.S.spends more than $2 trillion on all healthcare annually. At least 3% of that spending - or $68 billion - is lost to fraud each year. (National Health Care Anti-Fraud Association, 2008)

11/24/10

BNE Cost Saving Proposals—Official New York State Prescriptions

- Option 1 Practitioners and Institutions pay DOH for prescriptions

	Impact
Savings of 11M per year	Cost shift to practitioners- $100/year [$0.05 per prescription, 2000 Rx/year]
	Modification to DOH contract necessary. Implementation concerns, such as staffing, payment processing etc.
	Continues to effectively curtail fraud, Medicaid savings not affected

- Option 2 DOH approves vendors to provide prescriptions directly to Practitioners/Institutions

	Impact
Savings of 11M per year	Cost shift to practitioners-cost unknown but likely less than $100/year
	Loss of state standardized/serialized prescriptions—could impact (1) Savings to Medicaid (3M/month) and the data collected by the Department. Data could no longer be used to detect counterfeit prescriptions (duplicate serial numbers) and prescription theft would go undetected (no serial number to track or detect stolen prescriptions)
	Revision of contract necessary (current contract ends 2/28/12).

- Option 3 DOH sets forth guidelines for prescription paper (security features)-Practitioners/Institutions may order source of their choice

	Impact
Savings of 11M per year	Cost shift to practitioners-cost unknown but likely less than $100/year.
	Loss of state standardized/serialized prescriptions—would impact (1) Savings to Medicaid (3M/month) and the data collected and the data collected by the Department. Data could no longer be used to detect counterfeit prescriptions (duplicate serial

numbers) and prescription theft would go undetected (no serial number to track or detect stolen prescriptions)

Revision of contract necessary (current contract ends 2/28/12

- Option 4 DOH no longer requires official New York State Prescriptions

Savings of 11M per year

Impact

Same as indicated in Option 2 and 3.

Prescribers would still be required to follow CMS prescription security requirements.

- Option 5 DOH requires prescriptions for controlled substances ONLY

Savings of 9M per year

Impact (~16% of Rx's are for controlled)

Cost shift to Practitioner/Institutions for Non-CS prescriptions. DOH could provide list of vendors, or guidelines.

Cost savings to Medicaid projected to be Reduced from 3M/month to 500k/month. Revision of contract necessary (current contract ends 2/28/12.

BUREAU OF NARCOTIC ENFORCEMENT
NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
EXPENDITURE PLAN FOR SFY09-10

PROGRAM PROPOSAL

The Bureau of Narcotic Enforcement's (BNE) full implementation of the Official Prescription Program realized a decrease in the prescription fraud associated with forged and altered prescriptions. According to analysis performed by the Medicaid program, the expanded Official Prescription Program resulted in an initial cost avoidance of approximately $22 million in a two-month period. Ongoing cost avoidance associated with Official Prescriptions accounts for between 2 and 3 million dollars per month to the Medicaid program and considerably more to private insurers. Through the introduction of new legislation and amendments to Title 10 of the New York Compilation of Codes, Rules and Regulations, BNE will continue to move forward with programs aimed at preventing the diversion of controlled prescription drugs and thus help insure the health and safety of New Yorkers.

BNE completed its first full year of the Practitioner Notification Program and to date has informed almost 8000 prescribing practitioners of over 1450 patients filling controlled substance prescriptions from multiple practitioners at multiple pharmacies. This notification allows practitioners to consider whether their patients were legitimately receiving these drugs for their own use or whether they were "doctor shopping" for the purpose of obtaining controlled prescription drugs for illegal purposes. The program will be expanded to allow prescribers, suspicious of patients' motives, to log onto a secure web site (the Health Commerce System) and review patients' recent prescription history prior to writing a prescription for a controlled substance for that patient. This ability will prevent diversion and abuse at the time of the initial office visit or call from the patient.

New regulations adopted and in the process of implementation will continue to curtail prescription drug diversion and protect the public. Pharmacists are now required to submit information on the refilling of prescription controlled substances and the method of payment used by the individual acquiring the prescription controlled drug. This will allow the Department to identify those paying cash at varied pharmacies for the purpose of avoiding detection of "doctor shopping" activity and reveal those individuals receiving numerous refills of controlled substances for possible sale to others or other abuse. Additional savings are anticipated through this new method of fraud detection.

Other newly adopted regulations require licensed manufacturers and distributors to report sales of prescription drugs to the Department. Analysis of these data by BNE will combat drug diversion by detecting inappropriate procurement of controlled substances by practitioners, pharmacies and institutional dispensers. This analysis activity by BNE will close the loop of prescription controlled substance movement through the system to the end user and see further savings in prevention of fraudulently diverted prescription drugs.

The Department currently issues licenses to engage in controlled substance activity to hospital, residential health care facilities, scientific researchers, manufacturers, distributors and others. BNE's legislative proposal would also require Internet pharmacies to be issued licenses by the Department. Reducing drug diversion through illegal Internet sales will decrease health care costs associated with addiction treatment and side effects of abuse of controlled substances.

The appropriated budget for the Official Prescription Program for SFY 2008-09 was $21,500,000 and funded approximately 200 million prescription forms and serialized authentication labels issued to practitioners and institutions. The number of prescriptions needed increases yearly, therefore BNE estimates the need to issue approximately 236 million prescriptions in SFY09-10.

Accomplishments 2007-08FY:

- Hospitals and their affiliated clinics, previously exempted from the requirement to issue prescriptions for non-controlled substances on an official New York State prescription form, must now affix a serialized authentication label to written prescriptions, implement electronic prescribing or use official prescriptions. This completed the Official Prescription Program objective of bringing all prescribers into compliance with the program and allows for the tracking of all prescriptions written in NYS.
- In conjunction with the Albany County District Attorney's office, successfully prosecuted multiple defendants in an Internet illegal distribution of steroids case. These prosecutions led to more than 1.5 million dollars in fines, as well as prison sentences. This prosecution continues against major defendants later in 2008.
- Implemented an electronic barcode evidence tracking system in Central Office to more efficiently report, track and store drug evidence.
- Analysis of prescription data dramatically increased as the Practitioner Notification Program (PNP) analyzed almost 14,000 filled prescriptions, resulting in the preparation of Drug Utilization Reports on 854 patients. The reports were sent to 5478 practitioners, notifying them that their patient filled controlled substances prescriptions from multiple providers in a 30-day period and at multiple pharmacies.
- Emergency rule making was proposed (and put into effect this FY) amending regulations to begin requiring licensed distributors and manufacturers to submit data

on sales of controlled substances within NYS, thus tracking prescription controlled substances from initial source to end use.

- Emergency regulations were also adopted requiring pharmacies to submit the method of payment and whether a controlled substance was filled as an original prescription or as a refill, allowing the use of ketamine hydrochloride and sodium pentobarbital in schedule II formulation for euthanasia in animal shelters, providing practitioners greater flexibility in treating chronic pain in conditions other than diseases, and allowing hospice patients or others in residential health care facilities to partial fill their controlled substance prescriptions.
- Educational presentations on regulations and diversion prevention were increased, reaching over 670 pharmacists and 475 licensed prescribers at face-to-face training events. Informally, thousands more were reached through information posted on the DOH public web site and the Health Commerce System and through e-mails of newsletter updates to associations, societies, chain pharmacies and others. Mailing of educational materials for practitioners also occurred through the Practitioner Notification Program.
- Applied for and was awarded a $400,000 grant from the US Department of Justice, Bureau of Justice Assistance. Continued previous grant activities of educating the public on the dangers of prescription drug misuse through participation in health fairs, EAP events, school and community events.

Objectives 2008-09FY:

- Automate the Practitioner Notification Program to allow practitioners direct access to patient controlled substance activity via the secure Health Commerce System web site. This will allow the practitioner who suspects a patient may be obtaining controlled substances from multiple practitioners to view recent activity at the time of the office visit or patient telephone call.
- Implement all of the regulations drafted last FY and adopted as emergency regulations this FY. This will result in analysis of newly required sales data from manufacturers and distributors to identify possible diverted prescription controlled substances.
- Launch a statewide opioid treatment educational campaign aimed at both prescription drug abusers and their medical providers, informing them of effective in-office treatment available for opioid addiction.
- Place a practitioner's curriculum on the BNE web site to educate prescribers on regulations surrounding prescribing of controlled substances.
- Implement the electronic barcode evidence tracking system in all Regional Offices.
- Continue to stem the trafficking of legally manufactured controlled substances into illicit channels through more effective investigations and enforcement activities statewide.

Goals 2009-10FY:

- Work with contractor on needs assessment for customization of case data management system to improve reporting and management of controlled substances case investigation activities statewide. Identify database and record security by job function and geographic location within the Bureau. Assist developer with screens and processes for new system and training for users. Fully transition from old system and implement new system during FY.
- Improve the Bureau's ability to appropriately meet the challenges of the Internet regarding the diversion of licit controlled substances through development of a protocol for these unique and emerging situations.
- To increase the Bureau's staffing target to allow for the hiring of additional investigative and technical staff necessitated by expansion of the Official Prescription Program, the growing problem of prescription drug abuse, and the increase in data submitted by new reporting sources.
- To continue to provide emphasis on investigations of controlled substance diversion by healthcare professionals, thus protecting the health and safety of their patients.

BUDGET REQUEST FOR SFY 09-10

Category	Cost	Total
Personal Service		
Regular	$ 3,040,000	
Overtime	80,000	
Total Personal Service		**$ 3,120,000**
Non-Personal Service		
Supplies and Materials	$ 120,000	
Travel	100,000	
Contractual Services		
Postage	$15,000	
Help Desk (7 contract staff)	264,000	
OPP Hot-line	8,000	
Print & Distribution of Rx (236,000,000 x .055)	13,000,000	
Cell Phones	7,000	
Vehicle Maintenance	20,000	
Media Buy – Rx Drug Abuse Prevention Campaign	1,000,000	
Miscellaneous	41,000	
Equipment (includes 4 vehicle purchases)	$ 125,000	
Fringe Benefits @ 48%	$ 1,500,000	
Indirect Cost @ 3%	$ 140,000	
Total Non-Personal Service		**$ 16,340,000**
GRAND TOTAL		**$ 19,460,000**

PERSONAL SERVICE

Regular

A sum of $3,040,000 is requested to support the Official Prescription Program and the Bureau of Narcotic Enforcement. This amount is sufficient to fund the current year fill level of 50 ftes. The Bureau's investigative duties require an overtime budget of $80,000.

NON-PERSONAL SERVICES

Supplies

A requested amount of $120,000 will continue to support printing and mailing of information to 108,000 licensed health practitioners and 1,300 institutions , as well as continued outreach to facilities dispensing controlled substances. This amount will also support routine office supplies including subscriptions to health industry reference materials.

Travel

The requested amount of $100,000 will support the travel associated with the Bureau's 28 Enforcement items and 5 Administrative items whose job responsibilities include the prescription fraud prevention program, routine travel relating to investigations, travel to statewide training, and education and outreach events for health care and law enforcement professionals.

Contractual Services

A requested total of $14,355,000 will support the printing and issuance of 236,000,000 prescription forms, as well as official serialized authentication labels for facilities that computer-generate prescriptions. These funds will also be used to support the Official Prescription Program Help Desk, which handles approximately 50,000 inquiries annually, and purchase software updates to ensure DOH has the most current information on pharmaceutical industry growth. These funds will also support the continuation of the Bureau's Prescription Drug Abuse Prevention Campaign. The recommended appropriation includes $20,000 for vehicle maintenance, and $7,000 for cell phone service based on SFY 08 expenses.

Equipment

A recommended total of $125,000 is necessary to replace outdated office and computer equipment and purchase vehicles. Currently the Bureau of Narcotic Enforcement has 23 vehicles. Four new vehicles at the cost of $80,000 will be needed to

replace current fleet vehicles that have high mileage and that are in need of frequent repair.

Fringe Benefits

The requested fringe benefit appropriation of $1,500,000 is based on total personal service expenditure of $3,120,000 and an anticipated fringe rate of 48%.

Indirect Costs

The requested appropriation of $140,000 would support an indirect cost of 3%.

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
EXPENDITURE PLAN FOR SFY10-11

PROGRAM PROPOSAL

The Bureau of Narcotic Enforcement's (BNE) Official Prescription Program realized a decrease in the prescription fraud associated with forged and altered prescriptions. According to analysis performed by the Medicaid program, the expanded Official Prescription Program continues to result in a cost avoidance of approximately $3 million per month to the Medicaid program and considerably more to private insurers. Through the introduction of new legislation and amendments to Title 10 of the New York Compilation of Codes, Rules and Regulations, BNE will continue to move forward with programs aimed at preventing the diversion of controlled prescription drugs and thus help insure the health and safety of New Yorkers.

BNE completed its third year of the Practitioner Notification Program and to date has informed over 11,000 prescribing practitioners of over 2,400 patients filling controlled substance prescriptions from multiple practitioners at multiple pharmacies. This notification allows practitioners to consider whether their patients were legitimately receiving these drugs for their own use or whether they were "doctor shopping" for the purpose of obtaining controlled prescription drugs for illegal purposes. The program has been expanded to allow prescribers, suspicious of patients' motives, to log onto a secure web site (the Health Commerce System) and review patients' recent prescription history prior to writing a prescription for a controlled substance for that patient. This program will fully roll out in 2010. This ability will prevent diversion and abuse at the time of the initial office visit or call from the patient.

New regulations adopted and in the process of implementation will continue to curtail prescription drug diversion and protect the public. Dispensers are now required to submit information on the refilling of prescription controlled substances and the method of payment used by the individual acquiring the prescription controlled drug. This will allow the Department to identify those paying cash at varied pharmacies for the purpose of avoiding detection of "doctor shopping" activity and reveal those individuals receiving numerous refills of controlled substances for possible sale to others or other abuse. Additional savings are anticipated through this new method of fraud detection.

Other newly adopted regulations require licensed manufacturers and distributors to report sales of prescription drugs to the Department. Analysis of these data by BNE will combat drug diversion by detecting inappropriate procurement of controlled substances by practitioners, pharmacies and institutional dispensers. This analysis activity by BNE will close the loop of prescription controlled substance movement through the system to the end user and see further savings in prevention of fraudulently diverted prescription drugs.

The appropriated budget for the Official Prescription Program for SFY 09-10 was $21,500,000 and funded approximately 200 million prescription forms and serialized authentication labels issued to practitioners and institutions. The number of prescriptions needed increases yearly, therefore BNE estimates the need to issue approximately 210 million prescriptions in SFY 10-11.

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
PERSONAL SERVICE PLAN FOR SFY 10-11

Title/Grade		*Item Number*	*Annual Salary*
HEALTH PROG ADMR 2	25	75001	$84,416
MEDICAID INVEST 2	21	75002	$65,192
INFO TECH SPEC 2 PROG	18	75003	$62,685
AGENCY PRGM AIDE	13	75005	$41,780
HEALTH PROG ADMR 1	23	75006	$78,384
HEALTH PROG ADMR 2	25	75007	$70,9313
HEALTH PROG ADMR 4	663	75012	$105,000
NARC INVSTGR 2	23	75013	$74,888
NARC INVSTGR 1	18	75014	$62,685
NARC INVSTGR 1	18	75015	$62,685
NARC INVSTGR 1	18	75016	$50,989
HEALTH PRGM ADMR	18	75019	$50,828
NARC INVSTGR 1	18	75021	$56,069
INFO TECH SPEC 2	18	75023	$53,492
NARC INVSTGR 2	23	75024	$65,902
SECY 1	11	75025	$33,498
NARC INVSTGR 1	18	75027	$52,682
NARC INVSTGR 1	18	75028	$49,296
NARC INVSTGR 2	23	75029	$63,822
KEYBOARD SPEC 2	9	75030	$38,226
PHARMACY CONSULTANT	25	75031	$93,192*
PHARMACY CONSULTANT	25	75033	$88,687*
HEALTH PROG ADMIN 1	23	75034	$63,822
NARC INVSTGR 2	23	75035	$72,809
NARC INVSTGR 2	23	75036	$70,063
NARC INVSTGR 1	18	75037	$61,143

NARC INVSTGR 1	18	75038	$49,296
NARC INVSTGR 1	18	75039	$54,375
HEALTH PRGM ADMR	18	75040	$62,685
NARC INVSTGR 1	18	75041	$52,682
NARC INVSTGR 1	18	75042	$49,296
PHARMACY SUPVR HLTH	27	75043	$106,983*
PHARMACY CONSULTANT	25	75044	$88,688*
NARC INVSTGR 1	18	75045	$62,685
NARC INVSTGR 1	18	75102	$62,685
NARC INVSTGR 1	18	75103	$62,685
NARC INVSTGR 1	18	75202	$62,685
NARC INVSTGR 2	23	75301	$63,822
NARC INVSTGR 2	23	75402	$63,822
NARC INVESTR 1 SP L	18	75405	$57,759
KEYBOARD SPEC 1	6	75407	$34,227
NARC INVSTGR 2	23	75408	$72,143
HEALTH PRGM ADMR	18	75409	$57,366
INFO TECH SPEC 2 PROG	18	75501	$59,395
INFO TECH SPEC 4 DB	25	75502	$85,306
PRIN DATA ENTY MACH O	14	75503	$39,587
INFO TECH SPEC 2	18	75505	$62,685
HEALTH PROG ADMIN 2	25	75506	$70,931
CLERK 1	6	75507	$35,362
NARC INVSTGR 1	18	75508	$54,214
			3,405,362

* *Annual Salary* includes a professional differential of $11,000

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
EXPENDITURE PLAN FOR SFY10-11

Category	
Personal Service	
Regular	$ 2,288,372
Over Time	$0
Total Personal Service	**$ 2288372**
Non-Personal Service	
Supplies and Materials	$375,293
Travel	$209,767
Contractual Services	
Postage	$ 15,500
Help Desk (5 contract staff)	$ 216,000
Official Prescription Program Hot-line	8,500
Printing & Distribution of Official Prescriptions	$11,836,000
Cell Phones	$ 8,051
Vehicle Maintenance	$ 25,000
Misc. Contractual Services	$95,600
Equipment (includes vehicle purchases)	$190,698
Fringe Benefits @ 46%	$ 1,042,735
Indirect Cost @ 23.4%	$ 88,484
Total Non-Personal Service	**$ 14,111,628**
GRAND TOTAL	**$ 16,400,000**

PERSONAL SERVICE

Regular

The recommended sum of $2,288,372 is insufficient to support the Official Prescription Program and the Bureau of Narcotic Enforcement at current year fill level. An appropriation of $3,405,000 is needed to support the projected FY10-11 annual expense for the current year fill level of 50 ftes at a cost of $3,405,000.

The recommended personal service appropriation is insufficient to support overtime expenses. These expenses are primarily a result of investigations and case work by the Narcotic Investigator 1 positions. All overtime is pre-approved by supervisory staff and monitored closely to adhere to austerity budget guidelines. The amount of overtime may vary greatly from case to case depending on the number of interviews required, location of incidents and various other circumstances involved in an investigation. The Bureau continues to see a steady annual increase in the number of cases processed, making overtime necessary to accommodate the workload in a timely fashion.

Narcotic Investigator vacancies will be filled as waivers are received and are considered critical fill items due to patient safety and public health issues.

NON-PERSONAL SERVICES

Supplies

The recommended amount of $375,293 will continue to support outreach and education to health care professionals, educators and the general public. In late SFY09-10 the Bureau expanded its Practitioner Notification Program allowing practitioners to solicit drug utilization reports on patients via a secure web site. The full roll out of this program is expected in SFY 10—11. This change requires broad notification to practitioners. The recommended appropriation would be used for updating current publications used for educating medical practitioners, creating new posters for medical offices to display for patient waiting and exam areas, and mailings informing prescribing professionals of the expansion of the program. The recommended amount would also be used to purchase fuel for the Bureaus' 22 vehicles utilized by enforcement staff preventing the diversion of prescription drugs for illegal uses or sale on the street. This amount will also support routine office supplies including subscriptions to health industry reference materials.

Travel

The recommended amount of $209,767 will support the travel associated with the Bureau's 28 Enforcement items and 5 Administrative items whose job responsibilities' include prevention of prescription drug diversion, routine travel relating to investigations, travel to statewide training, and travel for education and outreach events for healthcare professionals, law enforcement, school professionals and the general public.

Final J.

Contractual Services

A total appropriation of $12,204,651 was recommended for Contractual Service expenditures. A recommended total of $11,489,000 will support the printing and issuance of 175,000,000 New York State official prescription forms, as well as official serialized secure labels for facilities that computer generate prescriptions. This includes the 5% increase in prescribing that the health care industry sees annually on a national basis. Contractual funds will also be used to support the Official Prescription Program help desk with 5 contract employees for an annual cost of $216,000. The Official Prescription help desk handles approximately 100,000 inquiries annually. The recommended appropriation includes $8,500 for the telephone line service fee to support the Bureau's hot-line. This hotline allows medical professionals, including pharmacists and prescribers, access to expert advice relating to controlled substance prescribing and registering for the official prescription program. Also included is $8,051 annual cost for cell phone service. This service is provided for investigative staff and Bureau administrators that spend extensive time in the field and need to be in contact with the main office. The recommended appropriation includes $15,500 for postage. Mailings in SFY10-11 will include notification to all pharmacies of a major change in electronic prescribing regulations, a notice to manufacturers and distributors of mandated electronic reporting, and practitioner mailings relating to increased online ordering and to identify inactive accounts. The recommended appropriation includes $25,000 for vehicle maintenance based on previous year expenses. These amounts are all continuing expenses and are based on previous year costs.

The sum of $95,600 of the recommended funds will purchase software upgrades to support and upgrade the Bureau's case-tracking, practitioner notification program and data analysis databases and to contract with Lexis Nexis to enable criminal background checks during investigations. This amount will also continue to support maintenance and repair agreements for office copiers, printers, scanners and fax machines.

Equipment

A recommended total of $190,698 is necessary to replace outdated office and computer equipment and for the purchase of vehicles. Currently the Bureau of Narcotic Enforcement has only 23 vehicles for 28 narcotic investigator and enforcement supervisory positions. Nine (9) of the existing vehicles have well over 100,000 miles on them, with some close to 200,000 miles. Five new vehicles, at an approximate cost of $100,000, will be needed to replace current fleet vehicles that have the highest mileage and are in need of frequent repair. Remaining funds would be used to replace aging body armor, update obsolete surveillance equipment and other aging equipment needed for enforcement activities.

Fringe Benefits

The recommended fringe benefit appropriation of $1,042,735 is based on total personal service expenditure of $2,288,372 and reflects an anticipated Federal Fringe Benefit rate of 46%

for SFY 10-11. However the FY10 Fringe Benefit rate has been set at 48.43% making the appropriation insufficient. The amount for this expense should be $1,108,000.

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Indirect Costs

The recommended appropriation of $88,484 would indicate a 3% indirect rate for SFY 10-11. This is significantly lower than the previous year's indirect cost rate of 19.6%. The amount of indirect cost for this period should be $652,900.

DEPARTMENT OF HEALTH
2010-2011 FISCAL YEAR
CASH DISBURSEMENT PLAN

PROGRAM TITLE: Official Prescription Program

APPROPRIATION AMOUNT: $16,400,000

FUND SOURCE: Suballocation Fund

DATE: 3/11/2009

Col. 1 Category	Col. 2 April-June 30 2009 Disbursements	Col. 3 July 1-Sept 30 2009 Disbursements	Col. 4 Oct 1-Dec 1 2009 Disbursements	Col. 5 Jan 1-Mar 31 2010 Disbursements	Col. 6 Total Fiscal Year Disbursements	Col. 7 Carryout
Carry-In	$ 2,250,000				$2,250,000	
2008-2009 Appropriation	2,,900,000	3,600,000	3,850,000	3,850,000	14,200,000	2,200,000
Total	5,150,000	$3,600,000	$3,850,000	$3,850,000	$16,450,000	$2,638.000

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
EXPENDITURE PLAN FOR SFY10-11

PROGRAM PROPOSAL

The Bureau of Narcotic Enforcement's (BNE) Official Prescription Program realized a decrease in the prescription fraud associated with forged and altered prescriptions. According to analysis performed by the Medicaid program, the expanded Official Prescription Program continues to result in a cost avoidance of approximately $3 million per month to the Medicaid program and also resulted in savings private insurers. BNE will continue to move forward with programs aimed at preventing the diversion of controlled prescription drugs and thus help insure the health and safety of New Yorkers.

BNE completed its third year of the Practitioner Notification Program and to date has informed over 11,000 prescribing practitioners of over 2,400 patients filling controlled substance prescriptions from multiple practitioners at multiple pharmacies. This notification allows practitioners to consider whether their patients were legitimately receiving these drugs for their own use or whether they were "doctor shopping" for the purpose of obtaining controlled prescription drugs for illegal purposes. The program has been expanded to allow prescribers to log onto a secure web site (the Health Commerce System) and review patients' recent prescription history prior to writing a prescription for a controlled substance for that patient. The program was implemented in February, 2010. The ability for practitioners to have secure online access to their patients' recent controlled substance utilization will prevent diversion and abuse at the time of the initial office visit or call from the patient.

Dispensers are required to submit information on the refilling of prescription controlled substances and the method of payment used by the individual acquiring the prescription controlled drug. This will allow the Department to identify those paying cash at varied pharmacies for the purpose of avoiding detection of "doctor shopping" activity and reveal those individuals receiving numerous refills of controlled substances for possible sale to others or other abuse. Additional savings are anticipated through this new method of fraud detection.

Other regulations require licensed manufacturers and distributors to report sales of prescription drugs to the Department. Analysis of these data by BNE will combat drug diversion by detecting inappropriate procurement of controlled substances by practitioners, pharmacies and institutional dispensers. The analysis of these data by BNE will close the loop of prescription controlled substance movement through the system from initial distribution to the end user. Further savings are expected in the prevention of fraudulently diverted prescription drugs.

The appropriated budget for the Official Prescription Program for SFY 09-10 was $21,500,000 and funded approximately 200 million prescription forms and serialized

authentication labels issued to practitioners and institutions. The number of prescriptions needed increases yearly, therefore BNE estimates the need to issue approximately 210 million prescriptions in SFY 10-11.

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
PERSONAL SERVICE PLAN FOR SFY 10-11

Title/Grade		*Item Number*	*Annual Salary*
HEALTH PROG ADMR 2	25	75001	$84,416
MEDICAID INVEST 2	21	75002	$65,192
INFO TECH SPEC 2 PROG	18	75003	$62,685
AGENCY PRGM AIDE	13	75005	$41,780
HEALTH PROG ADMR 1	23	75006	$78,384
HEALTH PROG ADMR 2	25	75007	$70,931
NARC INVSTGR 2	23	75013	$74,888
NARC INVSTGR 1	18	75014	$62,685
NARC INVSTGR 1	18	75015	$62,685
NARC INVSTGR 1	18	75016	$50,989
HEALTH PRGM ADMR	18	75019	$50,828
NARC INVSTGR 1	18	75021	$56,069
INFO TECH SPEC 2	18	75023	$53,492
NARC INVSTGR 2	23	75024	$65,902
NARC INVSTGR 1	18	75027	$52,682
KEYBOARD SPEC 2	9	75030	$38,226
PHARMACY CONSULTANT	25	75031	$93,192*
PHARMACY CONSULTANT	25	75033	$88,687*
NARC INVSTGR 2	23	75035	$72,809
NARC INVSTGR 2	23	75036	$70,063
NARC INVSTGR 1	18	75037	$61,143
NARC INVSTGR 1	18	75039	$54,375
HEALTH PRGM ADMR	18	75040	$62,685
NARC INVSTGR 1	18	75041	$52,682
NARC INVSTGR 1	18	75042	$49,296
PHARMACY SUPVR HLTH	27	75043	$106,983*
PHARMACY CONSULTANT	25	75044	$88,688*

NARC INVSTGR 1	18	75045	$62,685
NARC INVSTGR 1	18	75102	$62,685
NARC INVSTGR 1	18	75103	$62,685
NARC INVSTGR 1	18	75202	$62,685
NARC INVSTGR 2	23	75301	$63,822
NARC INVSTGR 2	23	75402	$63,822
NARC INVESTR 1 SP L	18	75405	$57,759
KEYBOARD SPEC 1	6	75407	$34,227
NARC INVSTGR 2	23	75408	$72,143
HEALTH PRGM ADMR	18	75409	$57,366
INFO TECH SPEC 2 PROG	18	75501	$59,395
INFO TECH SPEC 4 DB	25	75502	$85,306
INFO TECH SPEC 2	18	75505	$62,685
HEALTH PROG ADMIN 2	25	75506	$70,931
CLERK 1	6	75507	$35,362
NARC INVSTGR 1	18	75508	$54,214
			2,362,659

* *Annual Salary* includes a professional differential of $11,000

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICIAL PRESCRIPTION PROGRAM – SUBALLOCATION FUND

BUREAU OF NARCOTIC ENFORCEMENT
EXPENDITURE PLAN FOR SFY10-11

Category	
Personal Service	
Regular	$2,362,659
Overtime	18,500
Total Personal Service	**$ 2,381,159**
Non-Personal Service	
Supplies and Materials	$105,000
Travel	$160,000
Contractual Services	
Postage	$ 11,500
Help Desk (5 contract staff)	$ 216,000
Official Prescription Program Hot-line	8,500
Printing & Distribution of Official Prescriptions	$11,489,471
Cell Phones	$ 8,051
Vehicle Maintenance	$ 20,000
Misc. Contractual Services	$74,106
Equipment	$80,713
Fringe Benefits @ 48.43%	$ 1,142,000
Indirect Cost @ 19.6%	$ 687,000
Total Non-Personal Service	**$ 14,002,341**
GRAND TOTAL	**$ 16,400,000**

PERSONAL SERVICE

Regular

The recommended sum of $2,288,372 is insufficient to support the Official Prescription Program and the Bureau of Narcotic Enforcement at current year fill level. An appropriation of $2,362,659 is needed to support the current level of staffing for FY10-11.

Narcotic Investigator vacancies will be filled as waivers are received and are considered critical fill items due to patient safety and public health issues.

The recommended personal service appropriation is insufficient to support overtime expenses. These expenses are primarily a result of investigations and case work by the Narcotic Investigator 1 positions. All overtime is pre-approved by supervisory staff and monitored closely to adhere to austerity budget guidelines. The amount of overtime may vary greatly from case to case depending on the number of interviews required, location of incidents and various other circumstances involved in an investigation. The Bureau continues to see a steady annual increase in the number of cases processed, making overtime necessary to accommodate the workload in a timely fashion. Based on previous years expenses an amount of $18,500 is recommended for overtime.

An interchange between PS and NPS funds will be supported by the Division of Budget to cover the $92,787 deficiency. These funds can be interchanged from the Bureau's equipment and supplies categories.

NON-PERSONAL SERVICES

Supplies

The recommended amount of $123,500 will continue to support outreach and education to health care professionals, educators and the general public. In late SFY09-10 the Bureau expanded its Practitioner Notification Program allowing practitioners to solicit drug utilization reports on patients via a secure web site. The full roll out of this program is expected in SFY 10—11. This change requires broad notification to practitioners. The recommended appropriation would be used for updating current publications used for educating medical practitioners, creating new posters for medical offices to display for patient waiting and exam areas, and mailings informing prescribing professionals of the expansion of the program. The recommended amount would also be used to purchase fuel for the Bureaus' vehicles utilized by enforcement staff preventing the diversion of prescription drugs for illegal uses or sale on the street. This amount will also support routine office supplies including subscriptions to health industry reference materials.

Travel

The recommended amount of $160,000 will support the travel associated with the Bureau's Enforcement and Administrative items whose job responsibilities' include prevention of prescription drug diversion, routine travel relating to investigations, travel to statewide

training, and travel for education and outreach events for healthcare professionals, law enforcement, school professionals and the general public. Funding also supports travel related to the creation of a new Bureau Policy and Procedure Manual needed in response to the 2008 Inspector General report.

Contractual Services

A total appropriation of $11,827,628 was recommended for Contractual Service expenditures. A recommended total of $11,489,471 will support the printing and issuance of 210,000,000 New York State official prescription forms, as well as official serialized secure labels for facilities that computer generate prescriptions. This includes the 5% increase in prescribing that the health care industry sees annually on a national basis. Contractual funds will also be used to support the Official Prescription Program help desk with 5 contract employees for an annual cost of $216,000. The Official Prescription help desk handles approximately 100,000 inquiries annually. The recommended appropriation includes $8,500 for the telephone line service fee to support the Bureau's hot-line. This hotline allows medical professionals, including pharmacists and prescribers, access to expert advice relating to controlled substance prescribing and registering for the official prescription program. Also included is $8,051 annual cost for cell phone service. This service is provided for investigative staff and Bureau administrators that spend extensive time in the field and need to be in contact with the main office. The recommended appropriation includes $11,500 for postage. Mailings in SFY10-11 will include notification to all pharmacies of a major change in electronic prescribing regulations, a notice to manufacturers and distributors of mandated electronic reporting, and practitioner mailings relating to increased online ordering and to identify inactive accounts. The recommended appropriation includes $25,000 for vehicle maintenance based on previous year expenses. These amounts are all continuing expenses and are based on previous year costs.

The sum of $74,106 of the recommended funds will purchase software upgrades to support and upgrade the Bureau's case-tracking, practitioner notification program and data analysis databases and to contract with Lexis Nexis to enable criminal background checks during investigations. This amount will also continue to support maintenance and repair agreements for office copiers, printers, scanners and fax machines.

Equipment

A recommended total of $80,713 would be utilized to replace outdated office and computer equipment including a server to back up the increased data now being collected. Funds would be used to replace aging body armor, update obsolete surveillance equipment and other aging equipment needed for enforcement activities.

Fringe Benefits

The appropriation of $1,142,000 is recommended for fringe benefit based on total personal service expenditure of $2,362,659and an anticipated Federal Fringe Benefit rate of 48.34%.

Indirect Costs

The appropriation of $687,000 is recommended for SFY 10-11. This based on an indirect rate of 19.6%.

The National Center on
Addiction and Substance Abuse
at Columbia University

633 Third Avenue
New York, NY 10017-6706

phone 212 841 5200
fax 212 956 8020
www.casacolumbia.org

Shoveling Up II:
The Impact of Substance Abuse on Federal, State and Local Budgets

May 2009

*The National Center on Addiction and Substance Abuse at Columbia University is neither affiliated with, nor sponsored by, the National Court Appointed Special Advocate Association (also known as "CASA") or any of its member organizations, or any other organizations with the name of "CASA".

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Foreword and Accompanying Statement by
Joseph A. Califano, Jr., Founder and Chairman

In this report, The National Center on Addiction and Substance Abuse (CASA) at Columbia University has identified the total amount spent by federal, state and local governments on substance abuse and addiction--the first time such an analysis has ever been undertaken.

This CASA report finds that in 2005 federal, state and local government spending as a result of substance abuse and addiction was at least $467.7 billion: $238.2 billion, federal; $135.8 billion, state; and $93.8 billion, local.[*] Total government spending of $467.7 billion on substance abuse and addiction amounted to 10.7 percent of their entire $4.4 trillion budgets.

Of every dollar *federal and state governments*[†] spent on substance abuse and addiction in 2005, 95.6 cents went to shoveling up the wreckage and only 1.9 cents on prevention and treatment, 0.4 cents on research, 1.4 cents on taxation or regulation and 0.7 cents on interdiction.

Under any circumstances spending more than 95 percent of taxpayer dollars on the consequences of tobacco, alcohol and other drug abuse and addiction and less than two percent to relieve individuals and taxpayers of this burden would be considered a reckless misallocation of public funds. In these economic times, such upside-down-cake public policy is unconscionable.

The facts revealed in this report constitute a searing indictment of the policies of government at every level that spend virtually all of the funds in this area to shovel up the wreckage of substance abuse and addiction and practically nothing to prevent and treat it.

In the face of evidence that prevention programs aimed at smoking, illegal and prescription drug abuse and underage and excessive adult drinking

[*] In this report, numbers may not always add due to rounding.

[†] This analysis does not include local spending due to data limitations.

can be effective, and that many treatment programs have outcomes more favorable than many cancer treatments, our current spending patterns are misguided. They drain urgently needed funds from government budgets and permit the savaging of millions of lives through preventable accidents, homicides, suicides, domestic violence, child abuse, sexual assaults, unplanned pregnancies, homelessness, forgone educations, STDs, birth defects and more than 70 illnesses requiring hospitalization. It is past time for this fiscal and human waste to end.

The figures are based on 2005 spending because that was the most recent year for which data were available over the course of the study, but there is nothing to suggest that anything in this area has changed since then.

For three years, CASA has been analyzing the federal budget and budgets of the 50 states, the District of Columbia and Puerto Rico and reviewing local government expenditures, including case studies of four local jurisdictions. Based on a careful examination of national and peer-reviewed research, we have estimated the spending related to smoking, underage and excessive drinking and illegal and prescription drug abuse and addiction. The result of this effort is the first comprehensive picture ever assembled of substance-related spending across all levels of government.

Troubling as this unprecedented analysis is, it understates the burden of substance abuse and addiction on federal, state and local government taxpayers. In every case CASA made the most conservative assumptions about the burden of substance abuse and addiction on government budgets. Moreover, in some cases--higher education, tobacco and drug-related developmental disabilities, highway accidents linked to illicit or controlled prescription drug use, civil court costs, and workforce-related turnover and higher health insurance costs--we were unable to include any estimate at all due to data limitations.

In these areas where we could not estimate costs, we know that substance-related spending could be sizable. For example, 22.9 percent of full-time college students meet medical criteria for substance abuse and addiction and about 80 percent of heavy drinkers and two-thirds of illegal drug users in the U.S. are employed full or part time, imposing increased costs on governmental budgets for higher education and the workforce.

In spite of its conservative nature, the report offers the nation examples of just how much our failure to prevent and treat addiction costs federal, state and local governments. It also offers specific actions to reduce the burden on governments and taxpayers, save lives and untold agony for millions of families, and improve health.

Key 2005 findings of the report are:

- For every dollar *federal and state governments* spent to prevent and treat substance abuse and addiction, they spent $59.83 in public programs shoveling up its wreckage.

- If substance abuse and addiction were its own *state* budget category, it would rank second just behind spending on elementary and secondary education.

- If substance abuse and addiction were its own budget category at the *federal* level, it would rank sixth, behind social security, national defense, income security, Medicare and other health programs including the federal share of Medicaid.

- *Federal and state governments* spend more than 60 times as much to clean up the devastation substance abuse and addiction visits on children as they do on prevention and treatment for them.

Federal Outlays by Budget Function
Including Spending on Substance Abuse and Addiction
(in Billions)

Budget Function*	**2005**
Social Security	$523
National defense	494
Income security	348
Medicare	299
Other health	250
Substance abuse and addiction	**238**

* The top five budget categories also contain costs linked to substance abuse and addiction.

This report represents the second in CASA's analysis of the impact of tobacco, alcohol and other drug abuse and addiction on government. Our first report, *Shoveling Up: The Impact of Substance Abuse on State Budgets,* was released in 2001 and was limited to *state* spending. Such spending has increased since CASA's 2001 report. In 2005, *states* spent 15.7 percent of their budgets on substance abuse and addiction compared with 13.3 percent in 1998, up more than 18 percent.

Almost three-quarters (71.1 percent) of total federal and state spending on the wreckage or burden of addiction is in two areas: health care and justice system costs. Increasing costs in these areas are devastating state budgets while health care costs are consuming a larger and larger share of federal spending. The largest share of *federal and state spending* to shovel up the burden of substance abuse and addiction is in health care costs (58.0 percent). At the federal level, 74.1 percent of all shoveling up spending is in the area of health care, underscoring the critical importance of addressing this issue in the context of national health care reform.

Sin taxes are inadequate to compensate for the harm caused by tobacco use, underage drinking and adult excessive drinking. The public health goal for tobacco taxes is to help eliminate use. The public health goal for alcohol taxes is to curb underage and adult excessive drinking. For each dollar in alcohol and tobacco taxes and liquor store revenues that goes to *federal and state* coffers, these governments spend $8.95 on the consequences of smoking and alcohol abuse and addiction.

To stem this hemorrhage of government shoveling up spending, the report recommends action in several areas:

- Prevention and early intervention,
- Treatment and disease management,
- Tax and regulatory policies; and,
- Expanded research.

Prevention is the top priority and the surest way to reduce the burden that shoveling up imposes on children, families and taxpayers. Prevention begins with individuals changing their conduct. It requires the kind of public health campaign that cut smoking almost in half over the past three decades; engages our elementary, secondary and university educational systems; and engages the medical profession in screenings and brief interventions to avoid the problem or identify it early when it can be dealt with in time to reduce or eliminate the costs of substance abuse and addiction to families, government and society.

A focus of public health prevention efforts must be our children: 17 years of research at CASA have shown that a child who reaches age 21 without smoking, using illicit drugs or abusing alcohol is virtually certain never to do so. We need, for example, to launch an effective public health media campaign aimed at drug abuse and underage drinking as the American Legacy Foundations' **truth**® campaign has so effectively targeted youth smoking.

As with other chronic health problems, it is critical to acknowledge the issue of personal responsibility. While some people are at greater risk than others for developing addictive disorders (genetics, family and community characteristics, co-occurring health problems, etc.), in the vast majority of cases initial use of tobacco, alcohol or other drugs is very much a

matter of personal choice. When use of these substances progresses to the point of meeting medical criteria for abuse or addiction, changes have occurred in the brain which make cessation of use extraordinarily difficult. Having a chronic disease should not, however, excuse an individual from the consequences of his or her actions or society from providing appropriate health care. The bottom line is that while an individual is responsible for his or her actions related to the disease, the disease must be treated.

Effective, evidence-based treatment is critical since some nine percent of the U.S. population has a clinical substance use disorder. The return on investments in treatment would bring a smile to any corporate CEO: scientific research has established that every dollar spent on quality treatment can deliver a return of $12.00 or more in reduced substance-related crime and criminal justice and health care costs. Failure of the medical profession to treat substance abuse and addiction as a chronic disease where relapse may occur (like diabetes, depression, hypertension or asthma) and the failure of the health insurance industry across the board to provide adequate coverage for such treatment are inhumane and wasteful decisions that have resulted in broken families, lost lives and billions in wasted taxpayer dollars.

Deploying taxation to increase the price of cigarettes has been an effective companion to public health education in reducing smoking in our nation. This tool can be used to help reduce underage drinking and excessive adult drinking. Regulatory policies to curb underage access to tobacco and alcohol also can be effective in reducing use. Just as reducing smoking has cut health care costs, so can reducing underage and adult excessive drinking.

Finally, we need to increase our knowledge about the disease of addiction, its causes and correlates, and effective prevention and treatment strategies. This requires increased investments in research. On a health problem that costs this nation more than $450 billion in 2005, we spent only $1.6 billion on research. Instead, we spent billions researching the consequences of addiction: cancers, strokes, cardiovascular ailments, respiratory diseases and AIDS. In 2005, the National Institutes of Health which supports 90 percent of the nation's basic biomedical research, spent at least $11 billion researching these five diseases and 15 percent of this amount to study the largest single cause and exacerbator of that quintet of leading killers and cripplers.

To stop the nation's profligate spending on the burden of addiction, America must change its culture. Just as we did with tobacco, starting in 1978, we have to educate Americans of the health and other dangers of alcohol and other drug use. As a nation, we must face the fact that substance abuse is a public health problem and addiction is a medical problem and respond accordingly. We need the kind of campaign the public health community mounted with respect to AIDS: in a matter of a few years, AIDS went from being seen as a social curse to being recognized as a serious, treatable disease. It's time for the public health community to mount a similar effort with respect to alcohol and other drug abuse and addiction, to move the nation from stigmatizing it to recognizing it as a disease.

While America should invest both in supply and demand reduction strategies, when it comes to illicit drugs there appears to be much room for improvement in the efficacy of $2.6 billion in current federal drug interdiction activities. We have been able to keep biological and nuclear materials from entering our borders, but we haven't been able to stop the flow of illicit drugs that kill and maim so many of our people and destroy neighborhoods. We need to commit the same level of expertise to keeping drugs out of our nation that we have used so successfully for biological and nuclear weapons.

This report includes many examples of proven and promising practices to reduce the crushing substance-related costs to government. Some actions--like indoor smoking bans, alcohol tax increases, screening and brief interventions and addiction treatments--will yield immediate results; most promising practices presented in

this report will provide significant savings over longer periods.

One particularly promising change is that in October 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, with the support of key members of Congress including Representatives Patrick Kennedy and Jim Ramstad. The Act ensures that, as of January 2010, group health plans that provide any mental health and addiction treatment will provide the same coverage for mental health and addiction treatment as they do for all other medical and surgical care. While a major step toward coverage of addiction treatment, the Act only mandates parity for companies that already provide these services. The nation needs to make coverage for addiction treatment consistent with coverage for other chronic diseases.

This report lists the experts who served on our Advisory Commission and who made invaluable contributions. In particular, I would like to thank the Commission Chairman, Frederick M. Bohen, for his leadership and tireless effort. His work and that of the Commission members contributed significantly to the quality of this product.

Susan E. Foster, MSW, CASA's Vice President and Director of Policy Research and Analysis, was the principal investigator and staff director for this effort. The data analysis was conducted by CASA's Substance Abuse and Data Analysis Center (SADAC^{SM}), headed by Roger Vaughan, DrPH, CASA Fellow and Professor of Clinical Biostatistics, Department of Biostatistics, Mailman School of Public Health at Columbia University, and associate editor for statistics and evaluation for the *American Journal of Public Health*. He was assisted by Elizabeth Peters. Others who worked on the project are: Sara Blachman, Kristen Keneipp, MHS, Akiyo Kodera, Linda Richter, PhD, Varouj Symonette, JD, Sarah Tsai, MA, CASA's librarian David Man, PhD, MLS, library research specialist Barbara Kurzweil, and bibliographic data base manager Jennie Hauser. Project interns included Hannah Kim, Jason Lerner and Emily Toto. Jane Carlson handled administrative responsibilities.

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While many individuals and institutions contributed to this effort, the findings and opinions expressed herein are the sole responsibility of CASA.

Chapter I
Introduction and Executive Summary

In 2005, federal, state and local governments spent at least $467.7 billion on substance abuse and addiction. This report is the first comprehensive picture of substance related spending across all levels of government. Building on CASA's 2001 report, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, this report reveals the pervasive and devastating burden of substance abuse and addiction to all government budgets.

Federal and state[*] governments spent $3.3 trillion in 2005 to operate government and provide public services such as education, health care, income assistance, child welfare, mental health, law enforcement and justice services, transportation and highway safety. Hidden in this spending was a stunning $373.9 billion[†]--11.2 percent--that was spent on tobacco, alcohol and other drug abuse and addiction. A conservative estimate of local government spending on substance abuse and addiction in 2005 is $93.8 billion.

The vast majority of *federal and state*[‡] substance related spending--95.6 percent or $357.4 billion--went to carry the burden to government programs of our failure to prevent and treat the problem while only 1.9 percent was spent on preventing or treating addiction. Another 0.4 percent was spent on research and the remaining two percent was spent on alcohol and tobacco tax collection, regulation and operation of state liquor stores (1.4 percent) and federal drug interdiction (0.7 percent).[§] For every dollar the federal and state governments spent on prevention and treatment, they spent $59.83 shoveling up the consequences.

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[*] Including the District of Columbia and Puerto Rico. State funds include own source revenues, not federal transfers.

[†] In this report numbers may not always add due to rounding.

[‡] This analysis does not include local spending due to data limitations.

[§] Numbers do not add to 100 percent due to rounding.

A staggering 71.1 percent of total *federal and state* spending on the burden of addiction is in two areas: health and justice. Almost three-fifths (58.0 percent) of federal and state spending on the burden of substance abuse and addiction (74.1 percent of the federal burden) is in the area of health care where untreated addiction causes or contributes to over 70 other diseases requiring hospitalization. The second largest area of substance-related federal and state burden spending is the justice system (13.1 percent).

This report shows how governmental spending is skewed toward shoveling up the burden of our continued failure to prevent and treat the problem rather than toward investing in cost effective approaches to prevent and minimize the disease and its consequences. Despite a significant and growing body of knowledge documenting that addiction is a preventable and treatable disease, and despite a growing array of prevention, treatment and policy interventions of proven efficacy, our nation still looks the other way while substance abuse and addiction cause illness, injury, death and crime, savage our children, overwhelm social service systems, impede education and slap a heavy and growing tax on our citizens.

In the current fiscal climate of growing economic hardship, we no longer can afford costly and ineffective policies that sap on average $1,486 annually in government taxes and fees from each man, woman and child in America--$5,944 each year for a family of four.

Shoveling Up establishes the categories of state spending that are tightly linked to tobacco, alcohol and other drug abuse and addiction (including both illicit and controlled prescription drugs)--the targets for policy intervention. It uses existing research to establish the proportion of government spending in each of these target categories that is substance related, providing estimates of the total costs of substance abuse and addiction--the aggregate costs--which include both avoidable and unavoidable costs. The bottom line for government is identifying where substance abuse and addiction must be prevented or treated if public costs are to be reduced or avoided. We include examples of proven and promising ways to reduce those costs and examples of the potential for specific cost avoidance/savings.

Key findings of this report are that in 2005:

- The *federal* government spent $238.2 billion on substance abuse and addiction or 9.6 percent of the federal budget. If substance abuse and addiction were its own budget category, it would rank sixth in size--behind social security, national defense, income security,* Medicare and other health programs.†

- *State* governments, including the District of Columbia and Puerto Rico, spent 15.7 percent of their budgets ($135.8 billion) to deal with substance abuse and addiction--*up from 13.3 percent in 1998*. If substance abuse and addiction were its own budget category, it would rank second behind elementary and secondary education. States spend more on substance abuse and addiction than they spend on Medicaid, higher education, transportation or justice.†

- *Local* governments spent conservatively‡ $93.8 billion on substance abuse and addiction or 9.0 percent of local budgets, outstripping local spending for transportation and public welfare.†

- Of every dollar *federal and state* governments spent on substance abuse and addiction:

  - 95.6 cents went to pay for the burden of this problem on public programs.

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* Includes Temporary Assistance for Needy Families, Supplemental Security Income and Social Security Disability.

† Costs of substance abuse and addiction also are embedded in the top five categories of spending.

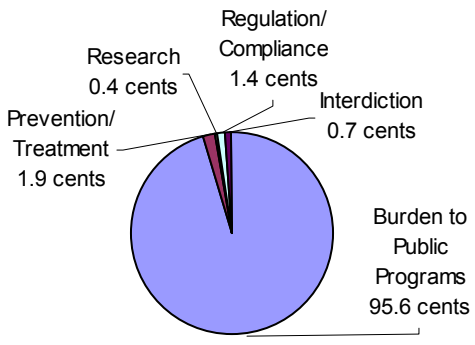
‡ Due to data limitations, does not include all areas of spending on the burden to public programs, prevention, treatment, research, or taxation/regulation of alcohol and tobacco.

Substance abuse and addiction increases, for example, the cost of America's prisons and jails; Medicaid and other health programs; elementary and secondary schools; child welfare, juvenile justice and mental health systems; public safety; and government payrolls.

- 1.9 cents went to fund prevention and treatment programs aimed at reducing the incidence and consequences of substance abuse and addiction.
- 1.4 cents covered costs of collecting alcohol and tobacco taxes, regulating alcohol and tobacco products and operating state liquor stores.
- 0.4 cents was spent on addiction-related research.
- 0.7 cents was spent by the federal government on drug interdiction. (Figure 1.A and Table 1.1)

Figure 1.A

The Substance Abuse Dollar



Note: Numbers do not add to $1.00 due to rounding.

- For every dollar *federal and state* governments spent to prevent and treat substance abuse and addiction, they spent $59.83 in public programs shoveling up its wreckage, despite a substantial and growing body of scientific evidence confirming the efficacy of science-based interventions and treatment and their cost-saving potential.
- The largest area of *federal and state* government spending on the burden of substance abuse and addiction was health care, totaling $207.2 billion (58.0 percent) in 2005. Federal substance-related health care spending totaled $170.3 billion, 74.1 percent of all federal burden spending.
- The second largest area of *federal and state* spending on the burden of substance abuse and addiction, and the largest area of state spending, is the justice system, including costs of incarceration, probation and parole, juvenile justice and criminal and family court costs of substance-involved offenders. These costs totaled $47.0 billion (13.1 percent) in federal and state burden spending in 2005. State substance-related justice spending totaled $41.4 billion, 32.5 percent of all state burden spending.
- Other areas of significant *federal and state* spending on the burden to government of our failure to prevent or treat substance abuse and addiction include:
  - $33.9 billion on the burden to education programs,
  - $46.7 billion on the burden to child and family assistance programs, and
  - $11.8 billion on the burden to mental health and developmental disabilities programs.
- Almost half (47.3 percent) of government spending on substance abuse and addiction cannot be disaggregated by substance. In fact, research shows that most individuals with substance use disorders use more than one drug. Of the $248 billion in substance-related spending that can be linked to specific drugs of abuse, 92.3 percent is linked to the legal drugs of alcohol and tobacco.
- For every dollar *federal and state* governments spent on prevention or

treatment for children, they spent $60.25 on the consequences of substance abuse and addiction to them. Combined federal and state government spending in 2005 on costs of substance abuse and addiction to children totaled $54.2 billion.

- Alcohol and tobacco taxes fail to pay their way. The public health goal for tobacco taxes is to help eliminate use. The public health goal for alcohol taxes is to curb underage and adult excessive drinking. For each dollar in alcohol and tobacco taxes and liquor store revenues that hit federal and state coffers, these governments spent $8.95 cleaning up the wreckage of substance abuse and addiction. Federal, state and local governments collected $14.0 billion in alcohol and $21.2 billion in tobacco taxes in 2005 for a total of $35.2 billion; 18 states expended $4.4 billion in 2005 operating liquor stores and collected $5.6 billion in revenues. Few governments dedicate revenues to reducing the burden of substance abuse or addiction or use alcohol tax increases as a way to reduce use by teens.

- According to the National Institute on Drug Abuse, the return on investing in treatment alone may exceed 12:1; that is, every dollar spent on treatment can reduce future burden costs by $12 or more in reduced drug-related crime and criminal justice and health care costs.

Building on the methodology developed for our first analysis, this report is the result of an intensive three year analysis. As part of this unprecedented study, CASA convened an advisory panel of distinguished public officials, researchers and representatives of federal, state and local governments and interest groups.

Table 1.1

For Every $100.00 Federal and State Governments Spend on Substance Abuse and Addiction:* [a]

[ranked by spending on prevention, treatment and research]

State	Amount Spent on Prevention, Treatment and Research	Amount Spent on Burden to Public Programs	Regulation/ Compliance[b]
Connecticut	$10.39	$89.27	$0.35
Kentucky	7.32	92.01	0.67
Wyoming	6.90	71.83	21.27[b]
South Dakota	6.80	93.13	0.07
Oregon	5.55	84.38	10.06[b]
Maryland	4.53	95.34	0.13
Arkansas	4.31	95.28	0.41
Illinois	3.70	96.13	0.17
Mississippi	3.67	80.05	16.28[b]
District of Columbia	3.31	96.69	NA
Colorado	3.23	96.54	0.23
Louisiana	3.07	96.61	0.32
Montana	2.93	84.20	12.87[b]
Pennsylvania	2.84	80.55	16.62[b]
Washington	2.81	85.34	11.84[b]
Iowa	2.66	87.46	9.88[b]
New Jersey	2.62	97.16	0.23
Idaho	2.58	67.96	29.46[b]
Georgia	2.42	96.38	1.20
Delaware	2.38	97.53	0.09
Minnesota	2.33	97.65	0.02
Oklahoma	2.30	97.31	0.39
Vermont	2.21	90.19	7.60[b]
Ohio	2.21	90.44	7.35[b]
New York	2.14	97.70	0.16
Wisconsin	2.12	97.83	0.05
Nebraska	1.99	97.86	0.15
Missouri	1.94	97.94	0.11
Texas	1.91	96.36	1.74
Florida	1.83	97.57	0.60
Arizona	1.77	97.97	0.27
California	1.71	97.99	0.30
Kansas	1.55	98.13	0.32
Virginia	1.54	84.93	13.53[b]
Massachusetts	1.45	98.51	0.04
West Virginia	1.33	91.75	6.92[b]
New Mexico	1.23	98.68	0.09
North Carolina	0.98	91.17	7.85[b]
Alaska	0.91	99.09	0.005
Michigan	0.90	88.53	10.58[b]
Maine	0.71	98.75	0.54[b]
South Carolina	0.64	99.29	0.07
Alabama	0.60	83.61	15.79[b]
Nevada	0.57	99.38	0.05
Hawaii	0.55	99.32	0.13
New Hampshire	0.22	61.09	38.69[b]
Puerto Rico	0.20	99.80	NA
Average State	**$2.38**	**$93.95**	**3.67**
Federal[c]	**$2.33**	**$96.53**	**0.03**
Average State and Federal Spending[c]	**$2.35**	**$95.59**	**1.35**

* Numbers may not add to 100 due to rounding.

[a] Throughout this report, "State Total" or "State Average" refers to the 50 states, Puerto Rico and the District of Columbia.

[b] One of 18 designated alcohol control states where state operates liquor stores. Total liquor store expenditures in these states in 2005 were $4.4 billion; total liquor store revenues were $5.6 billion.

[c] The difference between the sum of the columns and $100.00 is federal spending on interdiction.

For this report, CASA refined the methodology developed for its 2001 *Shoveling Up* report in several ways. In order to provide a basis of national comparison with 1998 state data, CASA recalculated state spending for 1998 based on these refinements. All comparisons of total state spending between 1998 and 2005 presented in this report are based on the refined methodology. Because CASA could not assure uniformity in each state's reporting between 1998 and 2005, state specific comparisons between these two years should not be made. (See Appendix B, Methodology)

CASA conducted an extensive review of more than 900 articles and publications linking substance abuse and addiction to public spending. In order to provide guidance to governments of more cost effective investments, we examined a large body of national and international research evaluating federal, state and local programs designed to prevent and treat substance use problems, regulate or tax addictive substances and deal with their consequences, and cost studies of their impact. In this report, we include examples of promising interventions along with available data on their results and cost avoidance or income generation potential.

Next Steps

In CASA's 2001 report, we made three key recommendations: a) make targeted investments in prevention and treatment; b) expand use of state powers of legislation, regulation and taxation to reduce the impact of substance abuse and addiction; and c) manage investments for better results. America's failure to act on these and other recommendations has contributed to the current economic crisis governments now face.

The U.S. federal, state and local governments no longer can afford profligate spending in the area of substance abuse and addiction. If current trends continue, by 2012 spending to shovel up the burden of substance abuse and addiction could consume more than 18 percent of state budgets. Current financial constraints coupled with a large and growing body of scientific evidence that substance use disorders are diseases for which effective treatments exist present many opportunities for more cost-effective investments.

As with other chronic health problems, it is critical to acknowledge the issue of personal responsibility. While some people are at greater risk than others for developing addictive disorders (genetics, family and community characteristics, co-occurring health problems, etc.), in the vast majority of cases initial use of tobacco, alcohol or other drugs is very much a matter of personal choice. When use of these substances progresses to the point of meeting medical criteria for abuse or addiction, changes have occurred in the brain which make cessation of use extraordinarily difficult. Having a chronic disease should not, however, excuse an individual from the consequences of his or her actions or society from providing appropriate health care. The bottom line is that while the individual is responsible for his or her actions related to the disease, the disease must be treated.

Alternative Practices to Reduce Disease and Costs to Government

There are four types of alternative actions that governments should take in order substantially to avoid or reduce the more than $467.7 billion this nation spends annually on the burden of substance abuse and addiction to government:

- Prevention and early intervention;
- Treatment and disease management;
- Tax and regulatory policies; and,
- Expanded research.

Prevention and Early Intervention. The largest impact on spending to shovel up the consequences of this problem would be to make significant investments in prevention to help avoid the costs altogether, and in screenings and brief interventions to catch the problem early and alter the course of the disease and its costs

to families, government and society. Prevention and early intervention strategies should include:

- **Public Health Information.** Consistent with other successful public health efforts to educate the public about little understood diseases including depression or HIV/AIDS, federal, state and local governments should educate the public about addiction as a disease, risk factors that increase individuals' vulnerability, the importance of screening, and programs people can turn to for help. All addictive substances should be addressed, including tobacco, alcohol and other drugs.

- **Comprehensive Prevention Messages and Programs.** Prevention is the cornerstone of any public health initiative. Prevention initiatives should be focused on children: 17 years of research at CASA have shown that a child who reaches age 21 without smoking, using illicit drugs or abusing alcohol is virtually certain never to do so. Prevention strategies should focus on curbing the human and social costs of substance abuse and addiction and co-occurring problems through comprehensive messages and approaches that are provided early and are reinforced in families, schools and communities.

  A key target of opportunity is high risk children in public programs. Governments should take advantage of points of leverage in government health, justice, public safety, education, child and family assistance, housing, mental health and developmental disabilities and workplace programs to provide targeted prevention messages, ensuring that initiatives are tailored to the age, gender and cultural groups they are targeting.

- **Screenings, Brief Interventions and Referrals to Treatment.** Because the costs of untreated addiction are so high and the human consequences so great, every person entering a government funded health service, criminal justice or social welfare setting should be screened for substance use disorders and offered effective interventions and treatment where indicated. Intervening early is essential to prevent addiction and its consequences and screenings and brief interventions have proven efficacy. Examples of venues for screenings and brief interventions include: emergency departments, health clinics, trauma centers and doctors' offices; schools and colleges; welfare, child welfare, mental health and developmental disabilities services; and traffic safety, juvenile justice and adult corrections programs.

Examples of Immediate Benefits of Interventions:

1. ***Screenings and Brief Interventions***-- reductions in hospitalizations.[1]

2. ***Alcohol and tobacco tax increases***-- reductions in cirrhosis, accidents and STD transmission for alcohol taxes,[2] and in heart disease, strokes, smoking related pregnancy and birth problems for tobacco.[3]

3. ***Indoor smoking bans***--reductions in hospitalization for heart attacks.[4]

4. ***Addiction treatments***--reductions in alcohol and other drug related medical visits and inpatient mental health visits.[5]

To implement such screenings and help assure access to needed services, CASA has drafted a Model Bill of Rights for Children in Juvenile Justice Systems. The model bill provides guidance to states for a legislative mandate and framework for improvements in the field of juvenile justice related to substance abuse.

Governments should train workers in publicly funded programs to provide screenings, brief interventions and referrals to treatment. They also should expand medical billing codes for screenings and brief interventions for tobacco, alcohol and other drug use in all health care venues and

assure coverage through all publicly funded insurance programs.

Treatment and Disease Management. Since approximately 9.0 percent of the U.S. population already has a clinical substance use disorder,[6] quality treatment and disease management services are essential. Failure to provide these services is just as unacceptable as failure of our health care system to provide treatment for diabetes, depression, hypertension or asthma would be.

- **Treatment.** As with any other health condition, it is essential to look for problems of addictive disorders, properly diagnose them and provide effective treatments. Government programs provide excellent opportunities to connect people with substance use disorders with the interventions and treatments they need, and have the leverage to keep them in treatment long enough to make a difference. In providing services through public systems, it is important to understand that relapse is frequently a part of the recovery process as it is with recovery from other chronic diseases.

  In all areas of government spending on the burden of substance abuse and addiction, governments should conduct comprehensive assessments of those who screen positive for a substance use disorder and assure access to the full range of behavioral and pharmacological treatment options and social supports, tailored to the gender, age, culture and life circumstances of patients.

  Treatments should include effective services for co-occurring health and mental health problems and the availability of detoxification services. Governments should assure that all treatment programs and services that receive government funds meet evidence-based medical criteria; assure that treatment providers are properly trained and licensed; and work with existing treatment providers and the medical community to integrate addiction treatment into the medical system.

  Providing treatment particularly is important for all substance-involved individuals who are in our nation's justice systems, diverting both adults and juveniles from further engagement with the justice system where possible. Governments should expand evidence-based alcohol and other drug treatment courts and diversionary treatment and aftercare programs for adult and juvenile offenders, and eliminate mandatory sentencing laws for substance-involved offenders that remove prosecutorial and judicial discretion in treatment referrals and monitoring and compliance with treatment protocols. Without treating the addiction of offenders, attempts to reduce justice-related costs will not succeed.

- **Disease Management.** To address the long-term disease management needs of those in publicly funded programs with chronic substance use disorders, government should assure access to long-term medical management as we do for any other chronic disease. This would include management of co-occurring health and mental health problems. Governments also should assure access to recovery support including education, vocational training, employment; life, parenting and other family skills; childcare, housing and transportation support; and mutual support through such programs as AA, NA or Smart Recovery. To assure that such recovery supports are available, governments should train publicly funded staff to help their clients access aftercare and mutual support programs.

Taxation and Regulation. Because regulatory and tax policies can have enormous impact on curbing underage and excessive use of alcohol and reducing smoking, they should be integral parts of a national strategy to prevent and treat addiction. Alcohol taxes, for example, yield immediate reductions in cirrhosis, accidents and STD transmission, while increases in tobacco taxes reduce the prevalence of heart disease, strokes, smoking related pregnancy and birth problems.

Governments should adopt a broad range of tax and regulatory policies including:

- Increase taxes on tobacco to help eliminate use, and on alcohol to prevent underage initiation and reduce adult excessive drinking; classify malternative beverages (alcopops) as liquor rather than beer.

- Restrict tobacco and alcohol advertisements from youth audiences, and prohibit direct to consumer marketing of controlled prescription drugs.

- Enact/increase enforcement of comprehensive clean indoor air laws and other smoking bans, and laws restricting the sale of tobacco and alcohol to minors.

- End insurance discrimination by requiring all public and private insurers to cover evidence-based prevention, intervention, treatment and management services for substance use disorders using the same payment and coverage requirements as other illnesses; abolish state Uniform Accident and Sickness Policy Provision Laws that limit insurers' medical liability if individuals are injured while they are intoxicated.

  Over half of federal and state spending on the burden of addiction is in the area of health. Health care reform that recognizes addiction as a disease and provides access to effective treatment is the best way to reduce these costs. In the absence of comprehensive health care reform, governments should make these changes in Medicare, Medicaid and other public health programs.

Research and Evaluation. America must increase knowledge about the disease of addiction, its causes and correlates and effective prevention and treatment strategies. This requires increased investments in research.

Research that increases our understanding of substance use disorders is key to quality assurance and will help to develop and guide future cost-saving initiatives. Such research should be designed to: increase our understanding of substance abuse and addiction through genetic, biological and social science research; establish a baseline against which to measure progress and document impact at regular intervals; and fund research on best-practices for prevention and treatment of substance use and co-occurring disorders. More research attention also should be devoted to documenting the benefits of prevention,

Examples of Alternative Practices to Prevent and Reduce Substance Abuse and Addiction

Prevention and Early Intervention

- Targeted media campaigns
- Comprehensive family, school and community-based prevention
- Screenings, brief interventions and treatment referrals

Treatment and Disease Management

- Behavioral and pharmacological treatments for chronic illness
- Intensive case management
- Drug treatment alternatives to prison
- Prison based treatment/aftercare
- Recovery coaching
- Supportive housing
- Employee Assistance Programs

Taxation and Regulation

- Alcohol and tobacco tax increases
- Health insurance coverage for addiction
- Indoor smoking bans
- Keg registration laws
- Lowered blood alcohol levels for intoxicated driving offenses
- Tobacco quit lines
- 21 year old drinking age

Research

- Factors influencing risk
- Best practices
- Costs and benefits of interventions

treatment, taxation and regulatory initiatives compared with the costs of our failure to do so.

Targeted Interdiction. In the face of limited evidence of the efficacy of current interdiction efforts to reduce drug use and related government costs, the federal government should reevaluate and retarget its investments in interdiction and reconsider the balance of investment in interdiction compared with investments in prevention and treatment.

Chapter II
Uncovering the Costs of Substance Abuse and Addiction to Government

As federal, state and local governments grapple with shrinking revenues and an unprecedented economic downturn, maximizing limited resources and controlling government waste are at a premium. Perhaps in no other areas of government spending are there such opportunities for cost avoidance and economic return than in spending on substance abuse and addiction.

In 2005, substance-related spending on the part of federal and state* governments amounted to an estimated $373.9 billion--11.2 percent of the total federal and state spending. Of this spending, 95.6 cents of every dollar went to shoulder the burden of our failure to prevent and treat substance abuse and addiction and only 1.9 cents was spent on prevention, treatment. Another 0.4 cents of every substance-related dollar was spent on research; 1.3 cents was spent on alcohol and tobacco taxation, regulation and operation of state liquor stores; the remaining 0.7 cents was spent on federal drug interdiction.† (Table 2.1)

While data are limited for substance-related spending at the local level, CASA estimates that local spending on the burden of substance abuse and addiction and local operation of liquor stores was at least $93.8 billion in 2005. Adding this amount to federal and state substance-related spending brings the total to $467.7 billion--more than the costs to society of heart disease, cancer or obesity.[1]

The enormous costs resulting from substance abuse and addiction, however, are not limited to government spending. The private sector loses billions each year through higher insurance rates, increased security and lost productivity caused by substance abuse and addiction. Other costs impossible to quantify are the human ones:

* Including the District of Columbia and Puerto Rico.
† Numbers do not add to 100 percent due to rounding.

pain and suffering because of homicides, suicides, rape and other sexual assault, illness, broken families, neglected and abused children, lives shattered by substance-impaired drivers, teen pregnancy, sexually transmitted diseases or domestic violence.[2]

In this groundbreaking new report, CASA updates its analysis of state spending first published in 2001 as *Shoveling Up: The Impact of Substance Abuse on State Budgets*. This 2009 report, for the first time, expands its analysis to include federal and select local jurisdictions in order to provide a more complete picture of government spending on this problem.

This new report is designed to:

- Reveal the true impact, often hidden, that substance abuse and addiction have on the costs of federal, state and local government.
- Itemize federal, state and local government spending on this problem, distinguishing costs for 1) *prevention, treatment and research*; 2) *interdiction*; 3) *regulation and compliance*; and 4) *the burden to public programs* of not preventing and treating substance abuse and addiction.
- Illustrate, through examples of promising programs, the value of more cost-effective government investments.

In addition to updating the impact of substance use on state budgets, this report offers insight into promising programs governments have used to control the costs associated with substance abuse and addiction. CASA conducted extensive literature reviews of academic articles and government research institute reports to find evidence-based programs that demonstrate efficacy as well as cost-effectiveness. Almost all promising programs have been evaluated by multiple reviewers or at multiple points in time.

Table 2.1
Federal and State Spending on Substance Abuse and Addiction

Budget Sector	$ in Millions	Percent of Substance-Related Spending
Burden Spending:	**$357,432.9**	**95.6**
Health	**$207,222.4**	
Justice	**46,976.8**	
Adult Corrections	33,136.5	
Juvenile Justice	4,318.9	
Judiciary	9,521.5	
Child/Family Assistance	**46,696.0**	
Education	**33,895.6**	
Mental Health/Developmental Disabilities	**11,771.6**	
Mental Health	9,272.7	
Developmental Disabilities	2,499.3	
Public Safety	**9,302.8**	
Federal and State Workforce	**1,567.7**	
Prevention/Treatment/Research:	**8,777.4**	**2.4**
Prevention	1,975.4	
Treatment	4,534.3	
Unspecified P/T*	663.6	
Research	1,604.1	
Interdiction (Federal Level Only):	**2,638.2**	**0.7**
Regulation/Compliance	**5,066.2**	**1.4**
Licensing and Control	308.0	
Collection of Taxes	346.4	
Liquor Store Expenses	4,445.7	
Total**	**$373,914.7**	**100.0**

* State reporting does not allow disaggregation of costs by category.
** Numbers may not add due to rounding.

Successful programs range, for example, from in-prison treatment and aftercare, to drug courts, screenings and brief interventions, school-based prevention, intensive case management and increased enforcement for DUI. Given the large and growing body of knowledge about the disease of addiction and how to prevent and treat it, America no longer can justify wasting billions in taxpayer dollars because of our failure to prevent and treat addictive disorders.

Methodology

Using the survey instrument created for its 2001 report, CASA administered a survey in July of 2006 to all 50 states, the District of Columbia and Puerto Rico. (See Appendix A, State Survey Instrument) Forty-five states, Puerto Rico and the District of Columbia completed the survey.* The participating jurisdictions constitute approximately 96.3 percent of total state budget spending for the nation and 94.5 percent of the population. In order to present a national picture of state spending, CASA estimated spending associated with substance abuse and addiction in the five non-participating states and for certain categories of spending not supplied by the participating states. (See Appendix B, Methodology)

Due to the impracticality of attempting to contact and survey all federal agencies, CASA collected federal fiscal year 2005 budget data, using the budget categories established in the state survey as a guide. CASA conducted a literature review on the federal budget process and examined federal programs and types of federal expenditures to ensure our estimates captured as much relevant spending as possible.

CASA developed a local budget survey instrument replicating the methodology used in the state survey. To account for the differences in state and local budget structures and expenditure areas, CASA reviewed budget documents from several local governments and the classification of local spending by the U.S. Census Bureau, and consulted with statistical as well as state and local finance experts. In September 2006, CASA began requesting the participation of 14 municipalities, selected in conjunction with leaders from the U.S. Conference of Mayors and the National Association of Counties, based on size, geography and government structure (city, county, or consolidated city-county). Four local jurisdictions completed the survey: Charlotte and Mecklenburg County, North Carolina; Nashville, Tennessee; and Multnomah County, Oregon. These local governments provide snapshots of local spending. CASA estimated total local spending using Census data. (See Appendix B, Methodology)

Linking Expenditures to Substance Abuse and Addiction

Substance abuse and addiction both cause and exacerbate costs governments bear. Untreated, addiction alone causes or contributes to more than 70 other diseases requiring hospitalization. Certain cancers, heart, liver and kidney diseases, for example, may be caused by smoking, drinking or other drug use.[3] Likewise, addiction may cause child abuse and neglect, violent crime or mental illness or it may be one of several contributing or precipitating factors.

This report provides estimates of the total costs of substance abuse and addiction--the aggregate costs--which include both avoidable and unavoidable costs. The bottom line for government is identifying where substance abuse and addiction must be prevented or treated if public costs are to be reduced or avoided.

This report establishes the categories of state spending that are tightly linked to tobacco, alcohol and other drug abuse and addiction (including both illicit and controlled prescription drugs)--the targets for policy intervention. It uses existing research to establish the proportion of government spending in each of these target categories that is substance-related, and then applies those percentages, weighted by state specific rates of heavy binge drinking and illicit drug use. (See Appendix B, Methodology)

* Indiana, North Dakota, Rhode Island, Tennessee and Utah did not participate in the survey.

Changes in Methodology between 1998 and 2005

For this report, CASA refined the methodology developed for its 2001 *Shoveling Up* report in the following ways (See Appendix B, Methodology):

- To provide more precise estimates and accommodate the inclusion of federal and local spending, we developed separate estimates by payer type (i.e., Medicare, Medicaid, other federal, other state, etc.) of the percent of health care costs attributable to substance abuse and addiction.

- Due to an inconsistency in reporting of state spending on regulation and compliance for the 17 liquor control states participating in our survey, we used the U.S. Census to identify state spending on liquor stores.

- We updated the percent of juvenile offenders who were substance involved based on CASA's 2004 study *Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind*.

- Due to a lack of consistency in how states reported spending on judicial programs, we have replaced all state data on judicial spending with estimates derived from data from the Bureau of Justice Statistics and the National Center for State Courts Court Statistics Project.

- In calculating the costs of substance abuse and addiction for the five non-participating states, we used secondary sources in those areas where secondary sources were used for all participating states.

- We adjusted the substance-related fractions of spending in each budget category to reflect differences among states and localities and changes in the prevalence of heavy binge drinking and illicit drug use between 1998 and 2005.

Because CASA could not assure uniformity in each state's reporting between 1998 and 2005, state specific comparisons between these two years should not be made; only gross national comparisons can be drawn. In order to provide a basis of national comparison for selected summary items, CASA recalculated state spending for 1998 based on these methodological refinements. All comparisons of total state spending between 1998 and 2005 are based on the refined methodology.

Shifts in Government Spending Patterns between 1998 and 2005

From 1998 to 2005, federal spending has grown from $1.7 trillion ($2.0 in 2005 dollars) to $2.5 trillion--a 22.1 percent increase in 2005 dollars. Spending by the Department of Health and Human Services increased 28.9 percent from $451.3 billion (in 2005 dollars) to $581.5 billion in 2005.[4]

The National Association of State Budget Officers indicates from 1998 to 2005, state spending increased by 15.7 percent from $736.0 billion in 2005 dollars to $851.2 billion.[5] Despite overall spending increases, significant cuts occurred in several budget areas while spending grew sharply in others. Spending on health care grew more than any other category--jumping 49.1 percent from $83.9 billion in 1998 (in 2005 dollars) to $125.1 billion in 2005. Spending on corrections also increased (16.8 percent) as did spending on elementary and secondary education (15.3 percent) and transportation (5.9 percent). States partially offset these increases with spending cuts to public assistance programs that serve the poor and needy. State spending for public assistance dropped more than 16.8 percent from 1998 to 2005 and spending for Temporary Assistance to Needy Families (TANF) decreased more than 37.1 percent.[6]

Costs of Substance Abuse and Addiction to Government

Most substance-related spending is found hidden in departments and activities that do not wear

the substance abuse or addiction label. This is because untreated substance use disorders wreak havoc with society--increasing crime, compromising parenting, disrupting education and the ability to engage in steady employment and weakening an already anemic health care system.

CASA estimated costs in four major categories:

- Spending to carry the burden of substance abuse and addiction in government programs including health, child/family/housing assistance, public safety, justice, elementary/secondary education, mental health, developmental disabilities and workforce;
- Spending for prevention, treatment and research programs;
- Spending on federal drug interdiction; and,
- Spending related to taxation and regulation of tobacco and alcohol and operation of state and local liquor stores.

By far, the largest share of spending is for the costs of carrying the burden of substance abuse and addiction in government programs. Federal, state and local costs to carry this burden equal a minimum of $1,486 for each person in America.

Federal Spending

CASA conservatively estimates that the federal government spent $238.2 billion on substance abuse and addiction in 2005, approximately 9.6 percent of the $2.5 trillion federal budget. If substance abuse and addiction were its own budget category, it would rank sixth--just behind social security, national defense, income security, Medicare and other health programs.

Of the $238.2 billion in federal substance-related spending, 96.5 percent was spent to carry the burden of our failure to prevent or treat it; 2.3 percent was spent on preventing or treating the problem and research, 1.1 percent on interdiction, and 0.03 percent on regulating alcohol and tobacco sales and collecting taxes. (Table. 2.2)

Of all federal spending on the burden of substance abuse and addiction, 74.1 percent occurs in a single area--health care.

Table 2.2
Federal Spending on Substance Abuse and Addiction

Budget Sector	$ in Millions	Percent of Substance-Related Spending
Burden*	$229,887	96.5
Prevention/Treatment/Research	5,543	2.3
Interdiction	2,638	1.1
Taxation & Regulation	82	0.03
Total	**$238,151**	**100.0**

* Includes spending in health, child/family/housing assistance, public safety, justice, elementary/secondary education, mental health, developmental disabilities and workforce.

Federal Outlays by Budget Function[7]
Including Spending on Substance Abuse and Addiction
(in Billions)

Budget Function*	2005
Social Security	$523.3
National defense	493.9
Income security	347.6
Medicare	298.6
Other health	250.4
Substance abuse and addiction	**238.2**

* The top five budget categories also contain costs linked to substance abuse and addiction.

State Spending

States spent a total of $135.8 billion on substance abuse and addiction in 2005, approximately 15.7 percent of total state spending ($864.3 billion). States spend more only on elementary and secondary education.

Of total state substance-related spending, 94.0 percent was spent to carry the burden in state programs of our failure to prevent or treat substance abuse and addiction while only 2.4 percent was spent on prevention, treatment or research. The remaining 3.7 percent was spent on regulating alcohol and tobacco sales, collecting taxes and operating liquor stores. (Table 2.3)

The largest share of state spending on the burden of substance abuse and addiction is in the area of justice (32.5 percent).

State Outlays by Budget Function[8]
Including Spending on Substance Abuse and Addiction
(in Billions)

Budget Function*	**2005**
Elementary & Secondary Education	**$235.2**
Substance Abuse and Addiction	**135.8**
Medicaid	123.0
Higher Education	108.2
Transportation	65.5
Corrections	40.8

* Spending on substance abuse and addiction also is included in other four budget categories.

Local Spending

Due to data limitations, CASA was unable to estimate the total costs to local governments of substance abuse and addiction. Using local census data, however, CASA estimated that local spending on the burden of substance abuse and addiction and local operation of liquor stores* was at least $93.8 billion in 2005--9.0 percent of total local budgets. The largest share of local burden spending was in the area of justice (29.2 percent).

* Montgomery County, Maryland only.

Table 2.3
State Spending on Substance Abuse and Addiction

Budget Sector	**$ in Millions**	**Percent of Substance-Related Spending**
Burden*	$127,545	94.0
Prevention/Treatment/Research	3,235	2.4
Taxation & Regulation	4,984	3.7
Total	**$135,764**	**100.0**

* Includes spending in health, child/family/housing assistance, public safety, justice, elementary/secondary education, mental health, developmental disabilities and workforce.

Of the four local jurisdictions that CASA surveyed, the average amount spent on substance abuse and addiction was 10.9 percent of local budgets. Of this spending, an average of 97.6 percent was spent to carry the burden in local programs of our failure to prevent and treat the problem. Only an average of 2.4 percent was spent on preventing or treating the problem.

Government Spending by Substance

Almost half (47.3 percent) of government spending on substance abuse and addiction cannot be disaggregated by substance. In fact, research shows that most individuals who abuse or are dependent on addictive substances use more than one drug.[9] Of the $248 billion in substance-related spending that can be linked to specific drugs of abuse, 92.3 percent is linked to the legal drugs of alcohol and tobacco.

Tobacco

Total government spending as a consequence of tobacco use that can be differentiated by substance is an estimated $79.4 billion, all in health-related costs:

- $57.2 billion in federal health care spending;
- $14.0 billion in state health care spending; and,
- 8.2 billion in local health care spending.

Alcohol

Total government spending that can be linked to alcohol alone is an estimated $149.2 billion:

- $112.3 billion in federal spending, including $109.3 billion in health care and the remaining $3.0 billion in alcohol enforcement efforts (underage drinking, drunk driving), prevention and treatment on Indian lands, NIAAA research and alcohol regulation and compliance.

- $23.9 billion in state spending, including $1.5 billion on highway safety and local law enforcement associated with drunk driving; $960.0 million in state costs for the developmentally disabled as a result of Fetal Alcohol Syndrome; and $21.5 billion in state health care costs.

- $13.0 billion in local health care spending.

Other Drugs

Total government spending as a consequence of other drug use that can be differentiated by substance is an estimated $18.7 billion:

- $16.4 billion in federal spending: $7.8 billion in dedicated drug enforcement,* $39.5 million in drug court costs, $2.6 billion for drug interdiction, $2.5 billion for prevention, treatment, research and evaluation, and $3.8 billion in health care costs.

- $1.9 billion in state spending: $336 million for public safety costs for drug enforcement programs, $138 million for drug courts, and $1.5 million linked to illicit and controlled prescription drugs in state spending on Medicaid.

- $342.3 million in local health care spending.

Government Spending for Children

For every dollar federal and state governments spent on prevention and treatment for children, they spent $60.25 on the consequences of substance abuse and addiction for them. CASA was able to identify $54.2 billion in 2005 federal and state government spending on the child-related costs of substance abuse and addiction. Of this amount, $53.3 billion was spent on all of the consequences to them while only $0.9 billion went to prevention and treatment for children.

CASA's research has shown that if we can keep children from smoking cigarettes, abusing alcohol or using other drugs until they are 21, their risks of ever doing so are profoundly diminished. One of the most striking findings in 2005 is that government at all levels continues to spend heavily to shovel up the wreckage that substance abuse visits on children while spending little to prevent and treat the problem.

The largest share of substance-related spending on the burden of substance abuse and addiction for children--$33.9 billion--was in the education system. School costs linked to substance abuse and addiction include increased special education for those with Fetal Alcohol Spectrum Disorder (FASD), increased security and health care costs, vandalism, lost productivity of staff and special programs for at-risk youth. Federal spending totaled $5.4 billion and state spending totaled $28.5 billion.

The second largest share ($15.1 billion) went for children who are victims of child abuse and neglect, foster care costs, independent living programs, adoption readiness, and other child welfare programs. Of this amount, $7.2 billion was spent by the federal government and $7.9 billion by the states.

An additional $4.3 billion ($194 million by the federal government and $4.1 billion by the states) was spent through the juvenile justice system.

* Programs focusing only on drug enforcement.

The Government Response to Addiction

Risky use of addictive substances is a public health problem that is preventable through changes in public attitudes and behaviors while addictive disorders are medical problems that must be addressed through a host of behavioral and pharmacological therapies and recovery supports.

The nation's failure to address addiction as a disease has resulted in staggering costs to American taxpayers. If left untreated, it can progress to a chronic health condition like heart disease, cancer or diabetes that requires continual and costly medical management.[10]

In the 2009 fiscal year, federal, state and local governments are facing unprecedented budget shortfalls.[11] Unemployment is at its highest level since 1983.[12] State and local income tax revenues are expected to decrease and sales and property tax revenues are also expected to decline significantly.[13] Dwindling government revenues are further complicated by the rapidly growing demand for government assistance as unemployed workers and their families seek social services, income assistance and health care while weathering the downturn.[14]

Without federal assistance, states and localities that are unable to borrow to cover their expenditures or draw down reserves will be forced either to increase taxes or make substantial cuts in spending. History indicates that health and social programs are the most frequent targets for spending cuts during difficult economic times. During the downturn from 2002 to 2004, states made substantial cuts to public health programs leading to the loss of health care coverage for over one million Americans.[15] At least 17 states have already proposed reducing access to health care services[16] and several states have specifically targeted programs providing services for drug treatment, drug courts and addiction-related services.[17]

As governments continue to cope with budget shortfalls, addiction prevention and treatment programs often are sacrificed as expendable. This approach is dangerous and shortsighted and will serve only to increase the costs of addiction to government.

Facing risky substance use and addiction as public health and medical problems before they impose huge social costs is the only way that government can curb this drain on the public tax dollar. Proven cost-effective alternatives and promising practices are presented in Chapters III-V to help guide government action.

Chapter III
The Burden of Substance Abuse and Addiction to Federal Programs

In 2005, 96.5 percent or $229.9 billion of total federal substance-related spending ($238.2 billion) went to shovel up the wreckage of substance abuse and addiction in Medicare, Medicaid, federal prisons, schools, child welfare, income assistance and other federal programs. (See Appendix B, Methodology). This is an amount equal to 9.3 percent of the entire federal budget in 2005.

Of this amount, an overwhelming 74.1 percent can be found in one budget category--health. Federal spending on the burden of substance abuse and addiction in health care programs dwarfs spending in all other areas of the burden combined. (Table 3.1, Figure 3.A)

Calculating the Federal Burden

1. Identify total federal spending for each budget category where substance abuse or untreated addiction have been demonstrated* to cause or increase spending.
2. Multiply total spending in each category by the share of such spending linked to substance abuse and addiction.*
3. Sum substance-related federal spending in all categories for total burden spending.
4. Identify total federal substance-related spending on prevention, treatment, research, alcohol and tobacco taxation and regulation and drug interdiction and add to total burden spending for total substance-related spending.
5. Divide burden spending by total substance-related spending for percent spent on burden.

* Identified through national and other peer-reviewed literature.

See Appendix B, Methodology.

Figure 3.A

Burden of Substance Abuse and Addiction on Federal Programs by Budget Sector (Percent)
Total = $229,887 Million

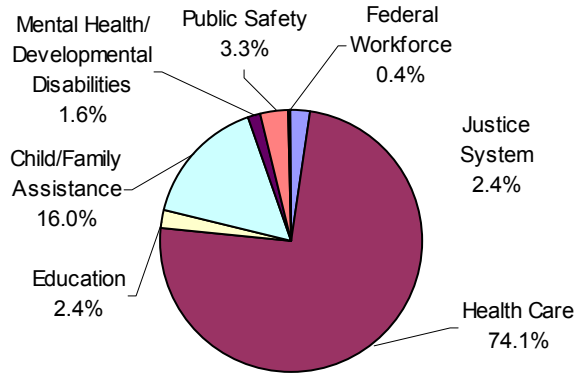
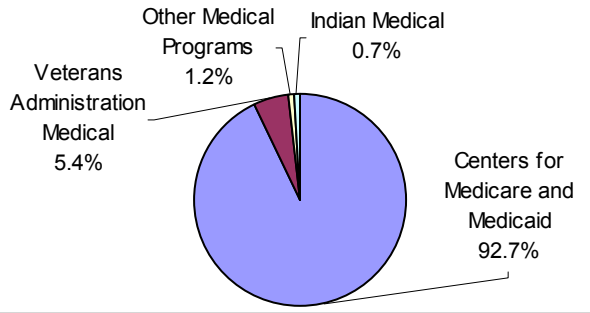


Table 3.1
Burden of Substance Abuse and Addiction on Federal Programs by Budget Sector

Federal Budget Sector	$ in Millions	Percent of Burden on Federal Programs	Per Capita Spending
Health	**$170,269**	**74.1**	**$561.34**
Child and Family Assistance	**36,693**	**16.0**	**120.97**
Child Family Assistance	9,809		
Child Welfare	7,172		
Income Assistance	5,608		
Employment Assistance	1,350		
Housing/Homeless Assistance	3,763		
Food/Nutritional Assistance	8,990		
Public Safety	**7,490**	**3.3**	**24.69**
Justice	**5,552**	**2.4**	**18.30**
Adult Corrections	3,951		
Juvenile Justice	194		
Judiciary	1,407		
Education (Elementary/Secondary)	**5,391**	**2.4**	**17.77**
Mental Health/Developmental Disabilities	**3,601**	**1.6**	**11.87**
Mental Health	2,062		
Developmental Disabilities	1,539		
Federal Workforce	**891**	**0.4**	**2.94**
Total	**$229,887***	**100.0**	**$757.89**[a]

* Numbers may not add due to rounding.
[a] CASA used population estimates for 2005 from the U.S. Census Bureau to calculate per capita spending.

Figure 3.B
Burden of Substance Abuse and Addiction on Federal Health Care Programs (Percent) Total = $170,269 Million



Health--The Predominant Area of Burden Spending

Health care spending by the federal government reached a high of $527.5 billion in 2005 representing 21.4 percent of the federal budget. Substance abuse or addiction caused or contributed to $170.3 billion or 32.3 percent of this amount.

Federal substance-related health care spending equals 74.1 percent of total federal spending on the burden of substance abuse and addiction and 6.9 percent of the entire federal budget.

The largest share of federal health spending on the burden of substance abuse and addiction ($157.8 billion) is found in the Medicare and Medicaid programs. The Veterans Health Administration spent an additional $9.2 billion on the burden of substance-related health care spending and Indian medical programs account for $1.2 billion. The remaining $2.1 billion is spent on other medical programs. (Figure 3.B)

The federal government spends more than 30 times as much to cope with the health consequences of substance abuse and addiction as it spends on prevention, treatment and research.

Promising Investments in Health

The federal government has taken several significant steps toward providing comprehensive insurance coverage for individuals with substance use disorders.

In 2001, the Federal Employee Health Benefit (FEHB) program ended insurance discrimination for mental health and substance use disorders. An evaluation of this change found that, contrary to fears, costs to insurance companies did not increase as a result. When secular trends were taken into account, only one plan showed a significant change in spending (a decrease of more than $288 per user); the change did not significantly affect the other plans. Out-of-pocket spending for mental health and substance use disorders decreased in six out of nine plans. Individuals' access to addiction treatment increased slightly but significantly in all nine plans.[1]

In October 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. The Act ensures that, as of January 2010, group health plans that provide any mental health and addiction treatment will provide the same coverage for mental health and addiction treatment as they do for all other medical and surgical care. The Act only mandates parity for companies that already provide these services. Insurance plans that do not offer any mental health or addiction treatment benefits will not be required to extend their coverage to include those services, but can continue to limit their coverage of mental health and substance disorder treatment services. Under the new law, addiction treatment coverage will not be restricted by any financial or benefit limitations. Businesses with 50 or fewer employees do not need to comply, and if a health plan experiences a two percent increase in actual total costs in the first year (one percent thereafter), it will be exempted from the law.[2]

The U.S. Preventive Services Task Force (USPSTF) in 2004 found good evidence that screening conducted in primary care settings can accurately identify patients engaging in risky alcohol use that endangers their health but who do not yet meet criteria for alcohol dependence. The Task Force also found good evidence that brief counseling and follow-up can reduce consumption.[3] Based on these findings, the USPSTF recommends that screening and counseling interventions be provided in primary care settings to reduce alcohol abuse by adults, including pregnant women.

The Centers for Medicare and Medicaid recently approved billing codes for alcohol and other drug assessments and brief interventions; however, use of these codes is limited.[4] For Medicare, services can be provided only to evaluate patients with perceived signs/symptoms of addiction, not as a routine screening measure.[5] For Medicaid, the codes must be activated under the state's plan in order to qualify for reimbursement.[6]

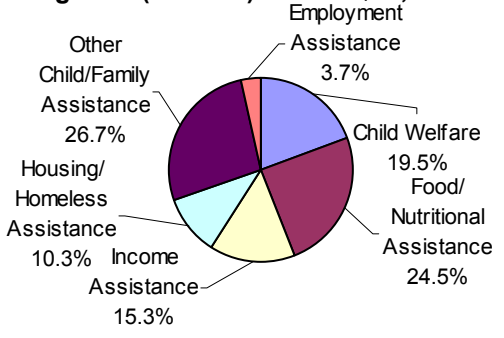
Child and Family Assistance

The second largest areas of federal spending on the burden of substance abuse and addiction is in child and family assistance programs.

In 2005, the federal government spent $235.4 billion on programs related to child and family assistance. Of this amount, 15.6 percent or $36.7 billion is directly linked to substance abuse and addiction, including child welfare, food and nutritional assistance, income assistance, housing/homeless assistance, child and family assistance and employment assistance. (Figure 3.C)

Figure 3.C

Burden of Substance Abuse and Addiction on Federal Child and Family Assistance Programs (Percent) Total = $36,693 Million



Of the $229.9 billion the federal government spends on the burden of substance abuse and addiction, 16.0 percent is devoted to child or family assistance. More than six times as much is spent coping with substance abuse in child and family assistance programs than is spent on prevention, treatment and research.

Child Welfare

Federal spending on child welfare totaled $9.7 billion in 2005. Of this amount, an estimated 74.1 percent or $7.2 billion is caused or exacerbated by substance abuse and addiction.

Food and Nutritional Assistance

The federal government spent $38.3 billion in 2005 on programs providing nutritional assistance, including food stamps and the special supplemental nutrition program for women, infants and children. Of this amount, 23.5 percent or $9.0 billion goes to cope with the burden of substance abuse and addiction.

Income Assistance

In 2005, total spending by the federal government for income support was $144.7 billion, including $17.3 billion for Temporary Assistance to Needy Families (TANF) and $127.4 billion for the Supplemental Security Income Program (SSI). An estimated 3.9 percent or $5.6 billion of this total was spent to support individuals coping with substance abuse and addiction.

Housing/Homeless Assistance

In 2005, the federal government spent $10.6 billion to provide housing assistance and programs assisting the homeless. Of this amount, 35.6 percent or $3.8 billion was spent to cope with the burden of substance abuse and addiction.

Other Child and Family Assistance Programs

In 2005, the federal government spent $26.2 billion on other child and family assistance programs including community and social services block grants. Of this amount, 37.4 percent or $9.8 billion was spent to cope with the burden of substance abuse and addiction.

Employment Assistance

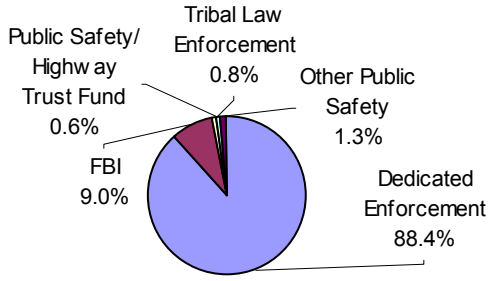
Spending by the federal government for employment assistance totaled $5.8 billion. Of this amount, 23.1 percent or $1.4 billion was associated with substance abuse and addiction.

Public Safety

In 2005, the federal government spent $10.7 billion on highway safety, accident prevention, investigation and dedicated drug enforcement programs.* An estimated $7.5 billion (70.0 percent) of this amount was spent on the burden of substance abuse. The majority of this money ($6.6 billion) was spent on dedicated drug enforcement programs. (Figure 3.D)

Figure 3.D

Burden of Substance Abuse and Addiction on Federal Public Safety Programs (Percent) Total = $7,490 Million



Dedicated drug enforcement efforts include the $1.1 billion spent on international drug control including illicit crop eradication, infrastructure development, marketing and technical support for alternative crops, promoting the rule of law,

* Programs focusing only on drug enforcement.

and expanding judicial capabilities. An example is the Andean Counterdrug Initiative in the State Department.

Plan Colombia: Drug Crop Eradication and Alternative Development in the Andes

In 2005 the United States provided counternarcotics assistance through the Andean Counterdrug Initiative (ACI) to support Plan Colombia-- introduced by President Pastrana to end the country's 40-year old armed conflict, eliminate drug trafficking, and promote economic and social development.[7] ACI funds were used for purposes of:

- Interdiction, to train and support national police and military forces, provide communications and intelligence systems, support the maintenance and operations of host country aerial eradication aircraft, and improve infrastructure related to counternarcotics activities.
- Alternative development to support infrastructure development and marketing and technical support for alternative crops in coca growing areas.[8]

Of the $229.9 billion spent by the federal government on the burden of substance abuse and addiction, 3.3 percent was spent in public safety. CASA believes that federal costs in this area actually are much higher because this estimate does not include costs of accidents linked to illicit or controlled prescription drug use; however, data are not available for a more precise estimate.

Justice

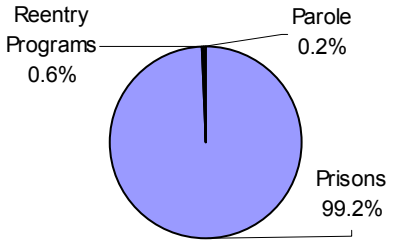
In 2005, the federal government spent $6.7 billion for justice-related programs in adult corrections, juvenile justice and the judiciary. Of this spending, 82.4 percent ($5.6 billion) was caused or exacerbated by substance abuse and addiction. Of the $229.9 billion substance-related spending on the burden of this problem in federal programs, 2.4 percent was spent in justice programs.

Adult Corrections

The federal government spent $4.9 billion in 2005 on adult corrections in the federal prison system including incarceration, reentry programs, and parole. Of this amount, 81.0 percent ($4.0 billion) was spent on substance-involved offenders. (Figure 3.E)

Figure 3.E

Burden of Substance Abuse and Addiction on Federal Adult Corrections Programs (Percent) Total = $3,951 Million

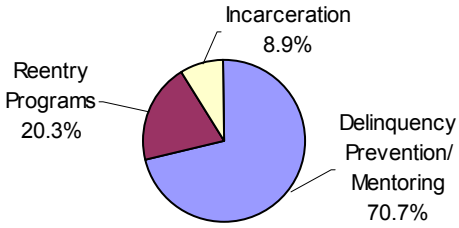


Juvenile Justice

A total of $244.1 million was spent by the federal government in 2005 for juvenile detention and corrections, and for delinquency prevention, mentoring and reentry programs. An estimated 79.5 percent of this amount ($194.1 million) was spent on substance-involved youth. (Figure 3.F)

Figure 3.F

Burden of Substance Abuse and Addiction on Federal Juvenile Corrections Programs (Percent) Total = $194 Million

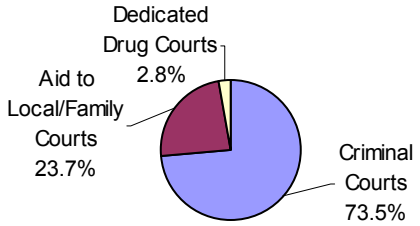


Judiciary

In 2005, the federal government spent $1.6 billion for federal criminal courts,* aid to local and family courts and for dedicated drug courts.† Of this amount, 86.9 percent ($1.4 billion) was for substance-involved offenders. (Figure 3.G)

Figure 3.G

Burden of Substance Abuse and Addiction on Federal Judiciary Programs (Percent) Total = $1,407 Million



CASA was unable to estimate the substance-related costs of civil courts; therefore, these costs were excluded leading to a very conservative estimate of the burden to the federal judiciary.

Promising Investments in Justice

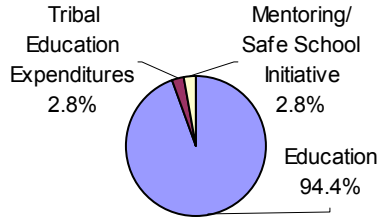
Based on a significant body of research, the National Institute on Drug Abuse has developed a set of principles to guide governments in dealing with substance-involved offenders. (See text box)

Education

In 2005, the federal government spent $44.3 billion on elementary and secondary education programs including grants to state and local educational agencies, Tribal education, mentoring and the Safe Schools Initiative. Of this amount approximately $5.4 billion or 12.2 percent was spent coping with the impact of substance abuse and addiction on America's schools. (Figure 3.H)

Figure 3.H

Burden of Substance Abuse and Addiction on Federal Education Programs (Percent) Total = $5,391 Million



The National Institute on Drug Abuse Principles of Drug Abuse Treatment for Criminal Justice Populations[9]

1. Drug addiction is a brain disease that affects behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
6. Drug use during treatment should be carefully monitored.
7. Treatment should target factors that are associated with criminal behavior.
8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
9. Continuity of care is essential for drug abusers re-entering the community.
10. A balance of rewards and sanctions encourages pro-social behavior and treatment participation.
11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.
12. Medications are an important part of treatment for many drug abusing offenders.
13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C and tuberculosis.

* At the federal level, probation is a function of the federal courts.
† Programs focusing only on drug courts.

Of the $229.9 billion federal burden of substance-related spending, 2.4 percent was spent in the area of elementary and secondary education, roughly equivalent to the total amount of federal spending on all substance abuse prevention, treatment and research.

CASA did not include estimates of the cost of substance abuse and addiction to higher education due to lack of available data, thus considerably underestimating the costs in this area.

Higher Education: A Missed Opportunity

Although CASA was unable to estimate the costs of substance abuse and addiction to higher education, those costs are likely significant. CASA's report *Wasting the Best and the Brightest: Substance Abuse at America's Colleges and Universities* found that almost one in four full-time college students (22.9 percent) meet medical criteria for substance abuse or dependence. Substance abuse and addiction among college students is linked to poor academic performance, property damage, vandalism, fights, a host of student health problems and institutional liability costs. [10] Each year more than 1,700 college students die from unintentional alcohol-related injuries; more than 97,000 students are victims of sexual assaults or date rape; and almost 700,000 students are assaulted by other students who were drinking.[11]

According to the Drug-Free Schools and Communities Act Amendments of 1989 (Part 86), in order to receive federal funding, institutions of higher education must implement policies and programs to prevent students' and employees' unlawful possession, use or distribution of alcohol and illicit drugs.[12] Nearly every institution of higher learning in the U.S. receives federal funding that would require them to meet these stipulations.

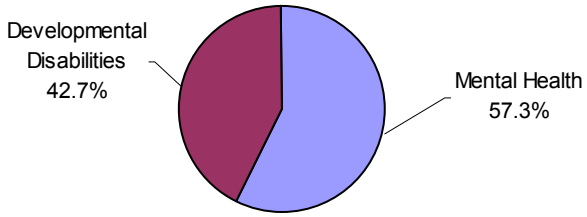
However, CASA was not able to identify any evidence that these regulations are, in actuality, enforced.[13] Furthermore, they do not apply to controlled prescription drug abuse or smoking--two forms of substance use that are prevalent on college campuses.[14] Federal implementation of this Act for alcohol and other drugs could have a profound effect on reducing the harm and costs of substance abuse and addiction to higher education.

Mental Health and Developmental Disabilities

In 2005, the federal government spent $18.7 billion in the area of mental health and developmental disabilities. An estimated $3.6 billion (19.3 percent) of this amount was spent on treatment of co-occurring mental health problems or developmental disabilities caused or exacerbated by substance abuse and addiction. (Figure 3.I)

Figure 3.I

Burden of Substance Abuse and Addiction on Federal Mental Health Programs (Percent) Total = $3,601 Million



Of the $229.9 billion the federal government spent on the burden of substance abuse, an estimated 1.6 percent was spent on substance abuse and addiction in the areas of mental health and developmental disabilities.

Mental Health

Federal spending in 2005 on mental health programs totaled $3.6 billion. An estimated 56.7 percent or $2.1 billion was spent by the federal government to cope with the impact of substance abuse and addiction in mental health programs including services for veterans.

Developmental Disabilities

In 2005, the federal government spent $15.1 billion on programs for the developmentally disabled. CASA estimates that 10.2 percent or $1.5 billion of federal costs for programs for the developmentally disabled are a result of Fetal Alcohol Syndrome. Because of data limitations, CASA was unable to estimate the costs to programs for the developmentally disabled

linked to tobacco or illicit drug use; hence this estimate is extremely conservative.

Federal Workforce

In 2005, the federal government spent $161.7 billion in payroll and an additional estimated $80.9 billion in fringe benefit costs for federal workers. Substance abuse and addiction compromise the productivity of any workforce and increase the costs of doing business.

Substance abuse is associated with lower productivity, increased turnover, workplace accidents and higher health insurance costs. Due to data limitations, CASA was able only to estimate the costs of substance abuse and addiction to the federal government for payroll and fringe benefits linked to absenteeism--0.4 percent or $890.8 million--thus significantly underestimating these costs. (Table 3.2)

Table 3.2
Burden of Substance Abuse on Workforce

Federal Budget Sector	**$ in Millions**
Payroll	$594
Estimated Fringe	297
Total*	**$891**

* Numbers may not add due to rounding.

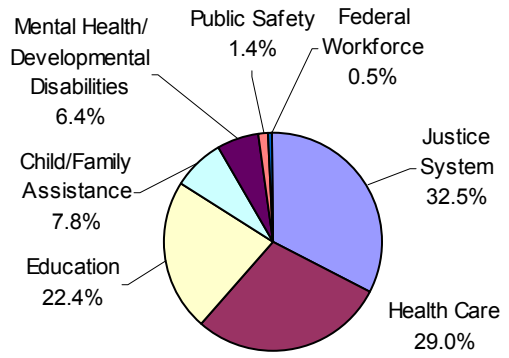
Chapter IV
The Burden of Substance Abuse and Addiction to State Budgets

In 2005, 94.0 percent ($127.6 billion) of total state substance-related spending went to carry the burden of our failure to prevent and treat addiction in public systems from criminal justice to Medicaid to transportation and public safety. This amounts to 14.8 percent of total state spending--up from 12.5 percent in 1998.

Since 1998, one major trend in spending stands out: the share of the burden of substance abuse and addiction to state health care programs has grown from 20.2 percent to 29.0 percent in 2005, surpassing spending in the area of education to make it second only to substance-related justice spending. (Figure 4.A and Table 4.1)

Figure 4.A

Burden of Substance Abuse and Addiction on State Programs by Budget Sector (Percent)
Total = $127,545 Million



Calculating the State Burden

1. For each state, identify total state spending for each budget category where substance abuse or untreated addiction have been demonstrated* to cause or increase spending.

2. Multiply total spending in each category by the share of such spending linked* to substance abuse and addiction, weighted by the state prevalence of heavy binge drinking and drug use compared with other states.

3. Sum substance-related state spending in all categories for total burden spending.

4. Identify total state substance-related spending on prevention, treatment, research, alcohol and tobacco taxation and regulation and add to total burden spending for total substance-related spending.

5. Divide burden spending by total substance-related spending for percent spent on burden.

* Identified through national and other peer reviewed literature.

See Appendix B, Methodology.

Table 4.1
Burden of Substance Abuse and Addiction on State Programs by Budget Sector

State Budget Sector	$ in Millions	Percent of Burden on State Programs	Per Capita Spending
Justice	**$41,425**	**32.5**	**$136.57**
Adult Corrections	29,186		
Juvenile Justice	4,125		
Judiciary	8,115		
Health	**36,953**	**29.0**	**121.83**
Education (Elementary/Secondary)	**28,504**	**22.4**	**93.97**
Child/Family Assistance	**10,003**	**7.8**	**32.98**
Child Welfare	7,893		
Income Assistance	2,111		
Mental Health/Developmental Disabilities	**8,170**	**6.4**	**26.93**
Mental Health	7,211		
Developmental Disabilities	960		
Public Safety	**1,813**	**1.4**	**5.98**
State Workforce	**677**	**0.5**	**2.23**
Total*	**$127,545**[a]	**100.0**	**$420.49**

* Numbers may not add due to rounding.
[a] State spending on the burden of substance abuse and addiction to public programs totals $127.545 billion. Spending for prevention, treatment and research equals $3.235 billion and spending for regulation and compliance totals $4.984 billion. The combined total equals $135.702 billion. CASA rounded total spending to $135.8 billion and spending on the burden to state programs to $127.6 billion.
[b] In this report, CASA used population estimates for 2005 from the U.S. Census Bureau to calculate per capita spending.

The Big Three: Justice, Health and Education

Spending in the three areas of justice, health and education account for 83.8 percent of total state spending on the burden of substance abuse and addiction--up from 79.9 percent in 1998.

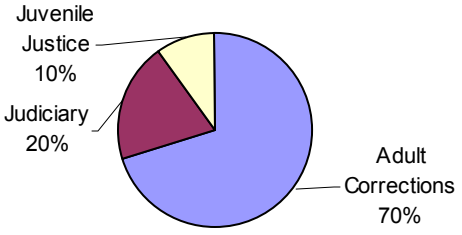
Justice

In 2005, states spent a total of $51.3 billion for justice-related programs in adult corrections, juvenile justice and the judiciary amounting to 5.9 percent of their budgets. Of this amount, $41.4 billion (80.7 percent) was linked to substance abuse and addiction because a significant majority of arrested and convicted offenders are substance involved.* Of justice spending on the burden, 70 percent was in adult corrections. (Figure 4.B)

The share of the burden of substance abuse and addiction states spend in the justice system has dropped from 37.7 percent in 1998 to 32.5 in 2005, offset by increases in state spending in health programs. States spend 13 times the amount shoveling up the wreckage of substance abuse and addiction in the justice system than on prevention, treatment and research combined.

Adult Corrections. The largest share of state justice-related spending is in the area of adult corrections.

Figure 4.B
Burden of Substance Abuse and Addiction on Justice Programs (Percent) Total = $41,425 Million



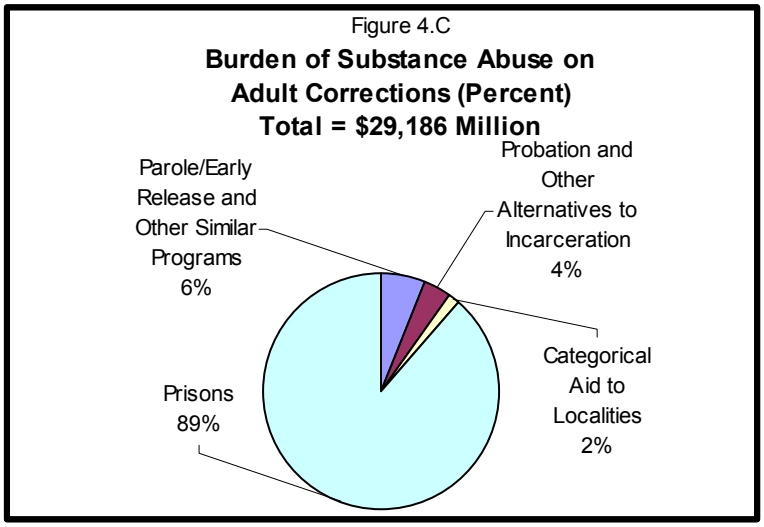
* The term "substance-involved offender" refers to an inmate with one or more of the following characteristics: ever used illegal drugs regularly; convicted of a drug law violation; convicted of an alcohol offense; under the influence of alcohol or other drugs during the crime that led to incarceration; committed offense to get money for drugs; had a history of alcohol abuse.

States spent $36.3 billion in 2005 for adult corrections including incarceration, probation and parole.

Of this amount, 80.5 percent ($29.2 billion) was spent on substance-involved offenders:

- $25.9 billion went to run and build prisons to house offenders;
- $1.8 billion for parole;
- $1.0 billion for probation; and,
- $473 million was spent on state aid to localities for substance-involved offenders. (Figure 4.C)

Figure 4.C



Promising Investments in Adult Corrections. Over the last 20 years, there has been a growing body of professional standards proposed for providing addiction treatment in prisons and jails, developed by professional societies and scientific agencies including:

- The American Correctional Association (ACA), in cooperation with the Commission on Accreditation for Corrections;
- The National Institute of Corrections, through its National Task Force on Correctional Substance Abuse Strategies;
- The Center for Substance Abuse Treatment (CSAT) at SAMHSA; and,
- The National Institute on Drug Abuse.*

There is, however, no mechanism in place to ensure implementation, making these standards and guidelines essentially non-binding recommendations often ignored by state legislatures and sparsely implemented by correctional authorities.[1]

As alternatives to spending billions on incarceration of substance-involved offenders, states have experimented with promising, cost-effective approaches that involve treating the addictions of offenders. Key program features include the use of standardized risk assessments to identify treatment needs and the use of evidence-based treatments, reentry planning and aftercare. In these promising programs, the combination of treatment and aftercare is critical to success.

In Illinois, for example, the state converted an entire state prison into a therapeutic community inpatient program with reentry services and an aftercare component. The Sheridan Correctional facility, located in LaSalle County, Illinois, was reopened as a treatment center in 2004. The prison serves offenders from across the State who participate on a voluntary basis. During the first three and a half years of operation, The Illinois Criminal Justice Information Authority found that Sheridan graduates saved the Department of Corrections approximately $2.1 million annually and a total of more than $7.3 million in avoided incarceration costs.[2]

Inmates who completed California's in-prison therapeutic community treatment program (Amity) had the option of continuing their recovery process with an aftercare program (Vista). Those who completed both in prison treatment and aftercare had re-incarceration rates

* See the NIDA Principles of Drug Abuse Treatment for Criminal Justice Population described in Chapter III.

Sheridan Correctional Facility[3]

Adult male offenders sentenced to serve nine- to 24-months in an Illinois state correctional facility, who screen positive for a substance use disorder can volunteer to enter the treatment program at Sheridan.*

Upon entry, Sheridan inmates undergo assessments that are used to develop individualized treatment plans. Prior to treatment participation, inmates go through a one month program orientation that introduces them to the program and the principles of therapeutic community treatment. After orientation offenders are required to attend daily addiction treatment therapy, educational and vocational programming and job assignments for the remainder of their sentence.

For every day participants comply with their treatment program they receive earned good conduct credits (EGCC). Each credit reduces offenders' sentences by half a day.

Prior to their release inmates receive re-entry planning services. They are required to participate in employment verification, urinalysis and aftercare/additional treatment for one to three years after re-entering the community.

Over the first three and a half years of operation, Sheridan graduates accumulated more than 133,000 days of EGCC; equivalent to accruing 364 years worth of avoided incarcerated days.† The average cost per inmate of a year of incarceration in the Illinois DOC is $21,600. Based on this figure, Sheridan graduates saved the DOC more than $7.3 million during the first three and a half years of operation, or $2.1 million annually.

These savings are only a small fraction of the potential program benefits. One year after their release, Sheridan graduates are 17 percent less likely than their peers to be rearrested for a new crime and 42 percent less likely to be reincarcerated. Reduced recidivism leads to decreased criminal justice costs and victim costs.

* Inmates must be sentenced for crimes appropriate for incarceration in a medium security prison--no murderers or sex offenders--and cannot be diagnosed with severe mental health problems.

† 133,000 days/365 days = 364.38 years.

that were half that of those who did not complete both components. Five years after being released from prison, 42 percent of inmates who completed the Amity treatment and Vista aftercare programs had been reincarcerated for an average of 343 days; 86 percent of inmates who completed only the Amity treatment program had been reincarcerated for an average of 634 days; and 83 percent of inmates who received no treatment while in prison had been reincarcerated for an average of 626 days.[4]

Juvenile Justice. In 2005, states spent a total of $5.2 billion for juvenile detention and corrections and for construction and maintenance of juvenile correctional facilities. An estimated 79.4 percent of this amount or $4.1 billion was spent on substance-involved youth.

Promising Investments in Juvenile Justice. In its 2004 report, *Criminal Neglect: Substance Abuse, Juvenile Justice and The Children Left Behind*, CASA found that substance-involved children and teens caught up in juvenile justice systems are more likely than other youth to come from broken and troubled families, to be abused or neglected, to have dropped out of school or to have learning disabilities and mental health disorders.[5] CASA recommended that each child entering the juvenile justice system receive a comprehensive personal, family, social and medical evaluation to determine their needs and that states provide appropriate treatment and other services to meet those needs.

To implement such screenings and help assure access to needed services, CASA has drafted a Model Bill of Rights for Children in Juvenile Justice Systems. The model bill provides guidance to states for a legislative mandate and framework for improvements in the field of juvenile justice related to substance abuse.

In 2000, Washington State implemented a treatment program for juvenile offenders with co-occurring substance use and mental health problems called Family Integrated Therapy (FIT). The program is available to offenders, ages 11 to 17 and a half, referred by the State Juvenile Rehabilitation Administration based on the diagnosis of co-occurring illnesses. The FIT

program incorporates components from four evidence-based treatment programs, Multi-Systemic Therapy, Motivational Enhancement Therapy, Relapse Prevention and Dialectical Behavioral Therapy.[6]

The program begins two months prior to an adolescent's release and continues for four to six months post-release. Therapists begin by motivating patients, families and community members in the program and work to increase parenting skills and strengthen family relationships. The focus later shifts to changing destructive behaviors with the involvement of family, peer, school and neighborhood networks. Through the program, patients learn how to regulate their emotions and improve coping skills and positive social behaviors. The FIT office in each county employs four therapists, including mental health and chemical dependency specialists. Therapists are available to families 24 hours a day and work closely with parole officers and juvenile rehabilitation staff.

The felony recidivism rate for FIT members 18 months following completion of the program was 27 percent, significantly lower than their peers'[*] rate of 41 percent. The cost per adolescent and family for the FIT program in 2004 was $8,968 (in 2003 dollars). Net savings equaled $11,749 in avoided justice system expenditures per FIT patient.[7]

Judiciary. The judicial system consists of criminal, family, juvenile and civil courts. CASA was not able to estimate the substance-related costs of civil courts because of the lack of available data, yielding a conservative estimate of the burden of substance abuse and addiction on the courts.

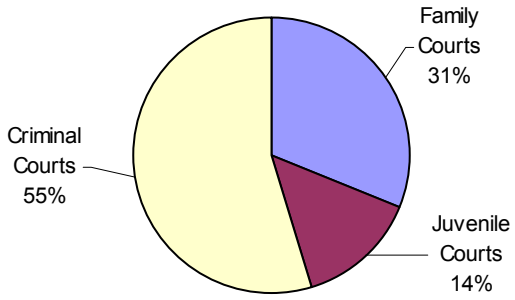
For all but civil courts, states spend approximately $9.9 billion each year.[†] Of this amount, $8.1 billion or 82.3 percent is spent on substance-involved offenders:

- $4.5 billion in criminal courts;
- $2.5 billion in family courts; and,
- $1.1 billion in juvenile courts.

Within these totals are a reported $432 million in state aid to local courts and $138 million for drug courts. (Figure 4.D)

Figure 4.D

Burden of Substance Abuse on the Judiciary (Percent)
Total = $8,115 Million



Promising Investments in the Judiciary. The Brooklyn Drug Treatment Alternatives to Prison Program (DTAP) is a residential drug treatment program with educational, vocational and social support services for non-violent, drug addicted, repeat felony offenders. A five year evaluation conducted by CASA found that DTAP graduates had lower rearrest rates, were less likely to return to prison, and more likely to be employed at about half the average cost of incarceration than a matched comparison group at two years post-program or post-release.[9]

> *I have found that drug courts are one of the best investments a state can make.*[8]
>
> --James McDonough
> Secretary of the Florida Department of Corrections

[*] Peers included juvenile offenders from counties without the FIT program who would have otherwise been eligible.

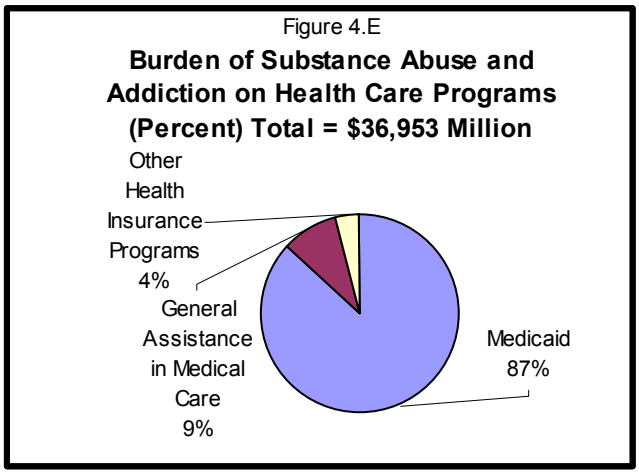
[†] Due to a lack of consistency in how states reported spending on judicial programs, CASA estimated state judicial expenditures using data from the Bureau of Justice Statistics and the National Center for State Courts' Court Statistics Project. See Appendix B, Methodology.

Health Care

In 2005, states spent approximately $130.1 billion of their own funds (15.1 percent of state budgets) to finance health care under the Medicaid program, the federal-state health insurance program for the poor and medically needy, and to finance health care costs for people who do not qualify for Medicaid. In 2005, states spent more on Medicaid than any other single budget sector other than elementary and secondary education.[10]

Between 1998 and 2005, the largest shift in state spending on the burden of substance abuse and addiction to state budgets occurred in the area of health care. The burden of substance abuse and addiction drained $37.0 billion (28.4 percent) from state health care budgets. Nearly all of these expenditures ($32.0 billion or 86.6 percent) are funds for the Medicaid program. General assistance medical care and other health insurance programs including SCHIP account for the remaining $5.0 billion (13.4 percent). (Figure 4.E)

Figure 4.E



States pay over 11 times the total amount spent on prevention, treatment and research coping with the burden of substance abuse and addiction in the health care system.

Promising Investments in Health Care. Although physicians and other health care professionals are often in the best position to address substance abuse in patients, they frequently lack the training to recognize the disease, fail to screen for it or do not know how to respond if they do spot it. Too often they focus instead on treating the symptoms or other acute illness resulting from it.[11] By spotting substance abuse early, states can prevent risky use from progressing to addiction thus saving billions in health care costs. Evidence has demonstrated that even minimal interventions can prevent risky substance use from becoming an addictive disorder. Screening and brief interventions have been shown to reduce harmful or risky drinking by up to 19 percent,[12] hospitalizations by up to 37 percent and emergency department visits up to 20 percent.[13]

Some states have begun investing in screening and brief intervention programs. A significant science-base documents the program and cost effectiveness of this approach in a variety of settings including emergency departments, primary care facilities, prenatal care facilities, college health centers, DUI offender programs and Employee Assistance Programs.[14]

Washington State began the Washington Screening, Brief Intervention, and Referral to Treatment (SBIRT) program in 2003 with federal grant assistance from the Federal Center for Substance Abuse Treatment. The initiative was implemented in nine hospitals in the counties of Tacoma, Everett, Olympia, Toppenish, Vancouver and Yakima. Incoming adult emergency room and trauma center patients were screened by full-time chemical dependency professionals in order to assess their risk for developing substance use disorders. Patients who screened positive for a moderate to high risk received one to four brief interventions employing self-awareness and behavioral motivation techniques. Patients with more severe problems were referred to brief therapy or directly to treatment programs. Through the SBIRT program, the monthly per member medical costs of the aged, blind or disabled Medicaid recipients participating in the program decreased by $190 six months to a year after

patients received their screenings and brief interventions.*

After six months, patients who were screened and provided with brief interventions cut their average monthly alcohol use in half (from 10 days to five days), reduced their average monthly binge drinking by more than two-thirds (from 10 days to three days) and cut their average illicit drug use in half (from 14 days to 7 days). Alcohol abstinence rates increased from 28 percent to 47 percent, and illicit drug abstinence rates increased from 55 percent to 71 percent. [15]

Washington Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Based on the rate of screenings in 2007, about 22,000 emergency room patients will be screened in 2008, and an estimated 1,200 aged, blind or disabled Medicaid recipients subsequently will receive brief interventions. The medical cost reductions for this population alone could lead to $2.7 million in Medicaid savings.[16]

Education

The third largest area of state spending on the burden of substance abuse and addiction is in education. Due to the lack of available data, CASA was not able to include any estimate of the cost of substance abuse and addiction to higher education, resulting in an extremely conservative estimate of substance-related education spending.

In 2005, States spent roughly $235.2 billion or 27.2 percent of their state budgets on elementary and secondary education. CASA estimates that 12.1 percent of this amount or $28.5 billion was spent coping with the impact of substance abuse in our elementary and secondary schools.

Of total state spending on the burden of substance abuse and addiction to public programs, 22.4 percent falls to the schools--almost nine times more than states spend on all prevention, treatment and research.

Promising Investments in Education. CASA's study, *Malignant Neglect: Substance Abuse and America's Schools*, found that most prevention initiatives employed in schools are narrowly focused, not evidence based or not faithfully replicated. Consequently, they fail to make a difference. Instead what is required is a comprehensive approach that targets the full range of risk factors children and teens face, including substance availability, parental substance abuse, mental health and behavioral problems, learning disabilities, community circumstances and low parental engagement.[17]

One school and community-based program that has shown success among high-risk 8- to 13-year old youth from socially distressed neighborhoods is CASASTART[SM] (Striving Together to Achieve Rewarding Tomorrows). The program focuses on preventing and reducing negative behaviors, such as being disruptive in school, participating in delinquent acts and substance use. CASASTART[SM] students and their families are provided eight core services: in-school case management, education services, family services, recreational after-school and summer time activities, mentoring, community policing, incentives and juvenile justice interventions.[18] Through collaborations between local law enforcement, schools, community organizations and social service and health agencies, the core services are tailored to fit the local cultures and practices.[19] Students generally stay in the program for two years.[20]

When compared with similar groups of students who did not participate in CASASTART[SM] programs, CASASTART[SM] students are involved with less drug use and drug trafficking and fewer violent crimes.[21] A year following program completion, CASASTART[SM] students were significantly less likely than their peers (51 percent vs. 65 percent) to report past-month use of cigarettes, alcohol, inhalants or marijuana.

* Relative to the medical costs of similar aged, blind and disabled beneficiaries who visited emergency rooms around the same time but were not screened or who did not receive a brief intervention.

They also were about half as likely as their peers (5 percent vs. 9 percent) to report past-month use of psychedelic, crack, cocaine, heroin or nonmedical prescription drugs. CASASTART[SM] participants were less likely to be involved with delinquent peers, felt as though they had more positive support from their peer groups, experienced less peer pressure than their peers, and were promoted to the next grade more often.[22]

Several federal agencies highlight model programs that consistently demonstrate strong positive short-term effects. CASASTART[SM] is hailed by SAMHSA, OJJDP and the National Dropout Prevention Center as a model program and was one of nine Safe and Drug Free School Programs the Department of Education ranked as exemplary in 2001.[23] The Life Skills Training (LST) Program, Project ALERT and Project Northland are other examples of multi-component prevention education curricula that have been identified as exemplary by SAMHSA and the U.S. Department of Education.

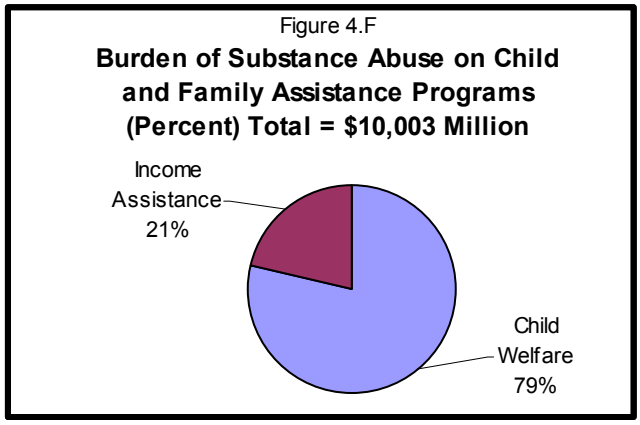
Other Service Programs

Approximately 14 percent of the burden of substance abuse and addiction to state programs fall in the categories of child and family assistance, mental health and developmental disability programs--down from 18.6 percent in 1998. Our failure to prevent and treat substance use disorders cost states $18.2 billion in 2005 through these programs; however, these same programs also represent opportunities for interventions that can reduce costs over the longer term. For example, providing treatment to substance-involved women who have neglected or abused their children may avoid costly foster care services, and providing prevention and early intervention services to their children may help avoid their own substance-related future problems.

Child and Family Assistance

In 2005, states spent $24.4 billion on child welfare and income support programs. Of this amount, the burden of substance abuse and addiction is $10.0 billion--41.1 percent of total spending in this area. Seventy-nine percent of this spending is in the area of child welfare. (Figure 4.F)

Figure 4.F



States spend three times more responding to the problem of substance abuse in child and family assistance programs than they report spending for all substance-related prevention, treatment and research.

Child Welfare. In 2005, states spent $10.6 billion of their own revenues on the child welfare system. Of this amount, at least 74.5 percent or $7.9 billion is caused or exacerbated by substance abuse and addiction. The largest share of spending was for adoption assistance, foster care and independent living programs ($4.9 billion). These costs signal the potential for future trouble since children who are neglected or abused by a substance-involved parent are more likely to abuse their own children and to develop substance use disorders.[24]

Promising Investments in Child Welfare. To address the problems of addiction in the child welfare system, Illinois started the Illinois Recovery Coach Program in Cook County in 2000 under a federal waiver that permitted the funding of alternative services under federal child welfare matching grant programs. Compared with a control group, the demonstration design matched custodial parents with substance use disorders whose children were in out-of-home care with intensive case management specialists known as Recovery Coaches (RCs). Judges, caseworkers or attorneys involved in families' temporary

placement hearings may refer parents for substance use assessments based on substantiated or alleged substance abuse. Following their assessments, parents deemed to have an unmet treatment need receive same-day program referrals and are assigned to a RC.

RCs are privately contracted intensive case management specialists. They help parents plan their treatment program and remain engaged with their recovery process. They also provide housing, domestic violence, parenting and mental health needs assessments and help their clients overcome personal barriers and access appropriate government benefits. RCs conduct outreach visits to families' homes and caregivers' treatment facilities in order to provide support and encourage parents to remain motivated. And, if necessary, RCs address families' emergency needs, including serving as client advocates in the child welfare and judicial systems. After treatment completion, RCs continue to work with parents and encourage their use of aftercare and recovery support services. Between 2002 and 2005, according to the University of Illinois, Children and Family Research Center, cumulative net savings due to the RC initiative as compared with the control group grew from $9,300 to $5.6 million in avoided child welfare expenditures.[25]

Income Support Programs. Total state spending for income support was $13.8 billion in 2005 for Temporary Assistance to Needy Families (TANF), General Assistance and state supplements to the Supplemental Security Income Program (SSI). Of this amount, a conservative estimate of $2.1 billion (15.4 percent) supports individuals with substance use problems:

- $1.7 billion through the TANF program (23.5 percent of TANF spending);
- $397 million in General Assistance (23.5 percent of General Assistance spending); and,
- $68.8 million in Supplemental Security Income (SSI) (1.2 percent of SSI spending).

Promising Investments in Income Assistance. CASASARD[SM], an ongoing welfare demonstration program for substance-addicted mothers, was designed to get women engaged in treatment and employment services, and help them become sober and successfully move to stable employment. Conducted in Essex (including Newark) and Atlantic (including Atlantic City) Counties, New Jersey, CASASARD[SM] uses an innovative intensive case management approach to providing services for these women compared with the standard care approach that focuses on employment first, screening and referral. The program includes:

- Outreach and assessments--all women applying for welfare benefits undergo brief screenings and those with potential disorders are given diagnostic assessments;
- Planning, motivational enhancement and treatment to encourage women in need to enroll in programs that address their individual problems;
- Treatment coordination, monitoring and advocacy to encourage women to stick with their program--case managers also help women overcome their related employment barriers such as childcare or lack of transportation;
- Aftercare follow-up, peer support meetings and relapse monitoring to encourage women to stick with abstinence; and,
- Crisis management and termination.

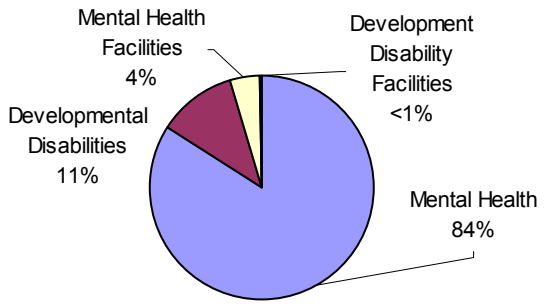
Compared to women receiving standard care, the women receiving the intensive case management approach were almost twice as likely to be completely abstinent at the 12 and 24 month follow-ups, and were more than twice as likely to be employed full-time at the end of two years. Based on these promising findings, New Jersey is expanding the program to an additional 17 counties.

Mental Health/Developmental Disabilities

In the areas of mental health and developmental disabilities, states spent $22.4 billion in 2005 of their own revenues. Conservatively, $8.2 billion (36.4 percent) of it was spent on treatment of a mental health problem or developmental disabilities co-occurring with and caused or exacerbated by substance abuse or addiction. The largest share (88.3 percent) was spent on mental health programs. (Figure 4.G)

Figure 4.G

Burden of Substance Abuse on Mental Health/Developmental Disabilities Programs (Percent) Total = $8,170 Million



For every dollar states report spending on prevention, treatment and research related to substance abuse and addiction, they spend almost two and a half dollars to deal with its burden in programs for the mentally ill and developmentally disabled.

Mental Health. State spending in 2005 on mental health programs totaled $12.8 billion. An estimated 56.3 percent or $7.2 billion was spent to cope with the impact of substance use disorders on the mental health system.

Developmental Disabilities. In 2005, states spent $9.6 billion on programs for the developmentally disabled. Substance use by a woman during pregnancy can result in developmental disabilities for the child. CASA estimates that at least 10.0 percent or $959.9 million of state costs for programs for the developmentally disabled are a result of Fetal Alcohol Syndrome (FAS). Because of data limitations, CASA was unable to estimate the costs to programs for the developmentally disabled linked to tobacco or illicit or controlled prescription drug use; hence this estimate is extremely conservative.

Promising Investments in Mental Health and Developmental Disabilities. The close relationship between mood disorders and substance use disorders can complicate diagnosis and treatment.[27] Scientific research has shown that individuals with anxiety or mood disorders are almost twice as likely to suffer from a substance use disorder. Among veterans with PTSD, for example, studies indicate that as many as half may have a co-occurring substance use disorder.[28]

My adopted son is now a 22 year old man with fetal alcohol syndrome. At 12 months he only weighed 12 pounds. He has made good progress despite an IQ of 64, skull and facial anomalies, 15 eye and ear surgeries, being high risk for vision loss, ADHD, poor judgment and an eating disorder. Now he is actively drinking on "weekends only." While my work on his behalf was given with love and he contributed his willingness to learn and grow, over his 22 years a range of supports--including an adoption subsidy, state medical assistance, energy assistance, HUD housing, WIC and food support, medical cabs, respite caregivers, special needs summer camp, sheltered employment and a special needs apartment with in-building staff--have all been poured into this one case. The financial worth of these supports--along with my lost earnings as a 20-year full time stay-at-home caregiver/educational advocate/medical case manager and loving MOM--have not been tabulated.[26] We pray his drinking will not increase.

--Linda Lee Soderstrom, MA, LPN

Research shows that treating co-occurring disorders together instead of separately can increase retention and reduce hospitalization and arrests among individuals with such disorders.[29] According to a study of 981 veterans with co-occurring psychiatric and substance use disorders from 15 treatment facilities, receiving services in a dual diagnosis treatment climate and greater participation in 12-step and mental health aftercare programs were associated with higher rates of abstinence during the year

following treatment completion. Aftercare participation was associated with higher levels of general and substance-specific coping in addition to abstinence.[30]

The Parent-Child Assistance Program (PCAP), initiated with the support of a federal research grant from the Center for Substance Abuse Prevention provided to Washington State in 1991, was designed to prevent developmental disabilities resulting from prenatal alcohol and other drug exposure. The program serves heavy substance using women who are pregnant or up to six months postpartum. Through regularly scheduled home visits, case managers provide practical assistance and emotional support to a small group of clients for up to three years.* In addition to connecting clients with treatment and other community services, case managers also keep an eye on the needs of their clients' children. Every four months case managers help their clients identify and re-assess their goals.[31]

Mothers involved in the initial demonstration program were more likely than their peers to enroll in inpatient or outpatient addiction treatment (52 percent vs. 44 percent), achieve at least one year of continuous abstinence (37 percent vs. 32 percent) and regularly use a reliable method of contraception (43 percent vs. 32 percent).[32]

Replications of the PCAP in Washington State have demonstrated even greater outcomes: 74 percent enrolled in inpatient or outpatient treatment, 53 percent achieved at least one year of continuous abstinence and 51 percent used a reliable method of contraception. Among women enrolled in the replication projects, an estimated 15 alcohol-exposed births were prevented over the course of their three years in the program. The cost of the three year program is just under $15,000 per client. The estimated average lifetime savings from preventing one case of FAS are $1.5 million.[33]

* Case managers are generally un-credentialed paraprofessional women who also have overcome significant hurdles such as poverty or substance use disorders.

Public Safety and the State Workforce

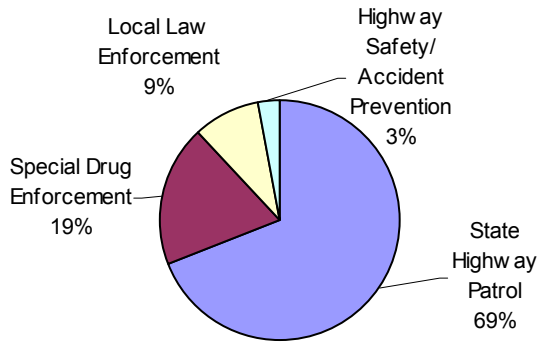
The remaining two percent of state spending on the burden of substance abuse and addiction to state programs is spent in the areas of public safety and the state workforce, costing states $2.5 billion in 2005. This is an extremely conservative estimate since, with the exception of special drug enforcement programs, CASA was able only to estimate costs linked to alcohol.

Public Safety

In 2005, states spent $8.2 billion on public safety including state highway patrol, special drug enforcement programs, local law enforcement programs and highway safety and accident prevention programs. Approximately $1.8 billion (22.0 percent--up from 16.9 percent in 1998) was spent on the cost of alcohol-involved traffic accidents to state and local law enforcement, drug enforcement and highway safety programs; 69 percent was through state highway patrol. (Figure 4.H)

Figure 4.H

Burden of Substance Abuse and Addiction on Public Safety Programs (Percent)
Total = $1,813 Million



CASA estimates that 19.7 percent of state costs to highway patrol, local law enforcement programs, and highway safety and accident prevention programs are due to alcohol abuse and addiction, and that 100 percent of the costs of special drug enforcement programs are attributed to substance abuse and addiction.

Promising Investments in Public Safety. Driving while impaired by alcohol or other drugs is commonly acknowledged to be one of the primary public safety problems in the United States.[34] The education campaigns, activist work and relevant policy changes, such as zero-tolerance laws and lower legal blood alcohol concentrations of the 1980s and early 1990s helped to reduce total alcohol-related traffic fatalities by 35 percent, from 26,000 deaths in 1982* to 17,000 deaths in 2003.[35] However, the number of cars on the road has increased substantially as has the annual number of vehicle miles traveled resulting in substantial declines in alcohol-related fatalities per registered vehicles in the U.S. and vehicle miles traveled during this period.[36] People living in states with more countermeasures against drunk driving, such as DUI specific laws and high enforcement rates, are less likely to report driving under the influence than those living in states with less stringent practices.[37]

Programs that have shown some promising results include: the use of sustained sobriety checkpoints, enhanced license suspension laws, targeted under-age drinking prevention programs, seizure of vehicle and license plates, alcohol interlocks and close monitoring strategies for persons with prior alcohol-related convictions.[38] Sobriety checkpoints have been found to reduce fatal motor vehicle accidents by more than 20 percent, producing positive returns on investment.† [39]

Other programs, such as the use of Drug Recognition Experts, can be used to increase the number of individuals referred to treatment. Increased treatment referrals may be able to reduce traffic accidents. Drug Recognition Experts are individuals, primarily from police departments, who receive 72 hours of classroom instruction, 40 to 60 hours of field experience, and pass a written exam as training to recognize if people are under the influence of drugs. In Oregon, Drug Recognition Experts had a 94.8 percent accuracy rate for identifying individuals who were under the influence of drugs and a 78.9 percent accuracy rate for identifying which drugs individuals had ingested.[40]

State Workforce

Substance abuse and addiction compromise the productivity of the state workforce and increase the costs of doing business. Substance abuse is associated with lower productivity, increased turnover, workplace accidents and higher health insurance costs.[41] The effects of substance use can reach beyond personal job performance. Up to 21 percent of employees report being subject to an injury or almost being injured, having to work harder, re-do work or cover for a coworker because of their coworker's alcohol use.[42]

Because of severe data limitations, however, CASA was able to estimate only those costs linked to absenteeism; that is, the extra days of absence by those who report illicit drug or heavy alcohol use or alcohol or other drug use disorders vs. those who do not report such problems. Workers who report illicit drug or heavy alcohol use or alcohol or other drug use disorders are more likely than those who don't to have missed two or more days of work in the past month due to illness/injury or skipped one or more day(s) of work in the past month.[43] Workers suffering from substance use disorders miss on average 0.51 days of work a month more than their peers.[44]

In 2005, states spent $182.1 billion in payroll and fringe benefit costs for state workers. CASA estimates that states spent 0.4 percent of payroll and fringe benefit costs or $676.9 million in absenteeism costs alone due to substance abuse and addiction. (Table 4.2)

Table 4.2
Burden of Substance Abuse and Addiction on State Workforce Costs

State Budget Sector	$ in Millions
Total payroll	$535
Total fringe benefits	142
Total*	**$677**

* Numbers may not add due to rounding.

* The year the Fatality Analysis Reporting System was established.

† Estimates and calculations of the cost-to-benefit ratio of sobriety checkpoints vary widely.

Promising Investments in State Workforce. Employee Assistance Programs (EAPs) can be used to help identify and address alcohol and other drug problems that may adversely affect employees' job performance. EAP services include:

- Working with employers to develop effective addiction-related workplace policies;
- Providing training to identify and assist employees that may have addiction-related problems;
- Providing access to professional services for addiction and related problems, including counseling, referrals, treatment or other support services; and,
- Providing access to educational materials and workshops.[45]

Clients with alcohol and other drug problems who received EAP services demonstrated a 66 percent reduction in reports of low productivity due to mental health problems; a 58 percent reduction in reports of low productivity due to physical health problems; and an 80 percent reduction in average lost time due to absenteeism or tardiness.[46]

State by State Burden and Per Capita Spending

State spending on the burden of substance abuse and addiction varies substantially by state, depending on differences in the state share of federal programs and different cost burdens they impose on localities. State burden spending ranges from 4.3 percent of state spending in Wyoming to 26.9 percent in Maine. Average burden spending is 14.8 percent. (Table 4.3)

To cope with this burden on state budgets, states collectively spend an amount equal to $420.49 for every person in America. State per capita spending ranges from a low of $216 in South Carolina to a high of $1,316 in the District of Columbia. (Table 4.4)

Table 4.3

Burden of Substance Abuse and Addiction on State Programs[a]

State	Percent of State Budget	$ in Millions
Maine	26.9	$1,180
Massachusetts	21.8	4,502
New York	21.1	13,132
New Mexico	20.9	1,346
California	19.1	19,473
Vermont	18.4	486
District of Columbia	18.3	765
New Hampshire	18.3	536
North Carolina	17.6	4,227
Kansas	17.4	1,194
Louisiana	17.0	1,376
Michigan	16.1	4,673
Florida	16.0	6,058
Pennsylvania	15.9	5,344
Missouri	15.8	2,144
Texas	15.8	6,400
Alaska	15.6	832
Colorado	15.1	1,616
Minnesota	14.9	2,774
Connecticut	14.9	2,610
Illinois	14.4	4,666
Nevada	14.9	757
Maryland	14.2	2,579
Puerto Rico	14.2	1,261
Georgia	13.9	2,495
Washington	13.4	2,746
Montana	12.6	308
Nebraska	12.0	616
Delaware	12.0	577
Idaho	11.9	359
Ohio	11.8	4,865
Oklahoma	11.8	999
New Jersey	11.7	3,780
Arizona	11.2	1,624
Mississippi	11.2	812
Hawaii	11.1	753
Alabama	10.8	1,142
Iowa	10.2	899
Kentucky	9.8	1,281
Wisconsin	9.6	2,384
Oregon	9.5	1,462
Virginia	9.4	2,379
South Carolina	8.5	934
Arkansas	8.5	846
South Dakota	8.1	180
West Virginia	5.0	705
Wyoming	4.3	177
Average	**14.8**	**$2,595**

[a] State programs include justice, education, health, child/family assistance, mental health/developmental disabilities, public safety and state workforce.

Table 4.4

Per Capita Burden of Substance Abuse and Addiction on State Programs[a]

State	Per Capita
District of Columbia	$1,315.97
Alaska	1,241.63
Maine	892.89
Vermont	778.75
Connecticut	744.79
Massachusetts	699.34
New Mexico	688.64
New York	680.19
Delaware	675.71
Hawaii	585.62
Minnesota	536.87
California	534.13
North Carolina	477.27
Michigan	462.88
Maryland	459.23
New Jersey	433.25
Kansas	432.05
Pennsylvania	429.59
Washington	429.35
Wisconsin	429.11
Ohio	423.84
New Hampshire	407.52
Oregon	394.98
West Virginia	387.58
Missouri	366.94
Illinois	363.62
Nebraska	348.20
Wyoming	343.88
Colorado	339.86
Florida	334.88
Montana	325.92
Puerto Rico	321.12
Louisiana	320.83
Virginia	311.21
Kentucky	304.50
Nevada	303.49
Iowa	301.52
Arkansas	300.85
Oklahoma	279.09
Mississippi	278.96
Texas	272.24
Georgia	266.45
Arizona	263.28
Alabama	248.34
Idaho	244.74
South Dakota	230.23
South Carolina	216.18
Average	**$420.49**

[a] State programs include justice, education, health, child/family assistance, mental health/developmental disabilities, public safety and state workforce.

Chapter V
The Burden of Substance Abuse and Addiction to Local Budgets

CASA estimates that in 2005, local governments spent $93.3 billion on the burden of substance abuse and addiction to local programs--8.9 percent of total local expenditures. This is a very conservative estimate based on local census data which do not permit the level of analysis possible with state programs. (See Appendix B, Methodology and Appendix E, Substance Abuse Spending by Local Budget Category)

As with the states, three areas of spending--justice, education and health--constitute the lion's share of local burden spending. Spending in these three areas equals 76.7 percent of the burden of substance abuse and addiction to local programs--$71.5 billion.

The next largest area of spending on the burden of substance abuse and addiction at the local level is public safety, accounting for $12.8 billion. Another $7.6 billion in burden spending is in child and family assistance programs and the remaining $1.4 billion is a function of workforce absenteeism. (Figure 5.A)

Calculating the Local Burden

1. Identify total local government spending for each budget category where substance abuse or untreated addiction have been demonstrated* to cause or increase spending.

2. Multiply total spending in each category by the share of such spending linked* to substance abuse and addiction. (For specific local jurisdictions, weight spending by the relevant state prevalence of heavy binge drinking and drug use compared with other states.)

3. Sum substance-related local spending in all categories for total burden spending.

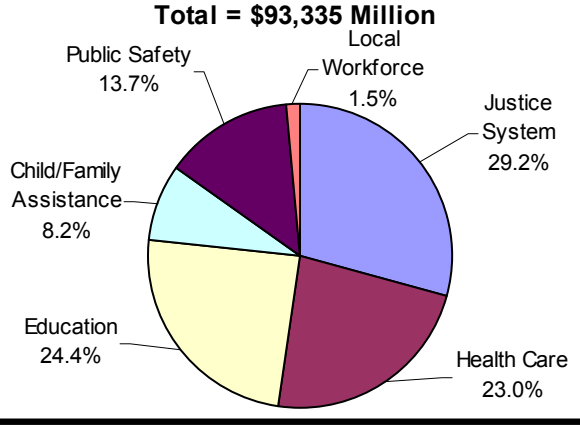
4. For specific local jurisdictions, identify total local substance-related spending on prevention, treatment, research, alcohol and tobacco taxation and regulation and add to total burden spending for total substance-related spending. Divide burden spending by total substance-related spending for percent spent on burden.

* Identified through national and other peer reviewed literature.

See Appendix B, Methodology.

Figure 5.A

Burden of Substance Abuse and Addiction on Local Programs by Budget Sector (Percent)
Total = $93,335 Million



Justice

Total local spending on justice programs--adult corrections, juvenile justice and the judiciary--equals the largest share of substance-related spending on the burden to public programs (29.2 percent) totaling $27.3 billion in 2005.

Promising Investments in Justice

The Multnomah County STOP drug court has served the State of Oregon for 18 years. At the recommendation of the county district attorney, non-violent offenders charged with possession of narcotics or similar crimes are presented the opportunity to enter treatment in lieu of incarceration. After treatment assessment, participants begin a minimum one-year treatment program including counseling, scheduled court visits and random drug tests. Upon successful completion of the program and at least six consecutive negative drug tests, the drug court judge will drop charges against program graduates. Aftercare services also are available to participants, but are not required. During its first 10 years of operation, 6,502 offenders participated in the Multnomah County drug court. Based on a randomized, experimental evaluation:

- Drug court participation costs an average of $5,170 per participant, including the expenses associated with their original arrest and booking, the drug court hearings, the pre- and post-graduation treatment and time spent on probation and in jail. In comparison, drug court eligible offenders who went through the standard adjudication process cost the criminal justice system $6,560 per participant. During the first 10 years of its operation the STOP drug court saved Multnomah County over $9 million, from these factors alone.

- Compared to eligible offenders who went through the standard adjudication process, STOP drug court participants are rearrested less often (four vs. six rearrests) and booked less often (two vs. three bookings) and spend less time in court and fewer days in jail (46 vs. 75 days), in prison (80 vs. 105 days) or on probation (529 vs. 661 days). Based on these findings, the Multnomah County drug court has saved the judicial and corrections system over $41 million over a 10 year period.[1]

Education

Education is responsible for the second largest area of local spending on the burden of substance abuse and addiction to local governments. Total local substance-related education spending accounts for 24.4 percent ($22.8 billion) of the burden to local programs.

Health

The third largest area of local spending on the burden of substance abuse and addiction to local programs is health--23.0 percent of burden spending or $21.5 billion.

Promising Investments in Health Care

New York City's Five Point Tobacco Control Plan is an example of a promising initiative that combines elements of prevention, treatment, regulation and taxation. Initiated in 2002, effects attributed to the campaign through pre- and post-initiation studies were visible almost immediately and included reduced smoking rates, decreased health spending on tobacco-related illnesses and improved health of city residents.[2]

The five component program included:

- Expanding the City's clean air laws to include all bars and restaurants and stricter enforcement of the existing anti-smoking regulations, for example, the consequences of selling tobacco to minors;

- Increasing quitline services, including the introduction of free six-week courses of nicotine replacement therapy (NRT) and complementary telephone counseling services;

- Increasing educational prevention resources, including anti-smoking media campaigns;
- Increasing the city's tobacco tax rate from $0.08 to $1.50; and,
- Monitoring program success.[3]

Public Safety

The burden of substance abuse and addiction to local public safety programs accounts for 13.7 percent of local spending on the burden--$12.8 billion.

Promising Investments in Public Safety

Locally-based initiatives such as Driving Under the Influence (DUI) Courts for repeat DUI offenders and sobriety checkpoints are effective at reducing alcohol-related fatalities.

DUI Courts use a Drug Court model to deter repeat DUI offenders from continuing to drink and drive by providing them with treatment in lieu of traditional sentencing procedures.[4] DUI participants from DUI Courts across the country are three times less likely to be rearrested and 19 times less likely to be rearrested for a DUI compared to their peers who receive traditional probation.[5] The cost-effectiveness of DUI Courts has not been well established in general; however research suggests that the program is an effective alternative when focused on serving repeat offenders with at least two prior DUI arrests.[6] As of 2007 there were only 110 designated DUI Courts and 286 DUI/Drug Court hybrids in the country, leaving room for program expansion.[7]

Sobriety checkpoints where police utilize selective breath testing--testing only those drivers whom they have reason to suspect were drinking--reduce fatal and non-fatal injury crashes by an average of 20 percent.[8] Well publicized sobriety checkpoint campaigns can be cost effective, even when only a few officers are present.[9] Research suggests that by doing so communities reduce the public costs of alcohol-involved crashes and can expect at least $6 in savings for every dollar they spend on the program.[10]

New York City Five Point Tobacco Control Plan

- For the first time in 11 years the prevalence of smoking among adult New Yorkers fell during the years following program implementation--11 percent between 2002 and 2003 and 15 percent between 2002 and 2004 or nearly 200,000 fewer adult smokers. Between 2002 and 2003, the heavy smoking rate decreased by almost 23 percent.[11]
- The free NRT program substantially increased NYC smokers' chances of successfully quitting for at least six months. Participants were more likely to follow through with attempts to quit (87 percent vs. 54 percent) and successfully remain smoke-free for six months (33 percent vs. six percent). NRT program participants substantially reduced their cigarette consumption over the six-month period: the percentage of pack-a-day smokers fell from 79 percent to 28 percent (among those who had not successfully quit). Individuals who utilized the free counseling services increased their chances of achieving abstinence by an even greater amount.[12]
- Almost half of NYC smokers (45 percent) reported reducing their consumption, quitting or attempting to quit in response to the tax increase. During fiscal year 2003, the cigarette tax revenues collected by the City were $260 million greater than the prior year.[13]
- A fifth of NYC smokers (21.4 percent) reported reducing their consumption due to the increased stringency of the indoor clean air laws. Residents also reported (46 percent) less second-hand smoke exposure.[14] These reductions have been linked to an accelerated decline in the monthly hospitalization rate for acute myocardial infarctions.[15]

Child and Family Assistance

Total local spending on the burden of substance abuse and addiction to child and family assistance programs equals 8.2 percent of total burden spending or $7.7 billion.

Mental Health and Developmental Disabilities

Due to data limitations, CASA was unable to separately estimate total local substance-related spending on the burden to local mental health or developmental disabilities programs. These costs are embedded in the areas of health and child and family assistance.

Local Workforce

Local government spending on the burden of substance abuse and addiction in terms of the cost of absenteeism in the local government workforce ($1.4 billion) accounts for approximately 1.5 percent of the burden to local programs.

Local Case Studies

To provide a more complete picture of the costs of substance abuse and addiction to government, CASA selected four local jurisdictions to serve as case studies for this report: Nashville, Tennessee; Multnomah County, Oregon; and Charlotte, North Carolina and Mecklenburg County, North Carolina. CASA combined Charlotte and Mecklenburg County into one jurisdiction to present a combined picture of city/county spending. These jurisdictions vary in size, government structure and local responsibilities. In Charlotte and Mecklenburg, for example, the City of Charlotte is responsible for providing police and fire protection and other local services while Mecklenburg County is responsible for corrections, education and human and social services.

While not representative of all local spending, these case studies provide three snapshots of city (Nashville), county (Multnomah) and combined spending in a city and county (Charlotte-Mecklenburg) governments. (See Appendix E, Substance Abuse Spending by Local Budget Category) Spending on the burden of substance abuse and addiction in these three local jurisdictions ranged from 7.7 percent of the local budget in Nashville to 15.5 percent in Multnomah County.

Supportive Housing: 1811 Eastlake Project

In 2005, Seattle, WA opened a supportive housing program for homeless men and women with chronic alcohol use disorders. The 1811 Eastlake Project is based on a harm reduction model: rather than requiring residents to achieve and maintain abstinence, the project takes a holistic approach aiming for general life improvements including treatment participation and reduced alcohol use. The county targets chronic public inebriates who cost them the most through continual use of public services. A space in the 75-unit residence comes with:[16]

- Case management and 24-hour staffing
- State licensed mental health and chemical dependency treatment
- On-site health care services
- Twice daily meals and weekly outings to local food banks
- Community building exercises.

The program is estimated to cost $950,000 annually or about $13,000 per resident.* This budget is provided by federal, state and local grants. At 12 months, residents reduced their total costs by more than $4 million, or $42,964 per person per year.[17]

* Not including the initial capital costs of $11.2 million.

In these three jurisdictions, spending on the burden of substance abuse and addiction to local government programs ranged from 94.7 percent of local substance-related spending in Multnomah to almost 100 percent in Charlotte and Mecklenburg.

Chapter VI
Government Spending on Prevention, Treatment and Research

Only 2.4 percent of total federal and state substance-related spending in 2005 ($8.8 billion) was for prevention, treatment or research; only 1.9 percent ($7.2 billion) was for prevention and treatment. (Table 6.1) For every dollar federal and state governments spend to prevent and treat substance abuse and addiction, they spend $59.83 in public programs shoveling up its wreckage, despite a substantial and growing body of scientific evidence confirming the efficacy of science-based interventions and their enormous cost-saving potential.

Table 6.1
Federal and State Spending on Prevention, Treatment and Research

	Expenditures ($ in Millions)	**Percent of Prevention, Treatment & Research Spending**	**Percent of Federal and State Addiction-Related Spending**
Prevention	$1,975	22.5	0.5
Treatment	4,534	51.7	1.2
Unspecified prevention/ treatment	664	7.6	0.2
Research	1,604	18.3	0.4
Total*	**$8,777**	**100.0**	**2.4**

* Numbers may not add due to rounding.

The importance of government investment in prevention, treatment and research is difficult to overstate. Individuals who reach the age of 21 without smoking, abusing alcohol or using other drugs are far less likely ever to do so. The savings from cutting off substance problems before abuse or addiction sets in far outweigh the price of effective prevention programming.

A recent study of two specific prevention programs found a nearly $10 return for every dollar invested in prevention.[*] [1] According to a

[*] Iowa Strengthening Families Program and Life Skills Training Program.

comprehensive review by the National Institute on Drug Abuse, the return of investing in treatment may exceed 12:1; that is, every dollar spent on treatment can reduce future burden costs by $12 or more in reduced substance-related crime and criminal justice and health care costs. Other major savings to individuals and society not included in this calculation are improvements in workplace productivity and reductions in drug-related accidents.[2]

Once addiction becomes a chronic condition, it requires a long-term care approach focused on disease management like asthma, diabetes and other chronic illnesses.[3] While symptoms may recur as they do with other chronic illnesses (relapse), such recurrence signals the need for an increased level or alternate approach to care to achieve remission. The stigma associated with substance use disorders, however, often prevents people from seeking the treatment they need, contributing to disease severity and staggering costs to public programs.[4]

To increase knowledge and understanding of the factors that protect against the development of addictive disorders, drive addiction and impede recovery, research and evaluation studies are critically needed.

Federal Spending

Of the $238.2 billion the federal government spent on substance abuse and addiction in 2005, only $5.5 billion--2.3 percent--was spent on prevention, treatment and research. Twenty-eight percent of this amount was spent on prevention, 44 percent on treatment and 28 percent on research. (Table 6.2)

State Spending

States spent just 2.4 percent of their total $135.8 billion in substance-related spending in 2005 on prevention, treatment and research ($3.2 billion). In 2005 dollars, this is less than they reported spending in 1998. Thirteen percent of this amount was spent on prevention, 65 percent on treatment, 21 percent on unspecified prevention and treatment and less than two percent on research. (Table 6.3)

Table 6.2
Federal Substance Abuse and Addiction: Prevention, Treatment and Research Expenditures

	Expenditures ($ in Millions)	Percent of Prevention, Treatment & Research Spending	Percent of Federal Addiction-Related Spending
Prevention	$1,558	28.1	0.7
Treatment	2,428	43.8	1.0
Research	1,557	28.1	0.7
Total	**$5,543**	**100.0**	**2.3**

* Numbers may not add due to rounding.

Table 6.3
State Substance Abuse and Addiction: Prevention, Treatment and Research Expenditures

	Expenditures ($ in Millions)	Percent of Prevention, Treatment & Research Spending	Percent of State Addiction-Related Spending
Prevention	$418	12.9	0.3
Treatment	2,106	65.1	1.6
Unspecified prevention/ treatment	664	20.5	0.5
Research	47	1.5	0.03
Total	**$3,235**	**100.0**	**2.4**

* Numbers may not add due to rounding.

Local Spending on Prevention, Treatment and Research

CASA was unable to identify total local spending on prevention, treatment and research due to data limitations. Of the local government case studies included in this report, spending on prevention, treatment and research ranged from two percent ($5.2 million) of total substance-related spending in Charlotte-Mecklenburg to five percent ($6.5 million) in Multnomah County. Like states, local jurisdictions did not always differentiate spending between prevention, treatment and research.

Prevention

The federal government spent $1.6 billion in 2005 to prevent substance abuse and addiction:

- $625.6 million through the Department of Education--$592.8 million for Safe and Drug Free Schools and Communities and $32.7 million for the reduction of alcohol abuse;
- $355.1 million through SAMHSA Substance Abuse Block Grants and an additional $197.2 million in other prevention programs;
- $207.1 million through the Office of National Drug Control Policy (ONDCP);
- $42.6 million through the Department of Justice;
- $8.9 million through the Drug Enforcement Administration;
- $120.4 million through the Department of Defense; and,
- $987,000 through the U.S. Small Business Administration.

Only $418 million in state funds is spent nationwide on substance abuse prevention. This includes $197.7 million through departments of health, $217.3 million through state substance abuse agencies. The remaining three million includes prevention programs through departments of Education and Juvenile Corrections.

Examples of spending for prevention include state-wide media campaigns, grants for community prevention programs and local prevention networks, and school- and community-based prevention programs.

Promising Investments in Prevention

The **truth®** campaign, launched in February 2000, is the largest national youth smoking prevention campaign in the country and the only national campaign not directed by the tobacco industry. Aimed at 12- to 17-year olds, **truth®** is designed to give young people the facts about the tactics of the tobacco industry, addiction, and the health effects and social consequences of smoking, and provide tools to help teens make informed decisions about tobacco use. The campaign includes television advertising, a Web site, interactive social networking sites, events and grassroots outreach.[5]

During the period of 2000-2002, the **truth**® campaign has been credited with reducing the number of children and teen smokers by 300,000.[6] A recent study published in the *American Journal of Preventive Medicine* indicated that the **truth**® campaign recouped its costs and averted almost $1.9 billion in medical costs to society.[7]

Treatment

The federal government spent $2.4 billion on treatment programs for substance use disorders in 2005:

- $1.8 billion through the Center for Substance Abuse Treatment (CSAT);
- $448.0 million through the Veterans Health Administration;
- $73.3 million through the Department of Justice;
- $54.8 million for Assistance in Transition from Homelessness (PATH);
- $10.1 million through the ONDCP; and,
- $5.5 million through the Department of Defense.

States report spending $2.1 billion a year on treatment for substance use disorders. Of this amount:

- $1.6 billion is spent through the state substance abuse agencies; and,
- $535 million through departments of health.

Examples of spending for treatment include grants for community treatment programs, addiction treatment for TANF recipients, detoxification clinics, community medical services and capital spending for treatment facilities.

Promising Federal Investments in Treatment

Based on extensive research and clinical practice, the National Institute on Drug Abuse has summarized the basic overarching principles that characterize effective treatment:[8]

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Multi-State Tobacco Settlement[9]

In 1998, the multi-state tobacco settlement agreement provided states with an estimated $246 billion to help prevent, treat and cope with the consequences of substance use and addiction.

Since 2000, only $6.5 billion of the $203.5 billion states received in tobacco revenue from tobacco taxes and the settlement has been spent on tobacco prevention and cessation programs. No state is funding tobacco prevention programs at the CDC recommended level. Instead many states have diverted these funds to pay for other programs and make up for current budget shortfalls.

The CDC estimates that using only 15 percent of tobacco money on prevention and cessation programs would bring every state up to the CDC recommended level.

Evidence from the National Treatment Improvement Evaluation Study shows that among clients participating in federally funded treatment programs there was a 53.5 percent reduction for alcohol- or other drug-related medical visits; a 52.9 percent reduction in TB problems in the past 30 days; a 10.7 percent reduction in inability to work due to health limits; and a 27.6 percent reduction in inpatient mental health visits a year after treatment. Clients also reduced drug use by approximately 50 percent, and criminal behavior declined by 70 to 90 percent after a year of treatment.[10]

The federal government provides grants to states and localities to fund treatment initiatives. These grant programs generally aim to connect under-served or other specific populations with the substance-related treatment and support programs they need. Examples include CSAT grants to residential treatment programs for pregnant and parenting women that would accommodate and incorporate both mothers and children into the treatment regime.

- The Pregnant and Postpartum Women (PPW) demonstration project provided long-term (6-12 months) comprehensive clinical, medical and social services for pregnant woman and mothers of children under the age of one.[16]

- The Residential Women and Children (RWC) project targeted mothers with children older than one. The treatment programs generally were small; 70 percent had between 10 and 20 treatment beds. They also attempted to target minority and low-income women who are traditionally underrepresented in treatment populations.[17]

Evidence-based practices commonly incorporated in these programs included standardized screening and assessments, individual case management, access to prenatal and pediatric care, mental health services, vocational and parenting classes, child care, preschool and transportation services.[18]

Of 39 programs examined, the annual cost of the RWC and PPW treatment programs was $160 per client per day and $25,700 per treatment episode (161.9 client days per treatment episode). Thirty-two percent of costs were for housing, 38 percent for client services and 30 percent for child care.[19] Costs of client services include either providing or supporting services such as counseling, medical care, case management, aftercare and transportation. Program results yielded approximately $89,100 in avoided costs per participant in one year post-discharge, including reduced crime, avoided TANF and food stamp payments, foster care placements and costs associated with low-birth weight deliveries.[20]

Findings from the Pregnant and Postpartum Women (PPW) and Residential Women and Children (RWC) Programs

- During the six months following their discharge, 61 percent of program participants remained abstinent from alcohol and other drugs.[11]
- Program participation decreased clients' arrest rate by 77 percent and increased their employment rate by 429 percent.[12]
- Clients' involvement with the foster care system decreased 29 percent; and their physical health and mental health problems decreased by 34 percent and 25 percent, respectively.[13]
- The rate of premature deliveries (7/100 live births) and low birth weight babies (6/100 live births) decreased in comparison to rates reported in multiple hospital-based studies of cocaine using women (27/100 live births and 34/100 live births, respectively).[14]
- The infant death rate decreased to 0.4/100 live births from 1.2/100, the rate reported by participants prior to program entry.[15]

Promising State Investments in Treatment

By providing treatment for substance-involved offenders, research has shown that states can cut chances of recidivism by half,[21] subsequently reducing their expenditures for arrests, adjudication and incarceration.[22] Treatment programs also have been shown to cut health

care costs for those with substance use disorders by one-quarter, primarily due to reductions in the number of annual hospital stays and emergency room visits.[23] Providing treatment for those with substance use problems who otherwise could not afford it can reduce future state spending on public insurance programs[24] and increase tax revenues, since individuals in recovery are more likely to be employed and are more productive than their peers who have not entered treatment.[25] These primary benefits are complemented by savings from decreased child welfare involvement.[26]

More than 17 states have or are conducting cost-offset studies to estimate the savings they can achieve through treatment for substance use disorders. According to their reports every dollar spent on treatment produces from almost $4 to more than $9 in savings from avoided criminal justice and medical costs and reduced welfare and disability payments.[27]

One study, examining more than 2,500 patients from 28 publicly funded treatment programs in California, found that outpatient and residential programs were solid investments. During the nine months following treatment admission, patients reduced their involvement with the criminal justice system and increased their income in comparison to the nine months prior to their admission.[28] On average, treatment was found to produce a greater than 7:1 ratio of benefits to costs. Benefits primarily were a function of reduced crime and incarceration and increased employment earnings.[29]

The average avoided policing, adjudication and incarceration costs during this period totaled $4,300 per participant, and participants' income increased on average by about $3,300. Among clients receiving outpatient and residential treatment as their primary services, the average weighted benefit-cost ratio was 12:1, largely due to reductions in crime and incarceration and to increased employment and reduced emergency room visits.[30]

Research

Dedicated federal spending in 2005 for addiction-related research totaled $1.6 billion, including biomedical research on the nature of addiction and strategies to treat and prevent addiction.[*] Research spending was concentrated in three primary agencies:

- National Institute on Drug Abuse ($1.0 billion);
- National Institute on Alcohol Abuse and Alcoholism ($438.3 million);
- Substance Abuse and Mental Health Services Administration (SAMSHA) ($101.5 million); and,
- The Office of National Drug Control Policy ($31.8 million).

States spent $47.4 million on substance abuse and addiction research and evaluation in 2005. Approximately $14.7 million was spent on research and $32.7 million was spent on evaluation. Only 20 states reported any spending in this area. Evaluation projects accounted for more than 69 percent of these expenditures.

State by State Spending on Prevention, Treatment and Research

State spending on prevention, treatment and research varies by state from 0.03 percent of the state budget in Puerto Rico to 1.74 percent in Connecticut. Average spending, however, amounts to only 0.37 percent of total state spending. (Table 6.4)

The average state spending on prevention treatment and research per capita is $10.64, ranging from $0.64 in Puerto Rico to $86.65 in

[*] While there may be additional addiction-related research spending embedded in other areas of spending, CASA was not able to disaggregate such costs.

Connecticut. Connecticut's per capita spending is almost twice that of the next highest spending jurisdiction--the District of Columbia ($45.07). (Table 6.5)

Table 6.4

Substance Abuse and Addiction: Prevention, Treatment and Research Spending by State

State	Percent of State Budget	$ in Millions
Connecticut	1.74	$304
Kentucky	0.78	102
Maryland	0.64	117
Oregon	0.63	96
District of Columbia	0.63	26
South Dakota	0.59	13
Pennsylvania	0.56	188
Illinois	0.55	180
Louisiana	0.54	44
Mississippi	0.51	37
Colorado	0.50	54
New York	0.46	288
Idaho	0.45	14
Vermont	0.45	12
Montana	0.44	11
Washington	0.44	91
Wyoming	0.41	17
Arkansas	0.38	38
Minnesota	0.36	66
Georgia	0.35	63
California	0.33	339
Massachusetts	0.32	66
New Jersey	0.32	102
Iowa	0.31	27
Missouri	0.31	43
Texas	0.31	127
Florida	0.30	114
Delaware	0.29	14
Ohio	0.29	119
Oklahoma	0.28	24
Kansas	0.27	19
New Mexico	0.26	17
Nebraska	0.24	13
Wisconsin	0.21	52
Arizona	0.20	29
Maine	0.19	8
North Carolina	0.19	46
Virginia	0.17	43
Michigan	0.17	50
Alaska	0.14	8
Nevada	0.09	4
Alabama	0.08	8
New Hampshire	0.07	2
West Virginia	0.07	10
Hawaii	0.06	4
South Carolina	0.05	6
Puerto Rico	0.03	3
Average	**0.37**	**65**

Table 6.5

Per Capita Spending for Substance Abuse and Addiction: Prevention, Treatment and Research by State

State	Per Capita
Connecticut	$86.65
District of Columbia	45.07
Wyoming	33.02
Oregon	26.00
Kentucky	24.22
Maryland	20.76
Vermont	19.07
South Dakota	16.81
Delaware	16.52
Pennsylvania	15.13
New York	14.90
Washington	14.16
Illinois	13.99
Arkansas	13.61
Minnesota	12.81
Mississippi	12.80
New Jersey	11.68
Alaska	11.39
Colorado	11.38
Montana	11.32
Ohio	10.34
Massachusetts	10.26
Louisiana	10.19
Wisconsin	9.32
California	9.31
Idaho	9.29
Iowa	9.16
New Mexico	8.61
Missouri	7.28
Nebraska	7.08
Kansas	6.80
Georgia	6.68
Oklahoma	6.59
Maine	6.40
Florida	6.29
Virginia	5.65
West Virginia	5.61
Texas	5.38
North Carolina	5.15
Michigan	4.92
Arizona	4.75
Hawaii	3.22
Alabama	1.78
Nevada	1.74
New Hampshire	1.47
South Carolina	1.39
Puerto Rico	0.64
Average	**$10.64**

Chapter VII
Government Spending on Regulation and Compliance, and Interdiction

The remaining categories of governmental spending on substance abuse and addiction are regulation and compliance, and interdiction.

In 2005, federal and state governments spent a combined $5.1 billion to regulate alcohol and tobacco products, collect alcohol and tobacco taxes and operate liquor stores. The federal government spent an additional $2.6 billion on drug interdiction. (Table 7.1)

Federal and state governments collected $13.6 billion in alcohol and $20.8 billion in tobacco taxes in 2005 for a total of $34.4 billion in 2005. For every dollar of tax and liquor store revenues collected, federal and state governments spend $8.95 on the burden of substance abuse and addiction.

Table 7.1
Federal and State Spending on Regulation and Compliance, and Interdiction

Budget Sector	Expenditures ($ in Millions)	Percent of Substance-Related Spending
Regulation/Compliance	$5,066	1.35
Licensing & Control	308	0.08
Collection of Taxes	346	0.09
Liquor Store Operation	4,446	1.19
Interdiction	2,638	0.71

Federal Government

The federal government spent $45.3 million in 2005 to collect $16.7 billion in alcohol and tobacco taxes--$8.9 billion from alcohol and $7.8 billion from tobacco.[1] For every dollar of tax revenue collected, however, the federal government spent $13.73 on the burden of substance abuse and addiction.

In 2005, the federal government spent an additional $37.1 million to regulate the sale of alcohol and tobacco.

State Government

In 2005, states spent an estimated $5.0 billion to regulate the sale of alcohol and tobacco, issue alcohol and tobacco licenses, collect alcohol and tobacco taxes and for governing or regulatory bodies. They collected $4.7 billion in alcohol taxes and $13 billion in tobacco taxes for a total of $17.7 billion. For every dollar states collected in tax revenue, they spent $7.23 on the burden of substance abuse and addiction.

Eighteen states (17 that participated in this survey) are liquor control states, meaning that they have state-run liquor stores. There are, however, variations among them in their rules about selling beer and wine in private stores and the alcohol by volume (ABV) levels that trigger requirements for sale in state run stores. State operation of liquor stores is based at least in part on the belief that the best way to control alcohol sales and therefore consumption within the state is to operate those businesses. In 2005, total state liquor control expenses equaled $4.5 billion and liquor control revenues amounted to $5.6 billion. For every dollar states collect in liquor store revenues and state taxes on alcohol and tobacco, they spend $5.50 dealing with the consequences of substance abuse and addiction.

There does not appear to be any relationship, however, between the increased state spending in liquor store operation and either reduced burden of substance abuse on public programs or increased spending on prevention and treatment. This might be a function of conflicting state roles of alcohol control and profits from beverage sales.

Because liquor control states varied greatly in the way they reported their expenditures in CASA's survey (reporting all, some or no expenses), CASA substituted reported expenses in this category for the 18 jurisdictions with Census data.

State Run Liquor Stores[2]

Alabama
Idaho
Iowa
Maine
Michigan
Mississippi
Montana
New Hampshire
North Carolina
Ohio
Oregon
Pennsylvania
Utah
Vermont
Virginia
Washington
West Virginia
Wyoming

Local Government

Due to data limitations, CASA was not able to estimate local spending on alcohol and tobacco taxation and regulation. Local governments in Maryland, South Dakota and Minnesota operated liquor stores at a cost of $439.5 million in 2005. Of the four local jurisdictions CASA examined, only Nashville reported any spending to collect alcohol and tobacco taxes ($140,000) or regulate alcohol or tobacco products ($130,000).

Local governments in 2005 collected $414.3 million in alcohol taxes and $398.0 million in tobacco taxes for a total of $812.3 million in revenue from the sale of alcohol and tobacco.[3]

Tobacco Taxation

At the federal level, the excise tax on cigarettes increased to $1.01 cent per pack in April, 2009.[4] Prior to the recent increase in the federal cigarette tax, federal excise taxes on tobacco had not increased in real dollars since 1964 when the Surgeon General first released his report on the danger of smoking on health.[5]

State excise taxes on cigarettes vary widely from a high of $3.46 per pack in Rhode Island to a low of $0.07 cents in South Carolina. The average state tax on cigarettes is $1.23.[6] Local taxes on cigarettes also vary widely from no tax at all in many cities and counties to a high of $2.00 per pack in Cook County, Illinois.[7]

Promising Investments in Tobacco Taxation

When it comes to tobacco products, the public health objective is to eliminate use. Taxing tobacco products has the dual advantage of reducing smoking initiation and offsetting some of the tobacco-related burden to federal, state and local governments. Raising cigarette prices leads to a decrease in demand for cigarettes.[8] Evidence suggests that a 10 percent increase in the price of cigarettes leads to a four percent overall reduction in the consumption of cigarettes. This reduction is even more pronounced in children and young adults: a 10 percent increase in the price of cigarettes can reduce smoking rates in children by six or seven percent.[9]

Tax-related reductions in smoking also result in cost savings to public health programs. A 25 percent reduction in state smoking levels, for example, is projected to save a total of $1.3 billion annually to Medicaid with $584.1 million of this amount going to states. Savings to the states based on smoking rates and Medicaid program structures would range from $400,000 in North Dakota to as much as $115.7 million in New York.[10]

Indexing cigarette taxes to inflation creates an opportunity for all levels of government to continue generating tax revenue from cigarettes while reducing the burden of tobacco.

State Tobacco Tax Increase[11]

The benefits of state tobacco tax increases vary depending on current smoking and tax rates. A $1.00 increase in South Carolina's $0.07 cigarette tax, which is the lowest in the nation and has not increased since 1977, could increase the state's annual revenue by $180 million.

• In five years, the increase in price would result in 78,200 fewer smokers and prevent more than 15,700 smoking-related deaths.

• Health savings from reductions in heart disease, strokes and smoking-related pregnancy and birth problems over this period could total more than $26.8 million.

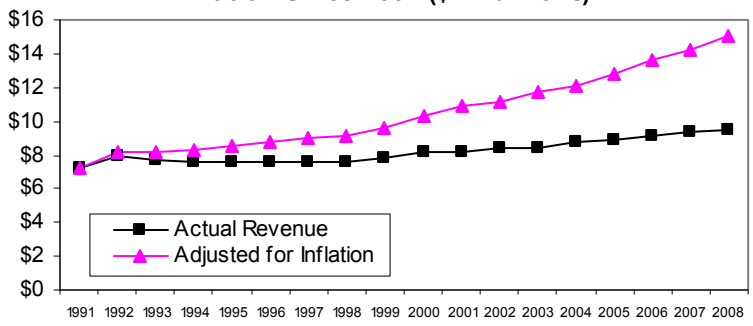
Alcohol Taxation

Most Americans who drink, do not drink excessively.[12] The public health objective as it relates to alcohol use is to curb underage drinking and adult excessive use. Empirical data suggest that drinkers are sensitive to changes in the price of alcohol, especially over the long-term, and that underage drinkers may be particularly responsive to tax increases.[13] Increasing alcohol taxes can both reduce consumption and provide critically needed revenues to help offset the costs of alcohol abuse to government.

Like tobacco, excise taxes on beer, wine and distilled spirits have failed to keep up with inflation.[14] (Figure 7.A) In fact, adjusted for inflation, the real rate of alcohol tax has been decreasing since 1951.[15] The federal excise tax on beer, for example, currently stands at approximately $0.05 cents per drink. Relative to the Consumer Price Index, however, the average price of beer has declined steadily over the past 40 years. To set taxes to the level they were in 1960, the federal excise tax per barrel would have to equal approximately $61.60, up from the current $18 per barrel.[16]

Figure 7.A

Actual Federal Alcohol Tax Revenues vs Potential Revenue Had Taxes Increased with Inflation Since 1991 ($ in billions)



Source: Center for Science in the Public Interest, Compilation April 2009.

State and local alcohol taxes vary widely by jurisdiction. For example, the tax per gallon of beer varies from $1.07 in Alaska to $0.02 cents in Wyoming, and from $0.53 in local jurisdictions in Georgia to no tax at all in many cities and counties.[18]

State Alcohol Tax Increase[19]--California

Increasing state alcohol taxes can counter the effect of inflation on alcohol prices. In California, inflation has resulted in a 45 percent decrease in the real value of state alcohol taxes. Increasing taxes on alcohol can generate revenue and reduce the negative consequences of alcohol to the state.

- A $0.25 cent tax per drink* on all alcohol including beer, wine and distilled spirits will generate as much as $3 billion per year.
- A $0.25 cent tax increase per drink on beer alone will generate as much as $2 billion per year to the state.
- A tax increase of as little as $0.05 cents per drink on all alcohol including beer, wine and distilled spirits can generate approximately $585 million per year.[20]

* One drink equals 12 ounces of beer, 5 ounces of wine or 1.5 ounces of distilled spirits.

Although most studies confirm that increased prices can simultaneously reduce consumption and raise substantial revenue, the projected price effects vary widely across studies[21] due to differences in statistical methods and pre-existing alcohol regulatory and taxation policies.[22] CASA's analysis found, for example, that states with higher beer taxes had, in general, lower rates of youth binge drinking. Overall, a dollar per gallon increase in tax on the alcohol in beer was associated with an 8.7 percent decline in youth binge drinking rates.[‡ 23] Higher alcohol taxes also are associated with decreased mortality and fewer motor vehicle crashes.[24]

Raising Beer Taxes in Alaska[17]

In 1983, Alaska raised its beer tax from $0.46 per gallon to $0.63 per gallon (in 2006 dollars). In 2002, the state raised beer taxes again to a nationwide high of $1.20 per gallon (in 2006 dollars). During the years following each increase, fatalities from disease that are 100 percent attributable* or partially attributable† to alcohol use fell significantly. After accounting for population changes and any changes in disease rates that occurred across the nation, the 1983 tax increase decreased alcohol-related disease fatalities by 20 percent and the 2002 tax increase decreased alcohol-related disease fatalities by 15 percent. Although the state savings have not been calculated, it is likely that in addition to increased tax revenues, Alaska also saw a decrease in health care-related spending.

* E.g., alcoholic liver disease, alcohol psychoses, alcohol dependence syndrome, alcoholic cardiomyopathy or acute alcohol poisoning.
† E.g., cirrhosis, acute and chronic pancreatitis, epilepsy, or ischemic and hemorrhagic stroke.

‡ Binge defined as: "Had five or more drinks of alcohol in a row within a couple hours on at least 1 day during the 30 days before the survey."

Promising Investments in Alcohol Taxation

The benefits of increasing alcohol taxes can be felt in several areas, including health care.[25] Increasing the beer tax by 50 cents per six pack of beer can result in an estimated 4.5 percent reduction in traffic fatalities.[26] A 20 cent tax increase on a six pack of beer can reduce gonorrhea rates by 8.9 percent.[27] Other research has found that a $1 increase in the distilled spirits tax per liter of ethanol can reduce death from cirrhosis rates by 5.4 percent in the short term and up to 10.8 percent in the long term.[28]

National Minimum Drinking Age

Underage drinking costs taxpayers an estimated $61.9 billion a year.[33] The National Highway Traffic Safety Administration (NHTSA) estimates that in 2007 alone, the minimum drinking age of 21 saved the lives of 826 18-20 year olds.[34]

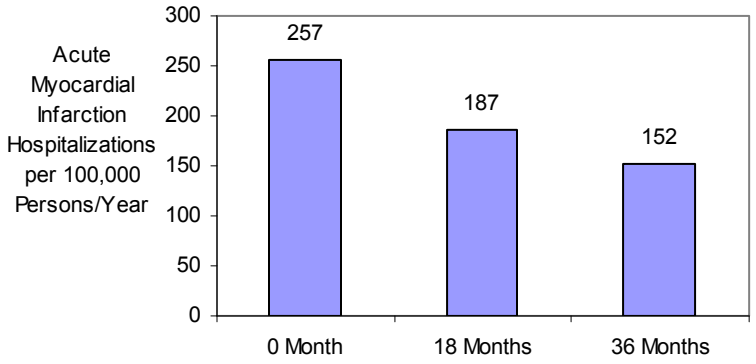
Regulation

Regulatory policies can have a significant impact on reducing the burden of substance abuse and addiction to government. For example, increased enforcement of retail sales, restricting the price, and limiting access to youth can reduce the burden of substance use to government and protect vulnerable populations from the dangers of addiction.[29] Maintaining existing limits on days in which alcoholic beverages are sold also is associated with reduced harm.[30]

Promising Investments in Regulation

Regulatory policies such as indoor smoking bans have shown great promise in reducing the burden of tobacco on health. A recent study in Colorado found an indoor smoking ban in Pueblo City, Colorado resulted in a 41 percent reduction in hospitalizations for heart attacks after three years.[31] (Figure 7.B) In large states, like New York, indoor smoking bans also have reduced hospitalization for heart attacks (eight percent) and resulted in savings of up to $56 million after one year.[32]

Figure 7.B
Three Year Impact of Indoor Smoking Ban on Hospitalizations for Heart Attacks, Pueblo City, CO



Two state regulations that have demonstrated potential to reduce spending on alcohol-related problems include keg-registration laws and the reclassification of alcopops from beer to liquor. States with keg registration laws require distributors to assign and mark each keg with an identification number and to collect the names, addresses, telephone numbers, etc. of keg purchasers and in some instances also the address where the alcohol is to be consumed. This information enables police to assign responsibility in cases of underage drinking or over consumption and related incidents of harm. Keg registration laws result in lower traffic fatality rates across all age groups, not only among underage drinkers.[35]

Alcopops refer to sweetened alcoholic beverages that resemble soda, fruit juice or energy drinks. Most states classify alcopops as beer rather than distilled spirits, subjecting the drinks to a significantly lower tax rate. Adolescent drinkers in the state of California consumed more than five times as many alcopops as adult drinkers; resulting in more than $1.25 billion in costs, including 60 deaths and 50,000 incidents of harm in a one year period.[36] Estimates of the costs of underage alcopop consumption to other states range from $29 million to $877 million, and consumption has been linked anywhere from one to 39 deaths and 1,000 to 38,000 incidents of harm, annually.[37] After the State of

California reclassified alcopops as distilled spirits in 2008, the price increased by 25 percent. Based on elasticity research, the 25 percent price increase will lead to a 35 percent reduction in consumption and eventually will produce $437 million in savings based on more than 17,000 avoided incidents of harm, including over 8,000 thefts, over 3,000 violent crimes, over 2,000 incidents of high risk sex and over 2,000 traffic accidents.[38]

Interdiction

In 2005, the federal government spent $2.6 billion to disrupt and deter the transport of illicit drugs into the United States. While international efforts to step up drug seizures may affect availability, price and consequences associated with a particular drug (i.e., cocaine or heroin), CASA was unable to find evidence that such strategies have an overall impact on reducing substance abuse and addiction or its costs to government.

> *...focusing on (drug) eradication is expensive and not very effective....interdiction has little effect on drug traffickers' ability to bring drugs into the United States and on to our street corners where they are sold.*
>
> --John Carnevale
> Served in three administrations in the White House Office of National Drug Control Policy

Chapter VIII
Moving from Spending to Investment

At every level of government, our country has been slow to respond to the growing evidence that substance use disorders are diseases for which effective treatments exist, and that substance abuse is a national public health problem demanding public education and prevention services. Our national blindness about the nature of addictive disease has led to billions in misspent taxpayer dollars--something this nation no longer can afford.

In CASA's 2001 report, we made three key recommendations: a) make targeted investments in prevention and treatment; b) expand use of state powers of legislation, regulation and taxation to reduce the impact of substance abuse and addiction; and c) manage investments for better results. America's failure to act on these and other recommendations has contributed to the current economic crisis governments now face. If current trends continue, by 2012 spending on substance abuse and addiction could consume over 18 percent of state budgets.

Current financial constraints coupled with a large and growing body of scientific evidence that substance use disorders are diseases for which effective treatments exist present many opportunities for more cost-effective investments.

As with other chronic health problems, it is critical to acknowledge the issue of personal responsibility. While some people are at greater risk than others for developing addictive disorders (genetics, family and community characteristics, co-occurring health problems, etc.), in the vast majority of cases initial use of tobacco, alcohol or other drugs is very much a matter of personal choice. When use of these substances progresses to the point of meeting medical criteria for abuse or addiction, changes have occurred in the brain which make cessation of use extraordinarily difficult. Having a chronic disease should not, however, excuse an individual from the consequences of his or her

actions or society from providing appropriate health care. The bottom line is that while the individual is responsible for his or her actions or society from providing appropriate health care related to the disease, the disease must be treated.

Examples of Immediate Benefits of Interventions:

1. ***Screenings and Brief Interventions***--reductions in hospitalizations.[1]
2. ***Alcohol and tobacco tax increases***--reductions in cirrhosis, accidents and STD transmission for alcohol taxes,[2] and in heart disease, strokes, smoking-related pregnancy and birth problems for tobacco.[3]
3. ***Indoor smoking bans***--reductions in hospitalization for heart attacks.[4]
4. ***Addiction treatments***--reductions in alcohol and other drug-related medical visits and inpatient mental health visits.[5]

Next Steps

There are four types of alternative actions that governments should take in order substantially to avoid or reduce the more than $450 billion this nation spends annually on the burden of substance abuse and addiction to government:

- Prevention and early intervention;
- Treatment and disease management;
- Tax and regulatory policies; and,
- Expanded research.

Prevention and Early Intervention

The largest impact on spending to shovel up the consequences of this problem would be to make significant investments in prevention to help avoid the costs altogether, and in screenings and brief interventions to catch the problem early and alter the course of the disease and its costs to families, government and society. Prevention and early intervention strategies should include:

- **Public Health Information.** Consistent with other successful public health efforts to educate the public about little understood diseases including depression or HIV/AIDS, federal, state and local governments should:
  - Educate the public about addiction as a disease, risk factors that increase individuals' vulnerability, prevention strategies, the importance of screening, and treatment options.
  - Clarify the difference between risky substance use, a behavioral choice that is amenable to change, and addiction, a medical condition that requires a broad range of treatments and recovery supports.
  - Address all addictive substances including tobacco, alcohol and other drugs.
  - Implement standardized workplace prevention programs covering tobacco, alcohol and other drugs.
- **Comprehensive Prevention Messages and Programs.** Prevention is the cornerstone of any public health initiative. Prevention initiatives should be focused on children: 17 years of research at CASA have shown that a child who reaches age 21 without smoking, abusing alcohol or using other drugs, is virtually certain never to do so. Prevention strategies should focus on curbing the human and social costs of substance abuse and addiction and co-occurring problems through comprehensive messages and approaches that are provided early and are reinforced in families, schools and communities.
  - Take advantage of points of leverage in government health, justice, public

safety, education, child and family assistance, housing, mental health and developmental disabilities programs to provide targeted prevention messages.

- Ensure that prevention initiatives are tailored to the age, gender and cultural groups they are targeting.

- Launch large-scale multi-media counter-marketing campaigns that target the perceptions and attitudes of adolescents toward tobacco, alcohol and other drugs, using tested marketing and branding tools to increase impact.

- **Screenings, Brief Interventions and Referrals to Treatment.** Because the costs of untreated addiction are so high and the human consequences so great, governments should use the opportunities inherent in their funded programs to look for substance problems and address them early. Intervening early is essential to prevent risky substance use and addiction and their consequences:

  - In each area of government spending on the burden of substance abuse and addiction, screen for substance abuse and provide brief interventions if needed. If more advanced disorders are suspected, refer for full assessments and offer effective and appropriate treatments if indicated. Venues for screenings and brief interventions include publicly funded programs and services such as: emergency departments, health clinics, trauma centers and doctors' offices; schools and colleges; welfare, child welfare, mental health and developmental disabilities services; and traffic safety, juvenile justice and adult corrections programs.

  - Train workers in publicly funded programs to provide screenings, brief interventions and referrals to treatment.

  - Expand medical billing codes for screenings and brief interventions and encourage providers to screen their patients for substance abuse.

  - Assure full coverage of screenings, brief interventions and treatment referrals for tobacco, alcohol and other drug use through publicly funded insurance programs, including Medicare, Medicaid and Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service for children, and the State Children's Health Insurance Program (SCHIP).

Treatment and Disease Management

Since approximately 9.0 percent of the U.S. population already has a clinical substance use disorder,[6] quality treatment and disease management services are essential. Failure to provide these services is just as unacceptable as failure of our health care system to provide treatment for diabetes, depression, hypertension or asthma would be.

- **Treatment.** As with any other health condition, it is essential to look for problems of addictive disorders, properly diagnose them and provide effective treatments. Government programs provide excellent opportunities to connect people who are misusing or addicted to tobacco, alcohol or other drugs with the treatments they need, and have the leverage to keep them in treatment long enough to make a difference. In providing services through public systems, it is important to understand that relapse is frequently a part of the recovery process as it is with recovery from other chronic diseases.

  - In all areas of government spending on the burden of substance abuse and addiction, governments should conduct comprehensive assessments of those who screen positive for a substance use disorder (including tobacco, alcohol and other drugs).

- Assure that all treatment programs and services that receive government funds meet medical, science-based criteria and that treatment providers are properly trained and licensed. To do this, governments working with professional organizations will have to create and improve standards of practice for treatment services and assure that providers meet appropriate licensing and certification requirements.

- Assure access to the full range of behavioral and pharmacological treatment options and social supports, tailored to the gender, age and life circumstances of patients. Successful treatment also requires effective services for the health problems that frequently co-exist, including mental health problems.

- Assure the availability of detoxification services and effective linkages to treatment. While often an important prerequisite to treatment, detoxification alone is not sufficient.

- Where possible, divert individuals from juvenile and adult corrections through expanded, evidence-based alcohol and other substance treatment and aftercare programs and through alcohol and other drug treatment courts.

- Eliminate mandatory sentencing laws for substance-involved offenders to enable prosecutorial and judicial discretion in treatment referrals and monitoring.

- Work with existing treatment providers and the medical community to integrate addiction treatment into the medical system. Providing effective treatments will require significant training of medical and other health professionals to recognize the signs and symptoms of addictive disorders, screen for these disorders, and know what to do when they identify them. This is particularly important because addiction treatment has been largely divorced from other medical care.

- **Disease Management.** To address the long-term disease management needs of those in publicly funded programs with chronic substance use disorders, government should:

  - Assure access to long-term medical management as we would for any other chronic disease, including management of co-occurring health and mental health problems.

  - Assure access to recovery support including education, vocational training, employment; life, parenting and other family skills; childcare, housing and transportation support; and mutual support through such programs as AA, NA, Smart Recovery etc.

  - Train publicly funded staff to help their clients to access aftercare and mutual support programs.

Taxation and Regulation

Governments should adopt a broad range of tax and regulatory policies to prevent underage initiation of substance use, decrease risky use and increase access to effective treatments.

- **Tax policy initiatives include:**

  - Increase taxes on tobacco to help eliminate use and on alcohol to prevent underage initiation and reduce adult excessive drinking. Increases in both taxes would help generate revenues to fund prevention and treatment services.

  - Classify malternative beverages (alcopops) as liquor rather than beer so they are taxed at a higher rate.

- **Regulatory policy initiatives include:**

  - Restrict tobacco and alcohol advertisements from youth audiences.

  - Prohibit direct to consumer marketing of controlled prescription drugs.

  - Enact/increase enforcement of laws restricting the sale of tobacco and alcohol to minors, including routine retailer compliance checks, keg registration and elimination of cigarette vending machine sales.

  - Increase use of sustained sobriety check-points and stricter license suspension laws for driving while intoxicated.

  - Enact/expand comprehensive clean indoor air laws and other smoking bans.

  - End insurance discrimination by requiring all public and private insurers to cover evidence-based prevention, intervention and treatment services for substance use disorders using the same payment and coverage requirements as other illnesses. Over half of federal and state spending on the burden of addiction is in the area of health. Health care reform that recognizes addiction as a disease and provides access to effective treatment is the best way to reduce these costs. In the absence of comprehensive health care reform, governments should make these changes in Medicare, Medicaid and other public health programs.

  - Abolish state Uniform Accident and Sickness Policy Provision Laws that limit insurers' medical liability if individuals are injured while they are intoxicated, since these laws provide doctors with disincentives to screen patients for substance problems or document substance-involved injuries.

Targeted Interdiction

In the face of limited evidence of the efficacy of current interdiction efforts to reduce drug use and related government costs, the federal government should reevaluate and retarget its investments in interdiction and reconsider the balance of investment in interdiction compared with investments in prevention and treatment.

Research and Evaluation

Research that increases our understanding of risky substance use and addiction is key to quality assurance and will help to develop and guide future cost-saving initiatives. Such activities should include:

- Increase our understanding of risky substance use and addiction through genetic, biological and social science research.

- Establish a baseline against which to measure progress and document impact at regular intervals.

- Fund research on best-practices for prevention and treatment of substance use and co-occurring disorders.

- Document the benefits of prevention, treatment, taxation and regulatory initiatives compared with the costs of our failure to do so.

Examples of Alternative Practices to Prevent and Reduce Substance Abuse and Addiction

Prevention and Early Intervention

- Targeted media campaigns
- Comprehensive family, school and community-based prevention
- Screenings, brief interventions and treatment referrals

Treatment and Disease Management

- Behavioral and pharmacological treatments for chronic illness
- Intensive case management
- Drug treatment alternatives to prison
- Prison based treatment/aftercare
- Recovery coaching
- Supportive housing
- Employee Assistance Programs

Taxation and Regulation

- Alcohol and tobacco tax increases
- Health insurance coverage for addiction
- Indoor smoking bans
- Keg registration laws
- Lowered blood alcohol levels for intoxicated driving offenses
- Tobacco quit lines
- 21 year old drinking age

Research

- Factors influencing risk
- Best practices
- Costs and benefits of interventions

Appendix A
State and Local Survey Instruments

CASA selected state and local budget officers as the appropriate target for data collection because they have the broadest view of and deepest expertise in the budget. We designed a questionnaire consistent with the way most budget offices are organized, dividing it into broad functional sections. To facilitate completion, we grouped the programs for which we needed data into 10 clusters: human/social services, developmental disabilities/mental health, health, education, corrections, public safety, judiciary, state workforce, regulation/compliance and capital spending. The instrument was designed in this fashion to make it easier for the budget office to parcel out the survey questions among a variety of specialists in the budget office.

The State and Local survey instruments requested data on:

- Fiscal Year 2005, own source general revenues including General Fund and non-General Fund spending, exclusive of funds received by states from federal sources or funds received by localities from state or federal sources;

- Reported expenditures (not appropriations) from the executive budget presented in the winter or spring of 2005. Differences between the proposed and adopted budgets were not expected to be large enough to skew the findings;

- All costs (program administration, fringe benefits, service providers and capital).

The full survey instruments can be downloaded at: www.casacolumbia.org/su2survey

As an example, attached is the adult corrections component of the state survey instrument.

CORRECTIONS BUDGET
Instructions for Adult Corrections Programs

Instructions: Provide the amount of state dollars spent in the fiscal year ending in 2005 (FY 2005), in actual dollars (as in $0,000,000), for the following programs on the attached worksheet.

1. Include state General Fund and state non-General Fund spending, including categorical state funding to localities. Do not include federal or local spending.

2. Separately identify capital spending (actuals or estimated actuals, not appropriations) **for adult corrections programs within the corrections budget**. Capital spending includes any spending that is paid for out of current general taxes or dedicated taxes ("Pay As You Go"), capital spending from bond proceeds (Bond Proceeds), and interest paid out for bonds already issued (Debt Service). Capital spending from bond proceeds includes capital projects funded by proceeds of GO bonds, revenue bonds, certificates of participation or other state-backed bonds. It is **not** necessary to separate capital costs for each separate facility. For example, if it is possible to express prison capital costs in the aggregate rather than for each prison individually please do so.

3. Include **all** program costs (not just substance abuse related costs) including the costs of caseworkers or service providers, program administrators and/or policy analysts who spend the majority of their time on this program, and contracted out services, and any grants to individuals or families. Please include the cost of fringe benefits for all state personnel; a rough estimate is all that is necessary.

4. If several small programs fall under one broad program heading, aggregate spending if it is easier to do so.

5. To avoid double counting, list only the spending for the programs that fall within the human/social services budget (see attached survey overview). Other department spending will be requested from other departments (e.g. health).

6. Do not include publicly funded health insurance programs. (In particular, do not include Medicaid spending).

7. Break out your spending into the following categories, if possible: drugs, alcohol and tobacco.

If you have any questions and/or problems with completing the survey, please contact Kristen Keneipp, Research Associate, The National Center on Addiction and Substance Abuse (CASA) at Columbia University, at (212) 841-5214 between 9:00 a.m. and 5:00 p.m. Eastern Time. You may also email Kristen at KKeneipp@casacolumbia.org.

CORRECTIONS BUDGET
Adult Corrections Program Descriptions

Total Prison Costs

Description: Any facility that is set up for the purpose of incarcerating individuals who have committed crimes. Included within these costs are all facilities costs and all psychiatric, education and job-training programs and central processing facilities that provide initial examination and evaluation of prisoners. Any substance abuse prevention and treatment programs and facilities for prisoners also are included.

Special Instructions: Please identify any special spending on substance abuse prevention and treatment programs and facilities **separately**. This number, however, should also be included within the **total** prison costs.

Parole/Early Release and Other Similar Programs

Description: Any program that manages the early release of prisoners. This includes programs that fund activities involved in the parole of prisoners and monitoring the parolees once they are released. Any substance abuse prevention and treatment programs and facilities for parolees also are included.

Special Instructions: Please identify any special spending on substance abuse prevention and treatment programs and facilities **separately**. This number, however, should also be included within the **total spending** for parole/early release and other similar programs.

Probation and Other Alternatives to Incarceration

Description: Any program that supervises and manages persons convicted of a crime but not incarcerated. Facilities that act as an alternative to the incarceration of individuals in prison also are included. This also includes programs that provide job training or education for these individuals. Any substance abuse prevention and treatment programs and facilities for individuals on probation also are included.

Special Instructions: Please identify any special spending on substance abuse prevention and treatment programs and facilities separately. This number, however, should also be included within the total spending for probation and other alternatives to incarceration.

Categorical Aid to Localities

Description: Any funding to localities for corrections activities.

CORRECTIONS BUDGET
State Spending on Adult Corrections Programs

Agency Name: _____ **Total State Budget for this Agency:** _____

PROGRAM NAME	AMOUNT BUDGETED FY 2005 Total State Funds (in actual dollars) (General Fund and Non-General Fund)	COMMENTS
1. Total Prison Costs: *Please identify any special spending on substance abuse prevention and treatment programs and facilities separately, but this number should also be included within the total prison costs.*		
Specific Program Names:		
a.		
b.		
c.		
d.		
e.		
2. Parole/Early Release and Other Similar Programs: *Please identify any special spending on substance abuse prevention and treatment programs and facilities separately, but this number should also be included within the total spending for parole/early release and other similar programs.*		
Specific Program Names:		
a.		
b.		
c.		
d.		
e.		
3. Probation and Other Alternatives to Incarceration: *Please identify any special spending on substance abuse prevention and treatment programs and facilities separately, but this number should also be included within the total spending for probation and other alternatives to incarceration.*		
Specific Program Names:		
a.		
b.		
c.		
d.		
e.		
4. Categorical Aid to Localities		
Specific Program Names:		
a.		
b.		
c.		
d.		
e.		

Appendix B
Methodology

For this update and expansion of CASA's analysis of the costs of substance abuse and addiction to governments, CASA builds on the strategies and methodologies developed for *Shoveling Up: The Impact of Substance Misuse on State Budgets*, 2001. CASA reconvened its original Advisory Commission, expanding it to include representatives of federal, state and local government, scholars, researchers, public interest groups and other distinguished officials. Commission members were selected for their extensive knowledge of substantive areas related to the project, including expertise in government policymaking and budgeting, issues of substance abuse and addiction, and cost-of-illness research. The Commission for this study was convened on June 21, 2006.

Literature Review

In order to refine our methodology and take advantage of research published since the release of our 2001 *Shoveling Up* report, CASA conducted an extensive literature review. A particular focus of the review was substance abuse costs studies released between 2001 and 2009 and work on the theoretical foundation of cost analysis and cost estimation models. We also tracked specific federal, state and local initiatives in substance abuse prevention and treatment and evaluations of such programs.

Most prior research on the costs of substance abuse and addiction has examined costs from a societal perspective. These studies largely estimated the total cost of substance abuse to society, often evaluating the data by cost component (e.g., criminal justice, health and productivity losses).[1]

The Lewin Group, in conjunction with the federal government, has conducted and updated comprehensive national estimates of the costs to society of tobacco, alcohol and other drug use. Cost areas include health care, lost productivity, crime and social welfare programs.

The costs of substance abuse and addiction to society also have been estimated internationally. Canada estimated the economic cost of the use and abuse of tobacco, alcohol and illegal drugs in the areas of productivity losses, health care costs, law enforcement costs, traffic accidents and social welfare programs. These costs amounted to a total of $1,267 to every man, woman and child in Canada in 2002.[2] An Australian report estimated the social costs associated with alcohol, tobacco and illegal drugs in fiscal year 1998-1999. Costs were attributed to associated health care (including estimates for secondhand smoking), crime, productivity losses (both in the workplace and the home), social welfare programs, accidents and fires.[3]

Other work, such as that done in Canada and Australia, has focused on documenting avoidable costs of substance abuse and addiction and the efficacy of a select number of prevention, treatment, taxation and regulatory policies or programs.[4]

While these studies provide rich and compelling information, they have not provided estimates of the total or aggregate costs of substance abuse and addiction to government. CASA's *Shoveling Up* report was the first to estimate the costs of substance abuse to state budgets. Substance-related costs were divided into three major categories: prevention, treatment and research; spending on the burden of substance abuse and addiction to government operations and programs; and spending on alcohol and tobacco taxation and regulation.

Since the release of this report, some states have begun to investigate state-level spending on the burden of substance abuse and addiction, suggesting a growing understanding of the impact of substance abuse and addiction on state budgets. Methodologies differ, however, making meaningful comparisons impossible. Some studies specifically target government spending while others calculate overall societal costs, which may include federal, state and local spending as well as costs to private citizens. Examples of state specific studies include Virginia, Oklahoma, Washington and Maine.[5]

Data Collection

For purposes of this study, CASA updated the costs of substance abuse and addiction to state budgets, and extended the analysis to federal and local governments.

The State Survey

The budget survey instrument used to gather data from the states was based on the survey initially developed for the first *Shoveling Up* report. Originally, CASA conducted an extensive review and chose five model states from which to gather information to develop a budget survey. The five states chosen provided insight into how total and program spending varied based on the size, location, demographic characteristics and economic conditions of a state.

To determine state programs to include in the study, CASA:

- Reviewed a wide range of literature on the consequences of substance abuse to government programs;
- Identified state programs designed to prevent or treat substance abuse and addiction or that deal with their consequences. In the latter category, we included only those programs that were large enough to be of any consequence in the overall sum of substance abuse spending.
- Consulted with state budget and program officials to understand how these programs are financed and to determine the most efficient and effective way to gather the spending data.
- Conducted site visits in the five selected states. Between March 1998 and August 1998, site visits were conducted in California, Florida, Minnesota, New Jersey and Vermont to inform our list of government programs that are affected by substance abuse and to learn what, if

anything, had already been done to track state substance abuse and addiction costs.

CASA selected state budget officers as the appropriate target for data collection because they have the broadest view of and deepest expertise in the budget. We designed a questionnaire consistent with the way most budget offices are organized, dividing it into broad functional sections. To facilitate completion, we grouped the programs for which we needed data into 10 clusters: human/social services, developmental disabilities/mental health, health, education, corrections, public safety, judiciary, state workforce, regulation/compliance and capital spending. The instrument was designed in this fashion to make it easier for the budget office to parcel out the survey questions among a variety of specialists in the budget office.

To capture as much of the spending associated with a particular program as possible, the survey instrument requested data on:

- State Fiscal Year 2005, state own source general revenues including General Fund and non-General Fund spending, but not federal or local funds;

- Reported expenditures (not appropriations) from the executive budget presented in the winter or spring of 2005, since some states do not publish adopted budget data. Differences between the proposed and adopted budgets were not expected to be large enough to skew the findings;

- All costs (program administration, fringe benefits, service providers and capital).

CASA administered the survey in July of 2006 to all 50 states, Puerto Rico and the District of Columbia (Appendix A). Forty-five states, the District of Columbia and Puerto Rico completed the survey. The participating jurisdictions constitute approximately 96.28 percent of total state budget spending for the nation, including DC and Puerto Rico. The five non-participating jurisdictions were: Indiana, North Dakota, Rhode Island, Tennessee and Utah.

The Local Survey

CASA developed a local budget survey instrument replicating the methodology used in the state survey. To account for the differences in state and local budget structures and expenditure areas, CASA reviewed the 2005 budgets of Louisville (KY), Multnomah County (OR), Nashville and Davidson County (TN) and Philadelphia (PA). The U.S. Census Bureau's *Finances of County Governments: 2002* and *Government Finance and Employment Classification Manual* also helped to guide the survey revision. Before finalizing survey modifications, CASA consulted with statistical as well as state and local finance experts.

The alterations made to the survey instrument based on CASA's investigation included:

- The addition of an environmental health programs subcategory under the health category, to account for the costs of methamphetamine laboratory clean up and the potential savings from clean indoor air laws.

- The addition of fire rescue/EMS, police and medical examiner subcategories under public safety.

As with the state survey, CASA targeted budget officers in the local data collection process because they have the broadest view of and deepest expertise in the budget. Paralleling the state request, the local survey instruments solicited information concerning:

- Local Fiscal Year 2005, localities own source general revenues including General Fund and non-General Fund spending, but not federal or state funds;

- Reported expenditures (not appropriations) from the executive budget presented in the winter or spring of 2005. Differences between the proposed and adopted budgets were not expected to be large enough to skew the findings.

- All costs (program administration, fringe benefits, service providers and capital).

In September 2006, CASA began requesting the participation of cities and counties throughout the United States. CASA appealed to 14 municipalities for their participation in the study. These local governments were handpicked in conjunction with leaders from the U.S. Conference of Mayors and the National Association of Counties. The jurisdictions are not a representative sample of local governments throughout the country. They were chosen based on size, geography and government structure (city, county, or consolidated city-county). Four local jurisdictions completed the survey: Charlotte, NC; Mecklenberg County, NC; Multnomah County, OR; and, Nashville, TN. Charlotte and Mecklenberg County were combined to present an example of combined city-county spending.

Estimating Total Local Costs

To derive a national estimate of local spending on substance abuse and addiction, CASA examined the United States Census data on state and local government. Totals were adjusted to reflect local spending only; state and federal transfers were removed from the totals. While these data were not as detailed as those available on the federal and state level, they did provide information on local spending in the areas of education, health, corrections, public safety, social services and local government workforce. The Census local data could not separately identify spending for prevention, treatment, research, mental health, developmental disabilities, domestic violence or environmental health. Spending for the District of Columbia was removed from the local Census totals because we included it as a separate jurisdiction in our state analysis.

State and Local Supplemental Data

In areas where states and localities did not report spending or where they could not provide the detail that CASA requested, CASA sought the information first from the state or locality's own budget documents, then from secondary sources. At the state level, the Final 2005 Report of State Expenditures by the National Association of State Budget Officers (NASBO) provided secondary data in the state spending categories of adult corrections, education, Medicaid, other health care spending, TANF and other public assistance when the state survey and/or the state's own budget documents failed to provide sufficient data. The Census Bureau's State and Local Government Finances by Level of Government and by State: 2004-05 provided workforce and public safety data when no other sources were available. At the local level, the four local jurisdictions' submissions were supplemented by their budget documents found on their respective Web sites.

In order to estimate local fund expenditures, the percentage of total revenues, CASA made two exceptions to the use of local Census data to estimate total local costs in the areas of justice and education spending. The Bureau of Justice statistics provided specific revenue source ratios for local police, corrections and courts. The U.S. Department of Education provided a similar ratio for local education expenditures. [6]

The Federal Analysis

Due to the impracticality of attempting to contact and survey the federal government, CASA collected fiscal year 2005 budget data. Using the budget categories established in the state survey as a guide, CASA identified federal agencies with budgets where substance abuse and addiction causes or contributes to their costs. We also conducted a literature review of federal spending and the budget process and examined federal programs and types of federal expenditures to ensure our estimates captured as much relevant spending as possible. Resources reviewed included:

- The Office of National Drug Control Policy (ONDCP) budget report which provides summaries of the budget authority of 11 federal agencies involved with illicit drug prevention, treatment and interdiction efforts;

- The United States Treasury's *Combined Statement of Receipts, Outlays and Balances, 2005*, an official publication of the federal government's annual receipts and outlays;

- The Catalog of Federal Domestic Assistance (CFDA), a database of federal programs available to state and local governments; tribal governments and U.S. Territories; domestic public, quasi-public and private profit and nonprofit organizations and institutions; specialized groups and individuals.

- www.FedSpending.org, a web-based database run by OMB Watch, based on the Census Bureau's Federal Assistance Award Data System. The Web site provides information on Federal contracts and grants awarded to individuals, governments, higher education institutes, nonprofits, for profits and other recipient types;

- The *Budget of the United States Government*, specifically agency-specific budget authority from the President's Budget and the Public Budget database, a companion resource to the President's Budget that provides account-level detail of budget authority and outlays.

CASA identified 15 federal agencies where substance-related expenditures could be quantified: Department of Homeland Security, Department of Education, Department of Defense, Department of Health and Human Services, Department of Justice, Department of Interior, Department of Labor, Department of Housing and Urban Development, Department of Veterans Affairs, Department of Agriculture, Treasury, Social Security Administration, Department of Transportation, Department of State and Office of National Drug Control Policy.

We collected fiscal year 2005 federal expenditure data using 2006 and 2007 agency-specific Congressional budget requests which document actual agency expenditures in 2005. Agency budget requests were ideal primary sources because they broke down spending into sub-agency and program-specific categories. This level of detail was necessary to capture the substance abuse and addiction-related expenditures of programs run by sub-agencies and to enable us to exclude services not related to substance use.

Linking Expenditures to Substance Abuse and Addiction

The data, by design, contain a mix of costs caused by substance abuse and addiction and costs where substance abuse and addiction play a significant contributing role. Costs attributed directly to substance abuse and addiction fall into five main categories:

1. Addiction-related prevention, treatment, research and evaluation, drug courts and dedicated drug enforcement programs;

2. The burden of substance abuse and addiction to health care spending based on the probable causal link between substance abuse and addiction and a particular disease state;

3. State worker absenteeism caused by substance abuse;

4. Alcohol and tobacco regulation and taxation and operation of liquor stores; and

5. Federal interdiction efforts.

For other areas of spending we were less concerned with whether substance abuse caused the spending than with whether treatment or intervention will *reduce the cost of the burden associated with the problem*. This is a very important policy distinction. The cost-of-illness model has focused on increasing the precision of linking costs to causality, and the cost-avoidance model focuses on a narrow subset of interventions proven to reduce costs to government. The operational question for a policymaker, however, is not how many welfare recipients are receiving assistance only because

of their substance abuse, but rather how many welfare recipients will be impeded in their efforts to leave the welfare rolls and return to work because they abuse or are addicted to alcohol or other drugs. Similarly, it is less important for our purposes to establish the percentage of state inmates who committed crimes as a direct result only of substance abuse or addiction than to determine the group of prisoners for whom addiction treatment is a necessary condition to keep them from returning to prison. Further, policymakers need to know the universe of these costs in order to develop and implement ways to avoid them.

In all areas where substance abuse and addiction places a burden on government programs, even health care and government employee costs, substance abuse and addiction can both cause and exacerbate the conditions that lead to the draw on public funds. Our estimates establish the pool of substance-involved costs--the target for policy intervention. Because substance abuse more often than not appears as one of a cluster of behaviors leading to increased costs to states, solving the addiction problem will be a necessary step to eliminating these costs.

Estimating Substance-Related Shares of Federal, State and Local Spending

CASA developed estimates of the share of spending for each government program for which there was credible documentation of attributed or associated substance-related costs, based on an extensive review of the literature, including our own research.

Prevalence of past 30 day heavy binge drinking (having five or more drinks on five or more occasions) and of past 30 day illicit drug use (including the abuse of prescription drugs) were used to estimate relative levels of substance abuse. These prevalence rates were obtained for each state, for the nation as a whole and for specific populations with unique characteristics. This level of detail allowed CASA to adjust the substance-related fractions to reflect the patterns of each given population. The Behavioral Risk Factor Surveillance System (BRFSS) was used to obtain rates of heavy binge drinking and the National Survey of Drug Use and Health (NSDUH) was used to obtain rates of past month illicit drug use.[*]

CASA adjusted the substance-related fractions of spending in each budget category to reflect differences among states and localities and changes in the prevalence of heavy binge drinking and illicit drug use between 1998 and 2005. For the local case studies, CASA used the substance-related fractions of their respective states.

1. We first identified and tallied spending on programs that were 100 percent attributable to substance abuse and addiction.

Substance-Related Prevention, Treatment and Research. CASA asked states and municipalities to report all spending for programs with the explicit goal of reducing tobacco, alcohol and other drug abuse and addiction, programs that provide treatment for substance use disorders and spending for substance-related research and evaluation. We identified federal expenditures for such programs based on Congressional budget breakdowns.

Examples of programs included in this category of spending are media campaigns, tobacco quit-lines, local prevention networks, interagency coordination of prevention programs, prevention education, treatment facilities, out-patient care programs, substance-related research and evaluation, and capital spending for treatment facilities.

Regulation and Compliance. CASA included in its analysis total spending on federal, state and local personnel who are responsible for collecting alcohol and tobacco taxes (including

[*] In the *first Shoveling Up* report, CASA used these two data sets since these variables were not available by state from one source. We have used the same approach for purposes of this update and expansion.

fringe benefits) and the funds budgeted for boards or governing bodies that enforce alcohol and tobacco regulation and/or issue alcohol and tobacco licenses. Revenues from alcohol and tobacco taxes at the state and local level were obtained from Census estimates. At the federal level, they were obtained from the Alcohol and Tobacco Tax and Trade Bureau.[7]

Eighteen states have state-run liquor stores (Alabama, Idaho, Iowa, Maine, Michigan, Mississippi, Montana, New Hampshire, North Carolina, Ohio, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, West Virginia and Wyoming), as do selected counties in several states. Due to an inconsistency in reporting of state spending on regulation and compliance for the liquor control states participating in our survey (Utah did not participate), CASA reports liquor stores expenditures and revenues for these state and local jurisdictions as reported by the Census.

Interdiction. A new budget category, interdiction, that includes spending to disrupt and deter the transport of illicit drugs into the United States was created for purposes of the federal analysis since this function is unique to federal agencies. Other federal international and domestic dedicated drug control spending is included in public safety.

2. CASA estimated the shares of government spending where the link is not necessarily causal but where addressing substance use problems is essential to reducing government costs.

For those programs where costs are partially linked to substance abuse and addiction, CASA scaled the shares to adjust for differences in prevalence of substance abuse by state and locality. The prevalence of heavy binge drinking and of illicit drug use in the past 30 days were weighted in a 50-50 proportion in each state (and local case study sites) due to the lack of data identifying the proportion of users in each category or the proportion of poly-substance users in each budget sector. This combined prevalence was then compared to the national combined prevalence and the attributable fraction for the given budget sector weighted accordingly. This methodology is employed in all budget sectors with these exceptions: spending for public safety and developmental disabilities where only heavy binge drinking prevalence rates were used because only alcohol-related costs could be calculated, and a different methodology was employed to estimate substance-related health care spending.

Health Care. Substance abuse and addiction increase health care spending in at least three ways:

1. Some people become ill or injured as a result of their own substance abuse and receive health care services related to the illness. For example, lung cancer resulting from smoking leads to a variety of health care expenditures, such as hospital, physician, and drug costs.

2. Substance abuse and addiction can injure innocent parties. Mothers who smoke during pregnancy may have low birth-weight babies, increasing government-financed costs upon the child's birth (and possibly increasing government-financed health expenditures throughout the child's life).

3. People who smoke or abuse alcohol or other drugs often have a generally lower level of health and have more frequent, longer, and more severe illnesses. For example, bouts with influenza tend to last longer for smokers than for nonsmokers. Because of constraints of available data, our analysis does not include these costs.

The underlying basis for estimates of health-related spending is epidemiological research showing a link between substance abuse and illness. In 2001, CASA devised a two step methodology to link the effects of substance abuse on particular diseases with health-related spending in order to estimate the substance abuse share, taking advantage of as much jurisdiction-specific data as possible:

Step One: Estimate National Attributable Fractions by Substance and Provider Type.

To estimate attributable fractions, we used population-attributable risk (PAR) values, either estimated directly or as reported in epidemiological research. A PAR value is an estimate of the probability that a given episode of disease is attributable to (or caused by) a factor such as substance abuse or addiction. It reflects both the relative risk of getting the disease and the prevalence of substance abuse and addiction.

An attributable fraction is an estimate of the share of spending in a given program that is caused by smoking, alcohol or other drug abuse. For example, if we say that the "smoking attributable fraction" for Medicaid-financed physicians' services is 12 percent, we mean that on average about 12 percent of Medicaid payments to physicians are caused by smoking. Or, if we say that the alcohol-related PAR value for liver cancer is 19 percent, we mean that 19 percent of new liver cancer cases result from alcohol abuse or addiction.

In CASA's 2001 *Shoveling Up* report, we developed national-level attributable fractions for each substance type (smoking, alcohol and other drugs), for each major type of medical provider (e.g., hospitals, physicians, home providers, etc.) paid by either Medicaid or another state government insurance. We developed 48 different attributable fractions in total--three substance types by eight provider types by two payer types.[*]

For alcohol, we used PAR values developed by NIAAA for specific disease states. For illicit drugs, we developed our own PAR values based on a thorough review of the epidemiological research. In the case of smoking, we applied jurisdiction specific attributable fractions that had been developed by other researchers.[8] We applied these PAR values to available public-use medical care databases to determine what portion of spending is linked to substance abuse, relying on the ICD-9 (International Classification of Disease, 9th Revision) coding system. The resulting national substance-related health care attributable fraction for individuals receiving state public health insurance (Medicaid and/or other state insurance) percentage for our 2001 report was 24.4 percent in 1998.

This year CASA refined its health care methodology in order to provide more precise estimates and accommodate the inclusion of federal and local spending. Using the same basic methodology, we developed separate estimates for all payer types (i.e., Medicare, Medicaid, other federal and other state) rather than just Medicaid and other state payers, adjusting the resulting fractions to 2005 prevalence levels of alcohol, tobacco and other drug use. These analyses resulted in a Medicare attributable fraction of 34.8 percent, a Medicaid fraction of 28.9 percent, an "other federal insurance" fraction of 28.4 percent and an "other state insurance" fraction of 29.6 percent.

Step Two: Applying Attributable Fractions to Governmental Health Spending.

To develop government estimates of Medicaid and other health spending attributable to substance abuse and addiction, CASA multiplied the attributable fractions by the reported 2005 health care expenditures. Where respondents were unable to provide this spending, CASA utilized the reported Medicaid and other health care expenditures in the 2005 National Association of State Budget Officers (NASBO) report. For each level of government we used a two-step process.

First, we calculated average attributable fractions by substance type effectively weighting the national attributable fractions by the jurisdiction's prevalence rates. We then multiplied these jurisdiction-specific weighted-average attributable fractions by 2005 total government spending on health programs to arrive at substance attributable spending. As no

[*] The provider types are: hospital inpatient, emergency room, outpatient, medical provider visit, home provider visit, medical supply purchase, prescription drugs and dental. The two payer types are Medicaid and other State insurance.

specific local government health care spending data were available, CASA used the "other state insurance" fraction (29.6 percent) as a conservative approach to estimating local government health care spending attributable to substance abuse and addiction.

Criminal Justice. In CASA's report, *Behind Bars: Substance Abuse and America's Prison Population*, we documented the enormous impact substance abuse and addiction have on corrections spending.[9] In that report, CASA found that 80 percent of federal inmates, 81 percent of state inmates, and 77 percent of local inmates were substance involved.

For purposes of this study, CASA defined 'substance involved' as those who: ever used illegal drugs regularly; convicted of a drug law violation; convicted of an alcohol violation; under the influence of alcohol and/or other drugs at the time of the crime that led to incarceration; committed the offense to get money to buy drugs; or had a history of alcohol abuse.

To arrive at total costs for adult corrections associated with substance abuse and addiction, CASA totaled expenditures for corrections in the following areas:

- Costs of running and maintaining adult correctional facilities, associated administrative and staffing costs,
- Costs of special programs such as mental health, education, vocational or religious services provided to adult inmates,
- Parole and early release programs,
- Adult probation,
- Capital spending on prisons or jails,
- For states, the categorical aid to localities for adult corrections, and
- For the federal government, the categorical aid to states and localities for adult corrections.

CASA adjusted the federal, state and local associated shares for the national prevalence rates of 2005 to obtain national adult corrections shares of 82.2, 81.0 and 85.3 percent respectively. These national shares were further adjusted by state specific alcohol and illicit drug use prevalence data. Any prevention and treatment programs were reported under prevention and treatment. We assumed that the same percentage of adult probationers and parolees were substance involved as were incarcerated individuals.

Juvenile Justice. In the absence of national estimates of substance involvement in the juvenile justice system, for purposes of its 2001 report CASA conducted an analysis of Arrestee Drug Abuse Monitoring Program (ADAM) data from the National Institute of Justice, 1997. Variables were chosen to mirror those in CASA's adult corrections report, *Behind Bars*. The categories of involvement were: tested positive for drugs; reported using alcohol in the past 72 hours; were under the influence of or in need of alcohol/drugs; received treatment in the past; currently receiving treatment for, or thinks they could use treatment for alcohol or illicit drug abuse.[*]

For this report, CASA updated the percent of juvenile offenders who were substance involved based on CASA's 2004 study *Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind*.[10] This report found that 78.4 percent of juvenile offenders were substance involved, meaning they were under the influence of alcohol or other drugs while committing their crime, tested positive for drugs, were arrested for committing an alcohol or drug offense, admitted having substance abuse and addiction problems, or shared some combination of these characteristics. CASA updated this estimate by applying 2005 prevalence rates to yield an associated fraction of 79.5 percent of juvenile offenders who are substance involved.

[*] Juveniles in the sample were all males. The sample size of females was too small to allow estimation of rates for females, but the associated percent of substance-involved juveniles was assumed to apply to females as well as males.

To arrive at total state costs for juvenile justice associated with substance abuse, CASA totaled state expenditures in the following areas:

- Juvenile corrections facilities including residential centers, boot camps and work/study camps,
- Diversion programs, and
- Capital costs of juvenile corrections facilities.

CASA applied the 79.5 percent share, adjusted by jurisdiction specific alcohol and illicit drug use prevalence data, to these juvenile justice costs. Any reported prevention and treatment costs were reported under prevention and treatment.

Judiciary. The judiciary system is carved into several branches--criminal, family, civil or drug courts (which may be further differentiated into family drug court or juvenile drug court). CASA did not identify any studies that documented the full impact of substance abuse on our courts, although several studies have identified the prevalence and characteristics of drug law offenders (drug possession and trafficking) in both juvenile and adult courts.[11] To develop a more comprehensive picture of the impact of substance abuse on the courts, CASA employed the following methodology:

- **Criminal Courts.** *For* CASA's first Shoveling Up report, we analyzed the substance involvement of arrestees, using the Arrestee Drug Abuse Monitoring Program (ADAM) 1997, to estimate the proportion of substance abusers entering the judiciary system. We used the following definitions of substance involved: tested positive for drugs; reported using alcohol in the past 72 hours; were under the influence of or in need of alcohol/drugs; received treatment in the past, are currently receiving treatment, or think they could use treatment for alcohol or various illicit drugs. Using this approach, 83.8 percent of 1997 criminal court costs were substance linked. Adjusting this percentage to reflect 2005 prevalence rates, 86.3 percent of criminal court costs were substance linked.
- **Family Courts.** Previous CASA research has shown that 70 percent of child welfare cases are substance involved;[12] that is, the case is either caused or exacerbated by substance abuse and addiction. In some states, juvenile justice cases may be represented in this category as well. Seventy percent of these costs were assumed to be linked to substance abuse. Adjusting this percentage to reflect 2005 prevalence rates, 74.1 percent of family court costs were substance involved.
- **Civil Courts.** No substance abuse share was developed for civil courts due to the lack of ability to link costs of tort, property rights, estate or small claims cases to substance abuse and addiction. Therefore civil court costs were not included in this analysis.
- **Drug Courts.** Any spending specifically on drug courts, including family dependency drug courts, was given a 100 percent substance abuse share.

To estimate substance abuse costs linked to courts, state and local governments were asked to identify all program costs for criminal, family, juvenile and drug courts including court personnel, contracted services, supplies and the cost of program administrators and/or policy analysts who spend the majority of time on the program.

For CASA's 2001 report, the substance abuse and addiction shares, adjusted by jurisdiction-specific heavy binge drinking and illicit drug use prevalence data, were applied to the total spending by court type. Substance-linked spending by court type was summed to produce a total for courts.

Due to a lack of consistency in how states reported spending on judicial programs, for purposes of this report we have replaced all state data on judicial spending with estimates derived

from data from the Bureau of Justice Statistics (BJS) and the National Center for State Courts (NCSC) Court Statistics Project. These alternate data sources uniformly reported across all states and identified caseloads and expenditures in civil, criminal and domestic (family) judicial categories. CASA used data from the BJS and NCSC to report judicial expenditures in the areas of criminal and family (including juvenile and domestic) courts. State survey data provided additional information on dedicated drug court* expenditures and aid to local courts.

Based on a report by the federal Office of the Inspector General (OIG), CASA determined that 21 percent of the Federal Bureau of Investigation's non-terrorist budget was drug enforcement.[13]

Education. In this area of the budget it is difficult to establish substance abuse shares for government spending for three major reasons. First, state and federal governments allocate most education funds in broad lump sums to local school districts. Second, there is a reluctance to label children; therefore, it is very difficult for researchers to determine which children were exposed to substances in *utero* or in the home and which children are using substances. Finally, there is very little literature or research that has been done linking costs in the education system to substance abuse.

Using the *International Guidelines for Estimating the Costs of Substance Misuse* as a benchmark, there is neither a matrix of costs nor has there been any delineation of the theoretical issues that help lead to agreement on how to measure those costs in the case of public education.[14] Nonetheless, there is a broad consensus that the costs are potentially significant.†

Substance abuse affects schools in several ways. Parental use can affect the capacity and readiness of children to learn. Faculty and staff use can affect the learning environment. Student use can affect their interest and capacity to learn and school security.

All of these factors might affect the costs of education. For example, maternal alcohol use during pregnancy could result in increased special education costs for students with Fetal Alcohol Syndrome (FAS). Parental substance abuse might result in programs for at-risk youth, staff-intensive compensatory education programs, after-school programs, summer school and other programs. Student use might necessitate increased support and health care staff or may result in class disruption. Violence associated with student use might require increased school costs for security personnel and equipment, insurance and workers compensation, and repairs and replacement of vandalized or stolen materials. Faculty use might involve increased workforce costs and lost productivity.

Few of these costs are reported to governments in ways that can be linked to budgets but in the aggregate represent considerable expenditures. To take the first steps toward developing an estimate of the costs of substance abuse to the education system, CASA identified cost areas that can be linked to substance abuse. These include:

- Lost productivity of staff and added costs for additional staffing,
- Special programs for children at risk,
- Special education programs for those with substance-related retardation or learning disabilities,
- Student assistance programs,
- Alcohol- and drug-related truancy,
- Administration costs linked to coping with alcohol and other drug problems,

* Programs focusing only on drug courts.

† Conclusion of a focus group conducted by CASA July 19, 1999, in Washington DC of experts in the field of education, school finance and substance abuse cost estimation.

- Property damage and liability insurance costs driven by alcohol and other drugs,
- Higher health insurance costs for substance-involved staff,
- Legal expenses linked to alcohol and other drugs,
- Drug testing costs,
- Employee assistance programs for substance abusers,
- Employee training, policy and staff development to increase awareness of and cope with substance abuse, and
- Capital outlays for special facilities needed for substance using students.

CASA estimates that the aggregate of these costs could total between 10 and 22 percent of annual expenditures for elementary and secondary education.

To review this approach and associated estimates of costs, CASA convened a group of experts in the area of school finance and substance abuse for the first Shoveling Up report. This group also was troubled by an inability to find data to make more precise estimates, but after reviewing and refining this list of effects informally posited a range of 10 to 20 percent for the estimated impact of substance abuse on the public education system. For the purposes of the first report, we chose the lower end of the range, 10 percent, as a conservative estimate of a substance abuse share for education spending. Adjusting this percentage to reflect 2005 prevalence rates, 11.4 percent of education costs were substance linked.

CASA has included this estimate for three reasons. First, state and local budgets are heavily dominated by education spending and failing to recognize costs in this area would be a major oversight. Second, according to experts in the field and qualitative literature, substance abuse has a significant impact on schools and on the achievement of their goals. Finally, schools represent an important opportunity to intervene since problems of substance abuse that start in elementary and secondary school will show up later in other government systems like corrections, child welfare, mental health or welfare. By including this budget estimate, CASA hopes to promote research into the question of the impact of substance abuse on schools and education spending.

Due to the lack of any available data, CASA was unable to estimate the costs of substance abuse and addiction to higher education, resulting in significant underreporting of the impact of this problem on education costs nationally.

Child and Family Assistance Programs. The link between substance abuse and addiction and child neglect and abuse has been well documented; CASA's report *No Safe Haven: Children of Substance Abusing Parents* (1999), found that an estimated 70 percent of child welfare cases are caused or exacerbated by substance abuse and addiction.[15] CASA used this fraction to calculate substance-related child welfare spending for its 2001 report. Adjusting this percentage to reflect 2005 prevalence rates, 73.1 percent of child welfare costs were substance related.

To determine child welfare spending, CASA identified federal programs and related spending, and asked state and local governments to identify all program costs including grants to individuals and families, the cost of caseworkers or service providers and other program costs. They were asked to include costs for adoption assistance; foster care; independent living; family preservation and other programs to prevent out of home placements, promote reunification of families, or provide a safe environment for children; child abuse and neglect intake and assessment; and administrative/staffing costs to run these programs.

The 73.1 percent substance-related share, adjusted by jurisdiction specific alcohol and illicit drug use prevalence data, was applied to total child welfare spending, after any child

welfare programs specifically aimed at substance abuse and addiction were removed.

Income Support Programs. Substance abuse and addiction may be the primary reason people need income assistance or it may impede a person's ability to become self-supporting. The income support programs included in this study are Temporary Assistance to Needy Families (TANF), General Assistance and state supplements to the Supplemental Security Income Program (SSI).

- **Temporary Assistance to Needy Families (TANF) and General Assistance (GA):** The majority of national and state prevalence studies have estimated that between seven and 37 percent of welfare recipients have a substance-related problem.[16] Two previous studies by CASA have estimated the prevalence of women on TANF with substance use disorders to be between 20 and 28 percent.[17] In our original report we used a more conservative 20 percent estimate as the substance-related share for TANF recipients. Very little data are available on the percentage of the GA population that is substance involved. In the absence of national data, CASA has used the substance-linked share for the TANF program, recognizing that it is probably a very conservative estimate. Adjusting this percentage to reflect 2005 prevalence rates, 23.4 percent of TANF and GA expenditures were substance linked.

- **Supplemental Security Income (SSI):** Federal legislation passed in 1996 ended payments to individuals who were receiving SSI because of alcoholism or other drug addiction. When benefits were terminated as of January 1, 1997, 2.6 percent of all beneficiaries were removed from the rolls. About a third (34 percent) of these people retained or re-established eligibility as of December, 1997 on the basis of a condition other than substance abuse or addiction.[18] Therefore, approximately one percent of people receiving SSI was originally certified by virtue of alcohol or other drug addiction. Other research has documented that six percent of SSI beneficiaries report heavy alcohol use and eight percent report illicit drug use.[19] In order to maintain a conservative estimate, we used one percent as the associated share for SSI in our original report and, updating this to reflect 2005 prevalence rates, 1.2 percent is the associated share for 2005.

- **Housing and Homeless Assistance:** CASA's literature review found that 66 percent of homelessness is attributable to alcohol and/or other drug abuse.[20] This fraction was applied to the housing and homeless-related costs reported by local government and identified in the federal budget.[21]

- **Employment Assistance/Food and Nutritional Assistance/Unspecified:** For these additional federal level programs, CASA used the income assistance fraction (TANF and GA) of 23.5 percent due to the similarity of target populations and eligibility criteria.

To estimate substance-linked costs for these programs, states and local governments were asked to identify costs for cash assistance, emergency assistance, employment and training services for the TANF or GA populations, income maintenance to the aged, blind, and disabled and administrative costs to run these programs. CASA identified the costs of these programs to federal government, including housing, employment assistance and nutritional assistance. Substance-linked shares, adjusted for differences in heavy binge drinking and illicit drug use prevalence, were applied to total costs in each area to develop aggregate spending for income support programs.

Mental Health. Data from a nationally representative sample of the civilian, non-institutionalized U.S. population indicate that 51 percent of those with a lifetime mental disorder also have a lifetime addictive disorder--alcohol or other drug abuse or dependence.[22] This may be a conservative estimate of the occurrence of a comorbid addictive disorder in the population that receives mental health treatment through the

state since the institutionalized population was not surveyed and people with more severe mental health problems often receive residential care.

Mental health costs included in this study are those for administration, community contracts, housing programs, institutionalization and capital costs for building and maintaining facilities. In CASA's 2001 report, a substance-linked share of 50.9 percent was applied to the total of these costs. Adjusting this percentage to reflect 2005 prevalence rates including jurisdictional difference, 55.9 percent of mental health care costs at the federal, state and local levels were substance linked.

Developmental Disabilities. To estimate the share of federal, state and local costs for the developmentally disabled caused or exacerbated by tobacco, alcohol or other drugs, CASA used data from *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992*.[23] The reported estimate of the population with FAS receiving care in 1992* (38,884) was approximately nine percent of the total developmentally disabled population of 434,657 served in 1992 in institutional and residential care across the United States.[24] While CASA believed that the nine percent share is conservative since it is based solely on FAS, we used it to calculate the substance abuse share of state spending for the developmentally disabled in our original report. Adjusting this percentage to reflect 2005 prevalence rates, 10.2 percent of these costs were substance-linked.

This share, adjusted for jurisdictional differences in prevalence of heavy binge drinking, was applied to total government expenditures for developmental disabilities--administration, community contracts, housing programs, institutionalization and capital cost to build and maintain facilities--to develop government totals of associated costs.

* Includes mild/moderately retarded FAS populations from ages 22 to 65 in the developmentally disabled systems, and severely retarded people with FAS in those systems from ages 5 to 65.

Public Safety. Very limited data are available for estimating costs of public safety programs. CASA asked state and local governments to report costs for special drug enforcement programs, highway safety and accident prevention programs, state highway patrol and local law enforcement programs. We combed through Congressional budgets to identify federal expenditures for similar programs. Local case study jurisdictions also were asked to report the costs of fire safety, Emergency Medical Services, police and medical examiners.

The main area where some data are available is for highway safety; that is, the proportion of car accidents that are alcohol involved. There is no database, currently, that collects the number of drug-related accidents. Using data collected by the National Highway Traffic Safety Administration,[25] CASA calculated an estimate of the proportion of reported accidents that are alcohol involved:

- Calculate the number of alcohol-positive crashes for each type of accident (property damage, injury, fatality). Alcohol-involved crashes account for 16.7 percent of property damage only accidents, 20.4 percent of accidents that involve injuries and 40.8 percent of accidents involving fatalities.

- Calculate the percent of total alcohol-involved accidents for each accident type. Alcohol-involved property damage represents 78 percent of all alcohol-involved traffic accidents; injuries represent 21 percent and fatalities represent .003 percent.

- Calculate an average for the total of alcohol-involved accidents.

Using this approach, CASA estimated in the original report that 17.6 percent of highway traffic accidents were alcohol involved. Adjusting this percentage to reflect 2005 prevalence rates, 19.7 percent of public safety costs were substance linked. One hundred percent of dedicated international and domestic drug control spending was included in this category.

In the absence of more specific estimates, we also applied the 10.7 percent fraction to fire safety, Emergency Medical Services, police, medical examiners, accident prevention programs, state highway patrol and local law enforcement programs that are not specifically targeted to alcohol or other drugs. Anecdotal evidence suggests, however, that this is a very conservative estimate of such costs. Costs were adjusted by differences in prevalence of alcohol use by jurisdiction. The total cost of programs specifically targeted to alcohol or other drug abuse or addiction was included.

Government Workforce. Several studies have focused on documenting and quantifying the adverse effects of alcohol, tobacco and illicit drug use on the workforce.[26] Some have been studies of just one organization, others of entire industries, and others of particular regions; therefore, comparison of the results has been difficult. A further complicating factor is the variation in definitions of the quantity and frequency of substance use.

Alcohol and other drug abuse have been associated with employee absenteeism, lower productivity, increased turnover, workplace accidents and higher health insurance costs. Because of severe data limitations, CASA has focused only on absenteeism for this study; that is, the extra days those who abuse substances are absent compared to nonusers.

In the original report, CASA adopted the methodology employed in its investigation of substance abuse and addiction and American business to calculate substance-related absenteeism costs.[27] While this methodology focuses on individuals who have a job and work for pay in the private sector (excluding farming, fishing and forestry), it provided a more detailed analysis that would otherwise be available.

For purposes of CASA's 2001 report, we conducted a logistical regression using *National Household Survey of Drug Abuse* (NHSDA) 1994 data and two panels of the *National Longitudinal Survey of Youth* (NLSY), (1984-88 and 1992-94). The NLSY allowed us to control for a large number of relevant demographic and socioeconomic variables and to capture absenteeism. CASA employed this methodology to pinpoint a probable causal relationship between employee substance abuse and absenteeism. From this analysis, CASA identified prevalence rates and extra days absent due to substance abuse and addiction among men and women by substance type.*

Next, we multiplied the prevalence of substance abuse and addiction (by gender and substance abuse type) to the government workforce (broken down by gender) to get the estimated number of substance involved individuals in the workforce by gender and type of substance. These subtotals were multiplied by gender and substance specific extra days of absences per person, per year to get the total number of days lost per year. That total was divided by the expected number of days of work per year (workforce x 230) to arrive at a substance-related share of 0.3 percent. CASA counted 100 percent of the substance-related employee assistance program costs.

In the workforce section of the state and local surveys, CASA requested payroll figures for government employees, total spending on fringe benefits and the substance-related share of employee assistance programs. CASA collected federal workforce data from agency budget documents. The substance-related share, adjusted by jurisdiction specific heavy binge drinking and illicit drug use prevalence data, was applied to the payroll and fringe benefits. Adjusting this percentage to reflect 2005 prevalence rates, the substance-related share increased slightly to 0.37 percent. That total was added to 100 percent of the substance-related share of employee assistance programs to

* Smoker: An employee who smokes 16+ cigarettes per day in the past month. Heavy Drinker: A male employee drinking 5+ drinks five or more times in the past month. A female employee drinking 3+ drinks five or more times in the past month. Current Drug User: An employee who uses marijuana and/or cocaine at all in the past month. Absent: An indicator for worker absence at any time during the survey month (NHSDA) or week (NLSY).

get total substance spending in the workforce sector linked to substance abuse and addiction.

Capital Costs. CASA included in its analyses state and local funds expended for new construction, capital improvements and equipment for adult and juvenile corrections facilities and treatment, mental health and developmentally disabled facilities. We included funds paid for out of current general taxes or dedicated taxes, capital spending from bond proceeds and interest paid out for bonds already issued. We used the adjusted substance-related share from the respective category to estimate the portion of capital spending linked to substance abuse and addiction. Substance-related capital spending was added to other costs in each respective category. In the federal analysis, CASA assumed any capital expenditures already were included in the budget authority.

Special Populations. For programs geared to specific populations (special needs, SSI recipients, homeless youth) across the budget categories (education, housing, homeless assistance, food, etc.), CASA used population specific fractions. For example, an educational program for homeless youth burden expenditure was calculated using the homeless youth fraction (66 percent) not the education fraction. Special populations included:

- Native American Populations: The national prevalence rates of heavy binge drinking and illicit drug use among Native Americans are approximately one and half times that of the nation as whole.[28] Because the difference is so pronounced and because federal monies to Tribal and Indian programs can be identified separately, CASA created associated fractions specific to the Native American Population. For programs related to alcohol and other drugs, the weighting was 1.599; for alcohol only, the weighting was 1.554. Native Americans were, in effect, treated as a state and each national fraction was adjusted to reflect this population's prevalence rates.

- Veterans: CASA's literature review revealed that there were areas unique to veterans that required specific substance-related fractions. In health care, one-half of all veterans' Hepatitis C cases are attributable to drug use and one-third (33.4 percent) of HIV positive cases are attributable to drug use.[29] Seventy percent of veteran's homelessness is attributable to alcohol and/or other drug abuse.[30] These substance-related fractions were used in our analysis of the veteran population.

- Homeless Population: CASA's literature review found that approximately 66 percent of homelessness can be attributed to alcohol and/or other drug abuse and addiction.[31] In addition to the category of homeless programs under Income Assistance, this fraction was applied to education programs for homeless youth.

Calculation of National Estimates

To derive a national estimate of state spending on substance abuse and addiction, CASA calculated average *per capita* spending in each program area for the total of the 47 responding jurisdictions. We multiplied these averages by the population of the non-responding states to estimate their overall spending in the affected budget areas. Estimated spending for both responding and non-responding jurisdictions was summed to estimate spending levels for the nation as a whole.

In calculating the costs of substance abuse and addiction for the five non-participating states, we used secondary sources in those areas where secondary sources were used for all participating states.

To derive a national estimate of local spending on substance abuse, CASA examined the U.S. Census data on state and local government. While these data were not as detailed as those available on the federal and state level, they did provide information on local spending in the areas of education, health, corrections, public safety, social services and local government workforce.

Comparison Between 1998 and 2005

In light of the methodological refinements from CASA's 2001 report and in order to provide a basis of comparison with 1998 state data, CASA recalculated state spending for 1998 based on these refinements. All comparisons of state spending between 1998 and 2005 included in this report are based on the refined methodology.

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Appendix C
Substance Abuse Spending by Federal Budget Category*

	Federal Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of Federal Budget	Per Capita
Burden Spending		***$229,887,452.8***		***9.3***	***$757.89***
Health	**527,452.831.0**	**170,269,388.1**		**6.9**	**561.34**
Other Health Spending	42,566,831.0	12,488,998.6	29.3		
Medicaid/Medicare	484,886,000.0	157,780,389.5	32.5		
Federal Workforce	**242,554,943.7**	**890,828.5**	**0.4**	**0.0**	**2.94**
Child/Family Assistance	**235,367,597.0**	**36,692,524.7**		**1.5**	**120.97**
Child Welfare	9,680,600.0	7,171,673.8	74.1		
Income Assistance	144,685,436.0	5,608,146.0	3.9		
Employment Assistance	5,844,000.0	1,350,463.1	23.1		
Housing/Homeless Assistance	10,568,478.0	3,763,078.7	35.6		
Food/Nutritional Assistance	38,345,000.0	8,990,289.2	23.5		
Unspecified Child/Family Assistance	26,244,083.0	9,808,874.0	37.4		
Education (Elementary/Secondary)	**44,300,000.0**	**5,391,451.3**	**12.2**	**0.2**	**17.77**
Mental Health/Developmental Disabilities	**18,686,006.0**	**3,601,494.4**		**0.2**	**11.87**
Mental Health	3,636,061.0	2,062,162.1	56.7		
Developmental Disabilities	15,049,945.0	1,539,332.3	10.2		
Public Safety	**10,699,606.0**	**7,489,892.6**		**0.3**	**24.69**
Dedicated Substance Use Enforcement	6,619,089.0	6,619,089.0	100.0		
FBI	3,156,218.0	672,047.4	21.3		
Public Safety	645,427.0	127,341.6	19.7		
Aid to Localities	278,872.0	71,414.7	25.6		
Justice	**6,739,413.0**	**5,551,873.1**		**0.2**	**18.30**
Adult Corrections	4,876,114.0	3,950,832.7	81.0		
Juvenile Justice	244,086.0	194,141.1	79.5		
Dedicated Drug Courts	39,466.0	39,466.0	100.0		
Criminal Courts	1,197,437.0	1,034,232.1	86.4		
Aid to Local Courts	382,310.0	333,201.2	87.2		
Interdiction	***2,638,242.0***	***2,638,242.0***	***100.0***	***0.1***	***8.70***
Regulation/Compliance	***82,336.0***	***82,336.0***	***100.00***	***0.0***	***0.27***
Licensing and Control	37,051.0	37,051.0			
Collection of Taxes	45,285.0	45,285.0			
Prevention, Treatment and Research	***5,542,791.0***	***5,542,791.0***	***100.0***	***0.2***	***18.27***
Prevention	1,557,646.2	1,557,646.2			
Treatment	2,428,423.8	2,428,423.8			
Research	1,556,721.0	1,556,721.0			
Total		***$238,150,821.8***		***9.6***	***$785.13***

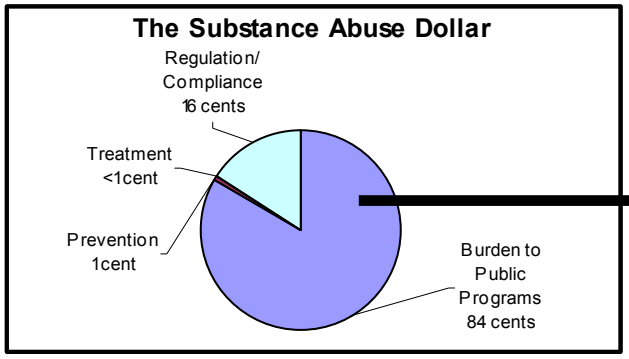
* Numbers may not add due to rounding.

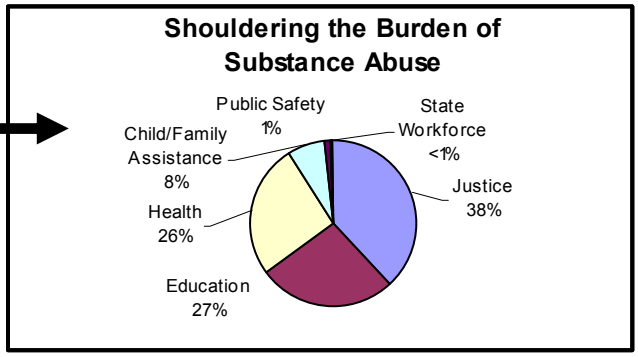
Appendix D
Substance Abuse Spending, State Tables

Alabama

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,142,119.0***		***10.8***	***$248.34***
Justice	**564,639.2**	**435,351.7**		**4.1**	**94.66**
Adult Corrections	318,859.7	245,539.2	77.0		
Juvenile Justice	72,901.3	54,907.7	75.3		
Judiciary	172,878.2	134,904.8	78.0		
Education (Elementary/Secondary)	**3,148,377.7**	**303,800.6**	**9.6**	**2.9**	**66.06**
Health	**1,167,571.0**	**300,434.3**	**25.7**	**2.8**	**65.33**
Child/Family Assistance	**140,954.9**	**86,367.8**		**0.8**	**18.78**
Child Welfare	118,729.8	82,116.4	69.2		
Income Assistance	22,225.1	4,251.4	19.1		
Mental Health/Developmental Disabilities	**NA**	**NA**		**NA**	**NA**
Mental Health	**NA**	**NA**	**NA**		
Developmental Disabilities	**NA**	**NA**	**NA**		
Public Safety	**38,044.1**	**11,731.5**	**30.8**	**0.1**	**2.55**
State Workforce	**1,537,175.8**	**4,433.1**	**0.3**	**0.0**	**0.96**
Regulation/Compliance	***215,752.7***	***215,752.7***	***100.0***	***2.0***	***46.91***
Licensing and Control	32,477.7	32,477.7			
Collection of Taxes	**NA**	**NA**			
Liquor Store Expenses	183,275.0	183,275.0			
Prevention, Treatment and Research	***8,185.2***	***8,185.2***	***100.0***	***0.1***	***1.78***
Prevention	618.0	618.0			
Treatment	5,533.7	5,533.7			
Research	80.1	80.1			
Unspecified	1,953.4	1,953.4			
Total		***$1,366,056.9***		***12.9***	***$297.03***





Total State Budget	$10,618 M
• Elementary and Secondary Education	$3,148 M
• Substance Abuse and Addiction	$1,366 M
• Medicaid	$1,191 M
• Higher Education	$2,304 M
• Transportation	$534 M
Population	4.6 M

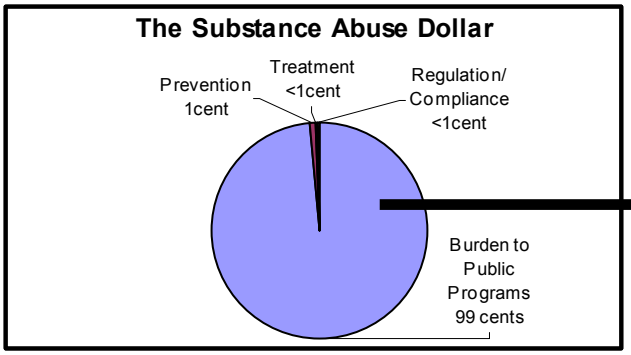
Tobacco and alcohol tax revenue total $271,174,000; $58.96 per capita.
Liquor store revenue total $177,534,000; $38.60 per capita.

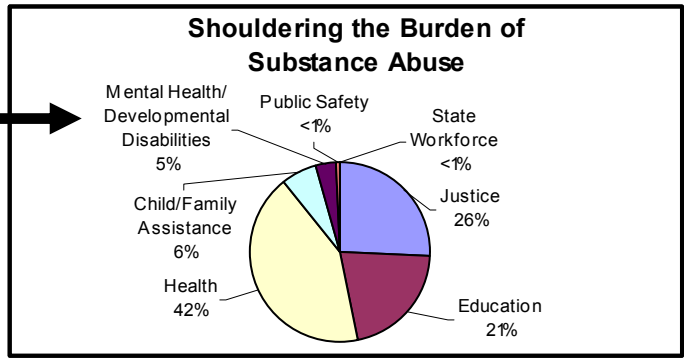
* Numbers may not add due to rounding.

Alaska

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$831,958.7***		***15.6***	***$1,241.63***
Justice	**243,741.4**	**212,372.9**		**4.0**	**316.95**
Adult Corrections	107,754.1	93,893.9	87.1		
Juvenile Justice	37,908.4	32,623.4	86.1		
Judiciary	98,078.9	85,855.5	87.5		
Education (Elementary/Secondary)	**977,070.8**	**173,588.2**	**17.8**	**3.3**	**259.07**
Health	**1,036,009.0**	**351,180.7**	**33.9**	**6.6**	**524.11**
Child/Family Assistance	**130,530.6**	**51,026.5**		**1.0**	**76.15**
Child Welfare	47,942.9	39,284.2	81.9		
Income Assistance	82,587.7	11,742.4	14.2		
Mental Health/Developmental Disabilities	**66,275.0**	**39,740.4**		**0.7**	**59.31**
Mental Health	57,880.2	38,687.2	66.8		
Developmental Disabilities	8,394.8	1,053.2	12.5		
Public Safety	**5,127.4**	**3,561.4**	**69.5**	**0.1**	**5.32**
State Workforce	**84,014.6**	**488.7**	**0.6**	**0.0**	**0.73**
Regulation/Compliance	***1,605.7***	***1,605.7***	***100.0***	***0.0***	**2.40**
Licensing and Control	778.4	778.4			
Collection of Taxes	827.3	827.3			
Prevention, Treatment and Research	***7,633.1***	***7,633.1***	***100.0***	***0.1***	***11.39***
Prevention	1,695.1	1,695.1			
Treatment	5,169.4	5,169.4			
Research	199.2	199.2			
Unspecified	569.3	569.3			
Total		***$839,617.8***		***15.7***	***$1,253.06***





Total State Budget	$5,334 M
• Elementary and Secondary Education	$977 M
• Substance Abuse and Addiction	$840 M
• Medicaid	$339 M
• Higher Education	$521 M
• Transportation	$411 M
Population	.67 M

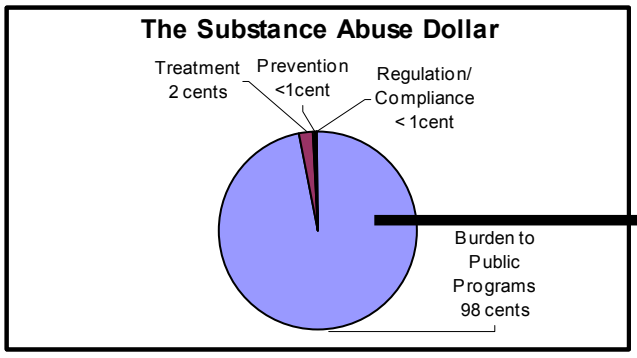
Tobacco and alcohol tax revenue total $90,800,000; $135.51 per capita.

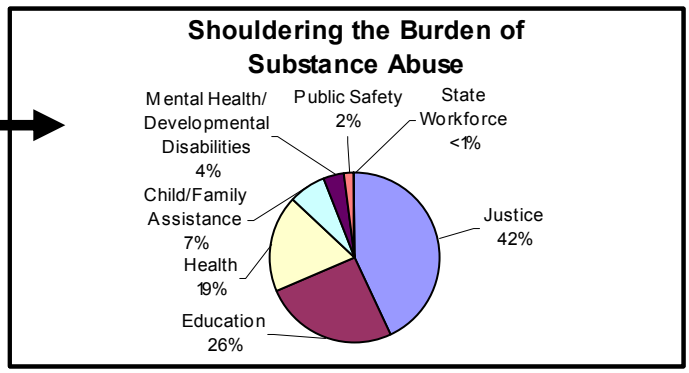
* Numbers may not add due to rounding.

Arizona

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,623,446.6***		***11.2***	***$263.28***
Justice	**859,173.3**	**687,734.1**		**4.7**	**111.53**
Adult Corrections	674,915.6	542,684.1	80.4		
Juvenile Justice	74,990.6	59,168.7	78.9		
Judiciary	109,267.1	85,881.3	78.6		
Education (Elementary/Secondary)	**3,608,139.6**	**417,592.7**	**11.6**	**2.9**	**67.72**
Health	**928,970.0**	**305,737.7**	**32.9**	**2.1**	**49.58**
Child/Family Assistance	**215,551.6**	**117,405.9**		**0.8**	**19.04**
Child Welfare	135,187.0	99,123.4	73.3		
Income Assistance	80,364.6	18,282.5	22.7		
Mental Health/Developmental Disabilities	**161,480.0**	**61,910.4**		**0.4**	**10.04**
Mental Health	97,334.8	53,512.9	55.0		
Developmental Disabilities	64,145.2	8,397.5	13.1		
Public Safety	**105,462.5**	**32,372.7**	**30.7**	**0.2**	**5.25**
State Workforce	**196,220.7**	**693.0**	**0.4**	**0.0**	**0.11**
Regulation/Compliance	***4,403.6***	***4,403.6***	***100.0***	**0.0**	***0.71***
Licensing and Control	3,565.7	3,565.7			
Collection of Taxes	837.9	837.9			
Prevention, Treatment and Research	***29,266.5***	***29,266.5***	***100.0***	***0.2***	***4.75***
Prevention	4,777.1	4,777.1			
Treatment	17,441.4	17,441.4			
Research	227.0	227.0			
Unspecified	6,821.1	6,821.1			
Total		***$1,657,116.8***		***11.4***	***$268.74***





Total State Budget	$14,502 M
• Elementary and Secondary Education	$3,608 M
• Substance Abuse and Addiction	$1,657 M
• Medicaid	$1,301 M
• Higher Education	$2,426 M
• Transportation	$1,107 M
Population	6.2 M

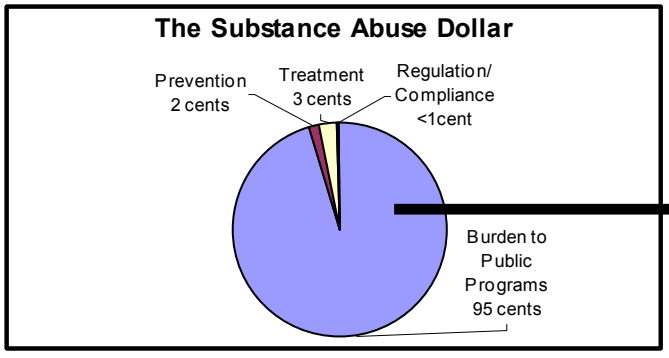
Tobacco and alcohol tax revenue total $349,725,000; $56.72 per capita.

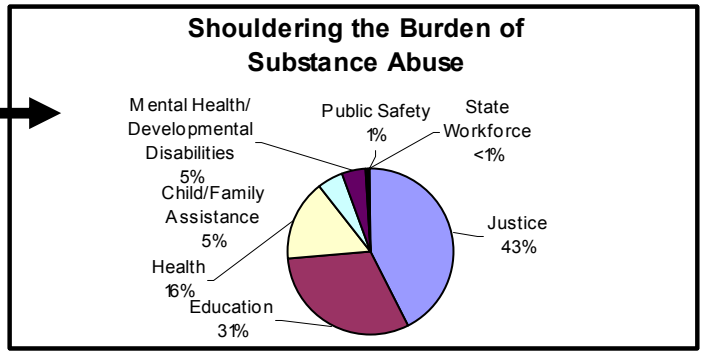
* Numbers may not add due to rounding.

Arkansas

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$845,655.6***		***8.5***	***$300.85***
Justice	**447,941.6**	**359,717.5**		**3.6**	**127.97**
Adult Corrections	296,924.1	237,674.3	80.0		
Juvenile Justice	45,747.8	35,920.7	78.5		
Judiciary	105,269.7	86,122.5	81.8		
Education (Elementary/Secondary)	**2,327,569.2**	**263,992.9**	**11.3**	**2.6**	**93.92**
Health	**522,228.8**	**133,199.6**	**25.5**	**1.3**	**47.39**
Child/Family Assistance	**71,971.0**	**40,808.1**		**0.4**	**14.52**
Child Welfare	48,931.8	35,658.7	72.9		
Income Assistance	23,039.1	5,149.4	22.4		
Mental Health/Developmental Disabilities	**113,880.6**	**40,213.2**		**0.4**	**14.31**
Mental Health	67,391.2	36,669.1	54.4		
Developmental Disabilities	46,489.3	3,544.0	7.6		
Public Safety	**33,506.0**	**5,972.9**	**17.8**	**0.1**	**2.12**
State Workforce	**507,299.2**	**1,751.5**	**0.3**	**0.0**	**0.62**
Regulation/Compliance	***3,626.4***	***3,626.4***	***100.0***	***0.0***	***1.29***
Licensing and Control	3,126.4	3,126.4			
Collection of Taxes	500.0	500.0			
Prevention, Treatment and Research	***38,242.8***	***38,242.8***	***100.0***	***0.4***	***13.61***
Prevention	9,774.3	9,774.3			
Treatment	17,072.7	17,072.7			
Research	NA	NA			
Unspecified	11,395.7	11,395.7			
Total		***$887,524.8***		***8.9***	***$315.75***





Total State Budget	$9,982 M
• Elementary and Secondary Education	$2,328 M
• Substance Abuse and Addiction	$888 M
• Medicaid	$771 M
• Higher Education	$2,129 M
• Transportation	$586 M
Population	2.8 M

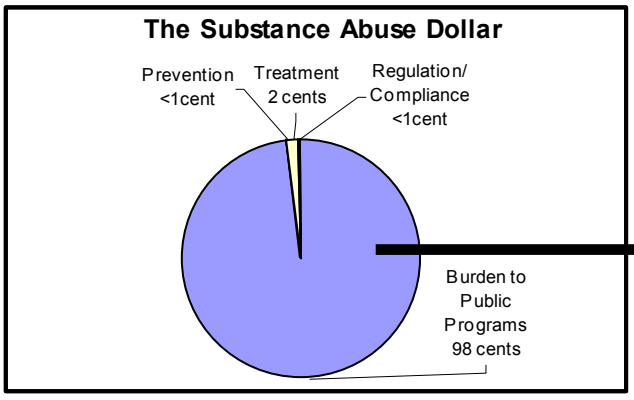
Tobacco and alcohol tax revenue total $191,239,000; $68.04 per capita.

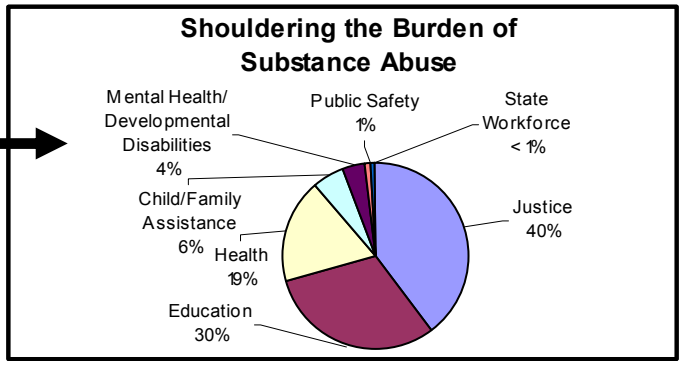
* Numbers may not add due to rounding.

California

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$19,473,068.4***		***19.1***	***$534.13***
Justice	**9,403,171.3**	**7,731,014.9**		**7.6**	**212.06**
Adult Corrections	6,882,586.7	5,621,051.0	81.7		
Juvenile Justice	376,745.0	302,291.2	80.2		
Judiciary	2,143,839.6	1,807,672.8	84.3		
Education (Elementary/Secondary)	**47,643,699.0**	**5,927,821.8**	**12.4**	**5.8**	**162.60**
Health	**14,058,757.0**	**3,664,594.2**	**26.1**	**3.6**	**100.52**
Child/Family Assistance	**6,155,731.3**	**1,071,688.2**		**1.1**	**29.40**
Child Welfare	724,547.3	542,687.5	74.9		
Income Assistance	5,431,184.0	529,000.8	9.7		
Mental Health/Developmental Disabilities	**1,337,373.0**	**753,814.7**		**0.7**	**20.68**
Mental Health	1,319,466.0	752,144.9	57.0		
Developmental Disabilities	17,907.0	1,669.8	9.3		
Public Safety	**1,321,429.0**	**240,152.8**	**18.2**	**0.2**	**6.59**
State Workforce	**21,907,383.0**	**83,981.7**	**0.4**	**0.1**	**2.30**
Regulation/Compliance	***60,211.0***	***60,211.0***	***100.0***	***0.1***	***1.65***
Licensing and Control	43,727.0	43,727.0			
Collection of Taxes	16,484.0	16,484.0			
Prevention, Treatment and Research	***339,303.3***	***339,303.3***	***100.0***	***0.3***	***9.31***
Prevention	38.0	38.0			
Treatment	244,611.0	244,611.0			
Research	600.0	600.0			
Unspecified	94,054.3	94,054.3			
Total		***$19,872,582.7***		***19.5***	***$545.09***





Total State Budget	$101,996 M
• Elementary and Secondary Education	$47,644 M
• Substance Abuse and Addiction	$19,873 M
• Medicaid	$16,331 M
• Higher Education	$9,829 M
• Transportation	$6,772 M
Population	36.5 M

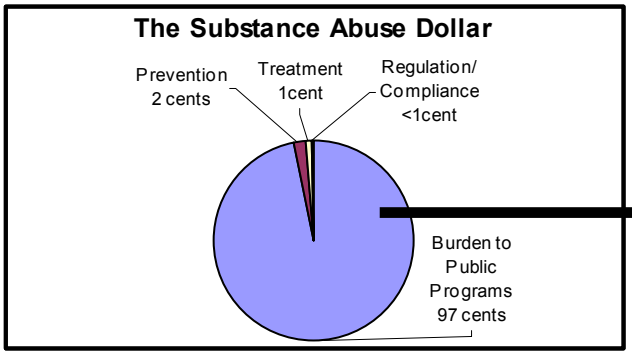
Tobacco and alcohol tax revenue total $1,410,476,000; $38.69 per capita.

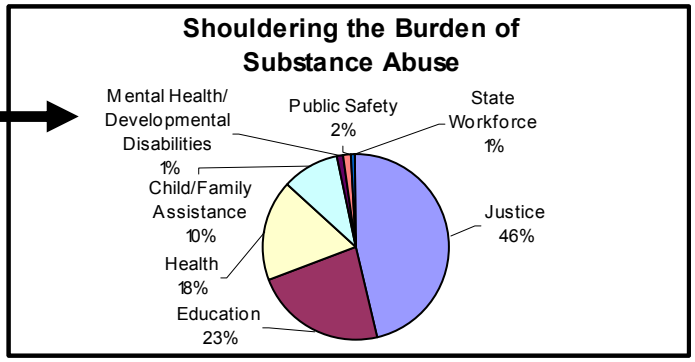
* Numbers may not add due to rounding.

Colorado

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,615,484.9***		***15.1***	***$339.86***
Justice	**886,351.6**	**745,476.6**		**6.9**	**156.83**
Adult Corrections	552,943.3	466,211.3	84.3		
Juvenile Justice	201,810.4	167,594.0	83.0		
Judiciary	131,597.8	111,671.3	84.9		
Education (Elementary/Secondary)	**2,504,364.3**	**366,489.4**	**14.6**	**3.4**	**77.10**
Health	**953,329.3**	**289,982.2**	**30.4**	**2.7**	**61.01**
Child/Family Assistance	**284,174.0**	**161,258.3**		**1.5**	**33.92**
Child Welfare	171,724.9	134,393.1	78.3		
Income Assistance	112,449.1	26,865.2	23.9		
Mental Health/Developmental Disabilities	**49,850.7**	**19,459.4**		**0.2**	**4.09**
Mental Health	27,597.5	16,980.6	61.5		
Developmental Disabilities	22,253.2	2,478.8	11.1		
Public Safety	**101,909.9**	**24,573.1**	**24.1**	**0.2**	**5.17**
State Workforce	**1,784,431.3**	**8,245.9**	**0.5**	**0.1**	**1.73**
Regulation/Compliance	***3,825.7***	***3,825.7***	***100.0***	***0.0***	***0.80***
Licensing and Control	3,619.7	3,619.7			
Collection of Taxes	206.0	206.0			
Prevention, Treatment and Research	***54,086.1***	***54,086.1***	***100.0***	***0.5***	***11.38***
Prevention	29,791.2	29,791.2			
Treatment	18,867.0	18,867.0			
Research	NA	NA			
Unspecified	5,427.9	5,427.9			
Total		***$1,673,396.6***		***15.6***	***$352.04***





Total State Budget	$10,727 M
• Elementary and Secondary Education	$2,504 M
• Substance Abuse and Addiction	$1,673 M
• Medicaid	$1,283 M
• Higher Education	$1,750 M
• Transportation	$607 M
Population	4.8 M

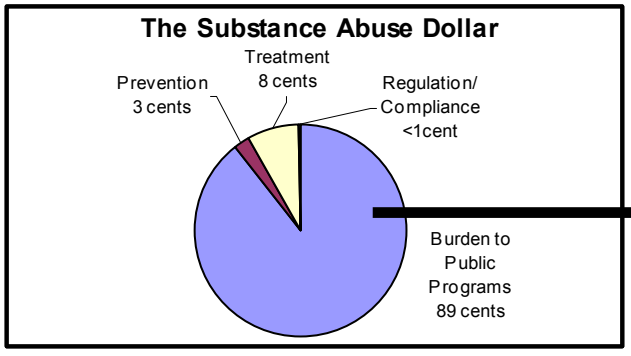
Tobacco and alcohol tax revenue total $161,699,000; $34.02 per capita

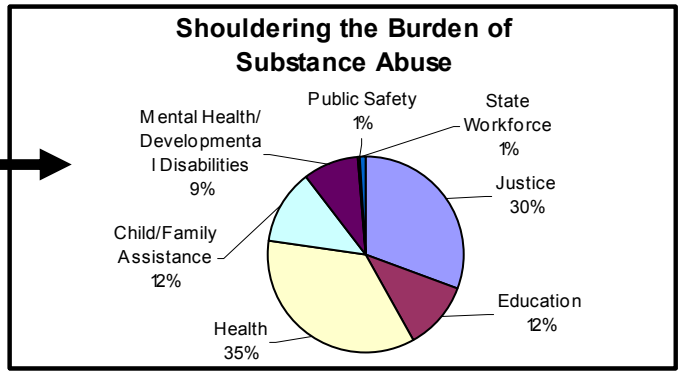
* Numbers may not add due to rounding.

Connecticut

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,610,358.3***		***14.9***	***$744.79***
Justice	**933,811.6**	**794,075.8**		**4.5**	**226.57**
Adult Corrections	580,410.6	487,102.4	83.9		
Juvenile Justice	31,355.1	25,908.6	82.6		
Judiciary	322,045.9	281,064.9	87.3		
Education (Elementary/Secondary)	**2,100,000.0**	**299,720.2**	**14.3**	**1.7**	**85.52**
Health	**3,262,232.5**	**919,667.0**	**28.2**	**5.3**	**262.40**
Child/Family Assistance	**556,451.9**	**320,563.9**		**1.8**	**91.46**
Child Welfare	334,451.9	260,066.4	77.8		
Income Assistance	222,000.0	60,497.5	27.3		
Mental Health/Developmental Disabilities	**398,858.2**	**241,245.5**		**1.4**	**68.83**
Mental Health	396,136.0	240,989.2	60.8		
Developmental Disabilities	2,722.2	256.3	9.4		
Public Safety	**64,523.0**	**13,948.4**	**21.6**	**0.1**	**3.98**
State Workforce	**4,709,343.0**	**21,137.4**	**0.4**	**0.1**	**6.03**
Regulation/Compliance	***10,223.7***	***10,223.7***	***100.0***	***0.1***	***2.92***
Licensing and Control	2,751.8	2,751.8			
Collection of Taxes	7,471.9	7,471.9			
Prevention, Treatment and Research	***303,695.3***	***303,695.3***	***100.0***	***1.7***	***86.65***
Prevention	67,071.5	67,071.5			
Treatment	208,978.0	208,978.0			
Research	NA	NA			
Unspecified	27,645.8	27,645.8			
Total		***$2,924,277.3***		***16.7***	***$834.36***





Total State Budget	$17,472 M
• Elementary and Secondary Education	$2,100 M
• Substance Abuse and Addiction	$2,924 M
• Medicaid	$3,716 M
• Higher Education	$1,940 M
• Transportation	$482 M
Population	3.5 M

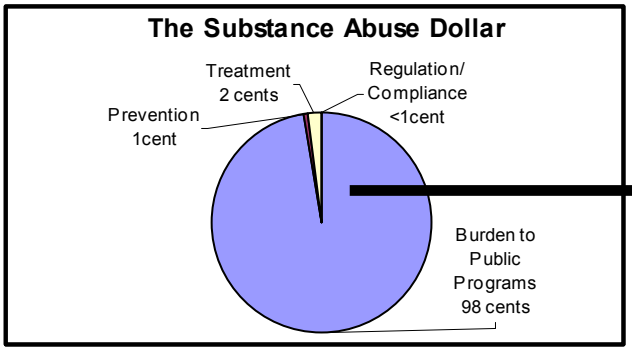
Tobacco and alcohol tax revenue total $317,628,000; $90.63 per capita.

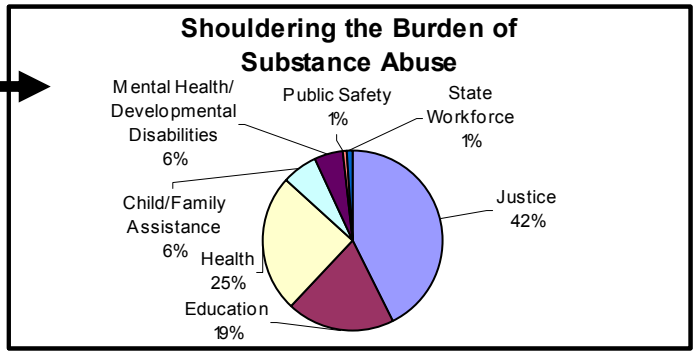
* Numbers may not add due to rounding.

Delaware

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$576,702.2***		***12.0***	***$675.71***
Justice	**293,341.0**	**242,465.9**		**5.1**	**284.09**
Adult Corrections	201,860.4	165,266.5	81.9		
Juvenile Justice	37,537.1	30,198.9	80.5		
Judiciary	53,943.5	47,000.5	87.1		
Education (Elementary/Secondary)	**886,973.7**	**111,667.4**	**12.6**	**2.3**	**130.84**
Health	**435,750.6**	**142,930.9**	**32.8**	**3.0**	**167.47**
Child/Family Assistance	**56,278.2**	**35,771.2**		**0.7**	**41.91**
Child Welfare	43,990.0	33,059.8	75.2		
Income Assistance	12,288.2	2,711.4	22.1		
Mental Health/Developmental Disabilities	**107,205.9**	**32,943.1**		**0.7**	**38.60**
Mental Health	43,522.0	24,952.9	57.3		
Developmental Disabilities	63,683.9	7,990.2	12.5		
Public Safety	**4,322.1**	**3,691.0**	**85.4**	**0.1**	**4.32**
State Workforce	**1,861,562.2**	**7,232.8**	**0.4**	**0.2**	**8.47**
Regulation/Compliance	***510.5***	***510.5***	***100.0***	***0.0***	***0.60***
Licensing and Control	455.8	455.8			
Collection of Taxes	54.7	54.7			
Prevention, Treatment and Research	***14,095.8***	***14,095.8***	***100.0***	***0.3***	***16.52***
Prevention	2,318.7	2,318.7			
Treatment	8,417.9	8,417.9			
Research	84.6	84.6			
Unspecified	3,274.6	3,274.6			
Total		***$591,308.6***		***12.3***	***$692.82***





Total State Budget	$4,794 M
• Elementary and Secondary Education	$887 M
• Substance Abuse and Addiction	$591 M
• Medicaid	$450 M
• Higher Education	$282 M
• Transportation	$596 M
Population	.85 M

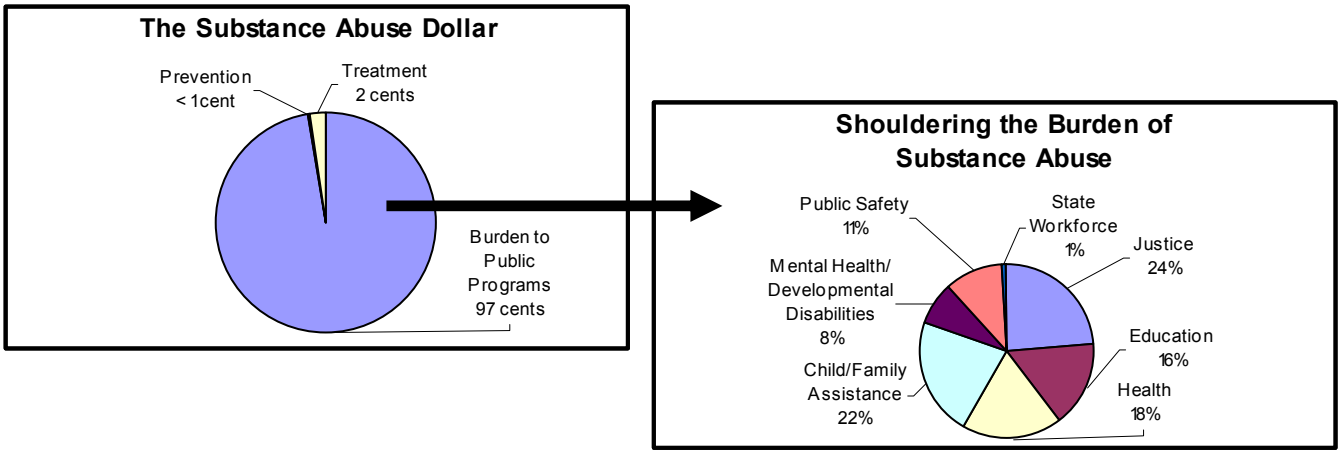
Tobacco and alcohol tax revenue total $94,210,000; $110.38 per capita.

* Numbers may not add due to rounding.

District of Columbia

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$765,274.7***		***18.3***	***$1,315.97***
Justice	**213,787.4**	**182,084.0**		**4.3**	**313.11**
Adult Corrections	129,533.9	110,464.6	85.3		
Juvenile Justice	60,796.8	51,113.5	84.1		
Judiciary	23,456.7	20,506.0	87.4		
Education (Elementary/Secondary)	**781,377.1**	**121,843.3**	**15.6**	**2.9**	**209.52**
Health	**486,924.5**	**140,539.5**	**28.9**	**3.4**	**241.67**
Child/Family Assistance	**288,968.1**	**169,481.7**		**4.0**	**291.44**
Child Welfare	168,782.3	134,192.8	79.5		
Income Assistance	120,185.8	35,288.9	29.4		
Mental Health/Developmental Disabilities	**116,732.5**	**62,014.5**		**1.5**	**106.64**
Mental Health	94,338.8	59,701.6	63.3		
Developmental Disabilities	22,393.6	2,312.9	10.3		
Public Safety	**375,948.9**	**82,546.0**	**22.0**	**2.0**	**141.95**
State Workforce	**1,359,075.0**	**6,765.6**	**0.5**	**0.2**	**11.63**
Regulation/Compliance	***NA***	***NA***	***NA***	***NA***	***NA***
Licensing and Control	NA	NA			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***26,207.1***	***26,207.1***	***100.0***	***0.6***	***45.07***
Prevention	638.5	638.5			
Treatment	17,968.7	17,968.7			
Research	7,599.9	7,599.9			
Total		***$791,481.8***		***18.9***	***$1,361.03***



Total State Budget	$4,186 M
• Elementary and Secondary Education	$781 M
• Substance Abuse and Addiction	$792 M
• Medicaid	$391 M
• Higher Education	$111 M
• Transportation	$109 M
Population	.58 M

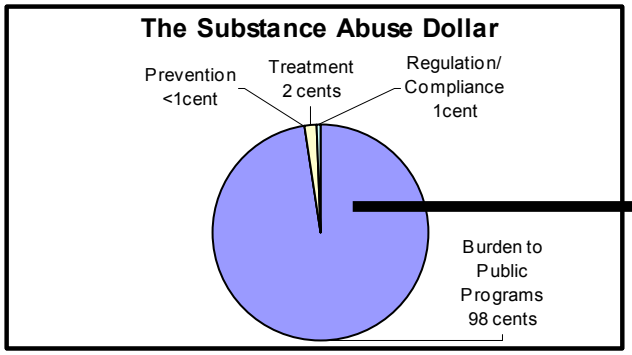
Tobacco and alcohol tax revenue total $27,347,000; $47.03 per capita.

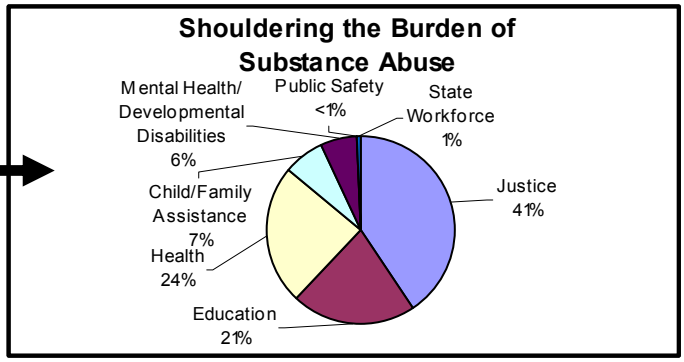
* Numbers may not add due to rounding.

Florida

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$6,057,914.0***		***15.9***	***$334.88***
Justice	**2,989,697.1**	**2,466,653.8**		**6.5**	**136.36**
Adult Corrections	1,702,783.5	1,410,989.0	82.9		
Juvenile Justice	544,925.5	444,129.5	81.5		
Judiciary	741,988.2	611,535.3	82.4		
Education (Elementary/Secondary)	**9,615,247.5**	**1,284,684.9**	**13.4**	**3.4**	**71.02**
Health	**4,728,761.9**	**1,461,633.2**	**30.9**	**3.8**	**80.80**
Child/Family Assistance	**771,992.9**	**421,074.5**		**1.1**	**23.28**
Child Welfare	438,744.8	335,230.2	76.4		
Income Assistance	333,248.1	85,844.2	25.8		
Mental Health/Developmental Disabilities	**1,042,688.3**	**375,117.4**		**1.0**	**20.74**
Mental Health	542,120.0	319,830.6	59.0		
Developmental Disabilities	500,568.3	55,286.8	11.0		
Public Safety	**13,482.6**	**13,482.6**	**100.0**	**0.0**	**0.75**
State Workforce	**8,480,000.0**	**35,267.7**	**0.4**	**0.1**	**1.95**
Regulation/Compliance	***37,245.3***	***37,245.3***	***100.0***	***0.1***	***2.06***
Licensing and Control	30,860.7	30,860.7			
Collection of Taxes	6,384.5	6,384.5			
Prevention, Treatment and Research	***113,822.2***	***113,822.2***	***100.0***	***0.3***	***6.29***
Prevention	3,409.7	3,409.7			
Treatment	73,648.5	73,648.5			
Research	NA	NA			
Unspecified	36,764.0	36,764.0			
Total		***$6,208,981.6***		***16.3***	***$343.23***





Total State Budget	$37,988 M
• Elementary and Secondary Education	$9,615 M
• Substance Abuse and Addiction	$6,209 M
• Medicaid	$5,624 M
• Higher Education	$4,072 M
• Transportation	$5,184 M
Population	18.1 M

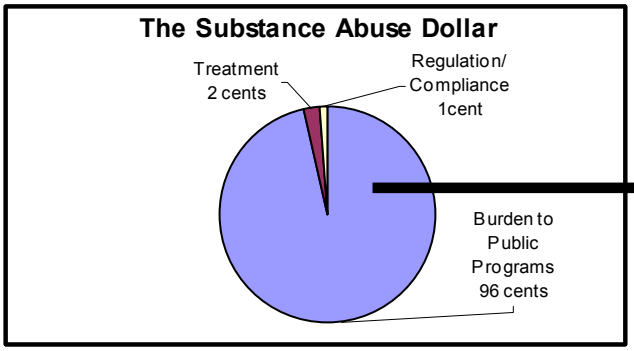
Tobacco and alcohol tax revenue total $1,088,407,000; $60.17 per capita.

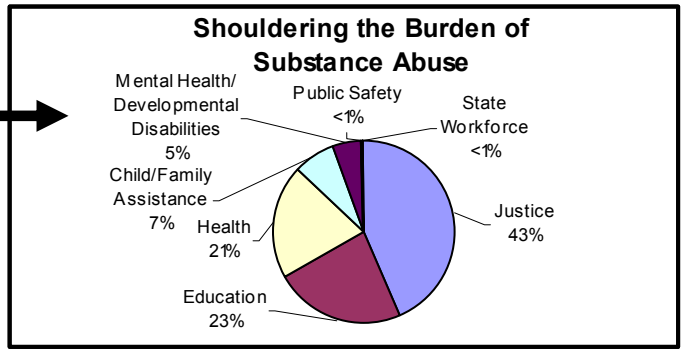
* Numbers may not add due to rounding.

Georgia

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,495,035.3***		***13.8***	***$266.45***
Justice	**1,407,049.1**	**1,078,190.8**		**6.0**	**115.14**
Adult Corrections	977,045.9	750,586.6	76.8		
Juvenile Justice	199,293.2	149,719.8	75.1		
Judiciary	230,710.0	177,884.4	77.1		
Education (Elementary/Secondary)	**6,056,487.2**	**578,986.9**	**9.6**	**3.2**	**61.83**
Health	**1,976,725.7**	**510,522.5**	**25.8**	**2.8**	**54.52**
Child/Family Assistance	**325,869.8**	**184,248.7**		**1.0**	**19.68**
Child Welfare	244,604.7	168,634.8	68.9		
Income Assistance	81,265.1	15,613.9	19.2		
Mental Health/Developmental Disabilities	**427,004.9**	**135,022.8**		**0.7**	**14.42**
Mental Health	239,213.1	118,775.6	49.7		
Developmental Disabilities	187,791.8	16,247.2	8.7		
Public Safety	**2,847.3**	**483.5**	**17.0**	**0.0**	**0.05**
State Workforce	**2,655,584.2**	**7,580.1**	**0.3**	**0.0**	**0.81**
Regulation/Compliance	***31,082.8***	***31,082.8***	***100.0***	***0.2***	***3.32***
Licensing and Control	4,461.8	4,461.8			
Collection of Taxes	26,621.0	26,621.0			
Prevention, Treatment and Research	***62,548.8***	***62,548.8***	***100.0***	***0.3***	***6.68***
Prevention	NA	NA			
Treatment	39,005.0	39,005.0			
Research	NA	NA			
Unspecified	23,543.8	23,543.8			
Total		***$2,588,666.9***		***14.4***	***$276.45***





Total State Budget	$18,026 M
• Elementary and Secondary Education	$6,057 M
• Substance Abuse and Addiction	$2,589 M
• Medicaid	$2,624 M
• Higher Education	$2,167 M
• Transportation	$790 M
Population	9.4 M

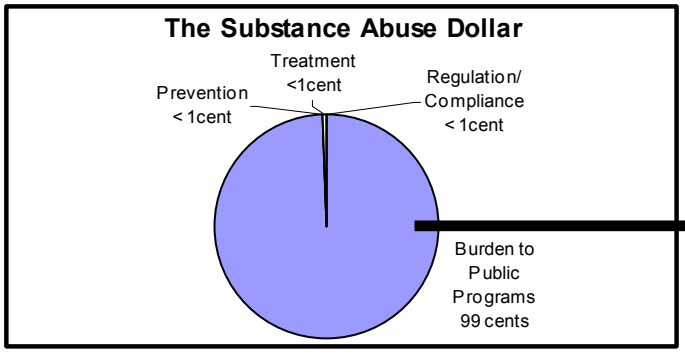
Tobacco and alcohol tax revenue total $398,926,000; $42.60 per capita.

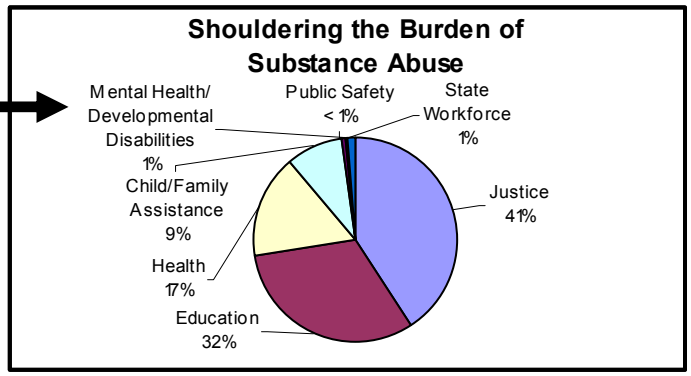
* Numbers may not add due to rounding.

Hawaii

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$752,808.6***		***11.1***	***$585.62***
Justice	**358,864.0**	**306,168.3**		**4.5**	**238.17**
Adult Corrections	186,376.9	158,600.7	85.1		
Juvenile Justice	10,070.9	8,447.4	83.9		
Judiciary	162,416.3	139,120.3	85.7		
Education (Elementary/Secondary)	**1,552,221.6**	**239,115.8**	**15.4**	**3.5**	**186.01**
Health	**339,976.7**	**123,824.8**	**36.4**	**1.8**	**96.32**
Child/Family Assistance	**138,188.6**	**66,767.1**		**1.0**	**51.94**
Child Welfare	60,188.7	47,712.0	79.3		
Income Assistance	77,999.9	19,055.1	24.4		
Mental Health/Developmental Disabilities	**32,203.3**	**5,298.6**		**0.1**	**4.12**
Mental Health	597.9	376.3	62.9		
Developmental Disabilities	31,605.4	4,922.2	15.6		
Public Safety	**1,379.1**	**1,379.1**	**100.0**	**0.0**	**1.07**
State Workforce	**2,089,722.6**	**10,254.9**	**0.5**	**0.2**	**7.98**
Regulation/Compliance	***985.0***	***985.0***	***100.0***	***0.0***	***0.77***
Licensing and Control	819.2	819.2			
Collection of Taxes	165.8	165.8			
Prevention, Treatment and Research	***4,134.7***	***4,134.7***	***100.0***	***0.1***	***3.22***
Prevention	151.9	151.9			
Treatment	1,779.0	1,779.0			
Research	346.7	346.7			
Unspecified	1,857.0	1,857.0			
Total		***$757,928.2***		***11.2***	***$589.60***





Total State Budget	$6,793 M
• Elementary and Secondary Education	$1,552 M
• Substance Abuse and Addiction	$758 M
• Medicaid	$364 M
• Higher Education	$755 M
• Transportation	$704 M
Population	1.3 M

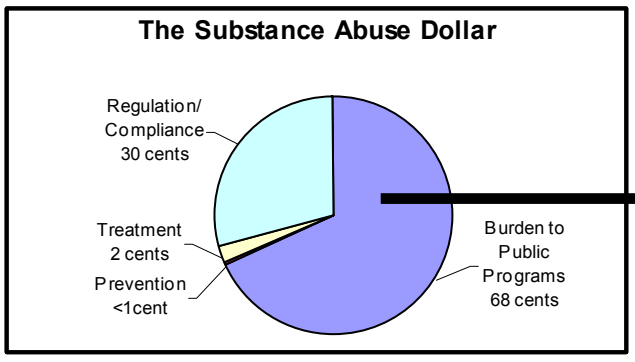
Tobacco and alcohol tax revenue total $128,961,000; $100.32 per capita.

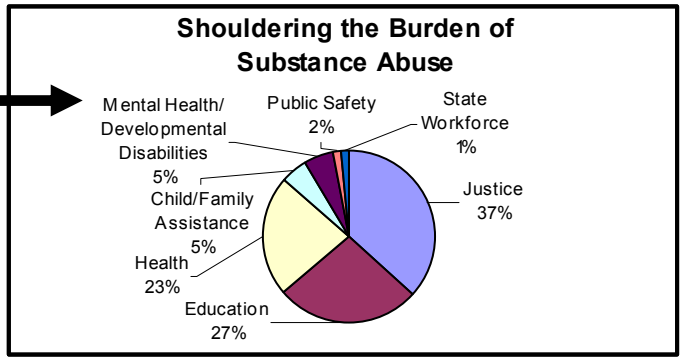
* Numbers may not add due to rounding.

Idaho

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$358,906.7***		***11.9***	***$244.74***
Justice	**164,647.9**	**131,422.5**		**4.3**	**89.62**
Adult Corrections	92,447.7	72,849.3	78.8		
Juvenile Justice	33,680.7	26,003.4	77.2		
Judiciary	38,519.5	32,569.9	84.6		
Education (Elementary/Secondary)	**917,706.5**	**97,258.9**	**10.6**	**3.2**	**66.32**
Health	**321,583.9**	**80,821.8**	**25.1**	**2.7**	**55.11**
Child/Family Assistance	**40,594.2**	**18,905.5**		**0.6**	**12.89**
Child Welfare	23,834.3	17,003.9	71.3		
Income Assistance	16,759.9	1,901.6	11.3		
Mental Health/Developmental Disabilities	**47,245.2**	**19,313.7**		**0.6**	**13.17**
Mental Health	34,736.6	18,242.6	52.5		
Developmental Disabilities	12,508.6	1,071.2	8.6		
Public Safety	**23,163.3**	**6,468.2**	**27.9**	**0.2**	**4.41**
State Workforce	**1,473,761.4**	**4,716.1**	**0.3**	**0.2**	**3.22**
Regulation/Compliance	***155,615.8***	***155,615.8***	***100.0***	***5.1***	***106.12***
Licensing and Control	NA	NA			
Collection of Taxes	92,561.8	92,561.8			
Liquor Store Expenses	63,054.0	63,054.0			
Prevention, Treatment and Research	***13,616.6***	***13,616.6***	***100.0***	***0.5***	***9.29***
Prevention	745.1	745.1			
Treatment	4,827.9	4,827.9			
Research	167.5	167.5			
Unspecified	7,876.1	7,876.1			
Total		***$528,139.2***		***17.5***	***$360.14***





Total State Budget	$3,023 M
• Elementary and Secondary Education	$918 M
• Substance Abuse and Addiction	$528 M
• Medicaid	$368 M
• Higher Education	$424 M
• Transportation	$327 M
Population	1.5 M

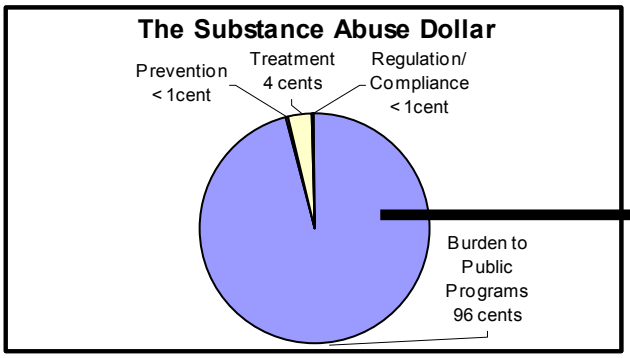
Tobacco and alcohol tax revenue total $58,656,000; $40.00 per capita.
Liquor store revenue total $85,508,000; $58.31 per capita.

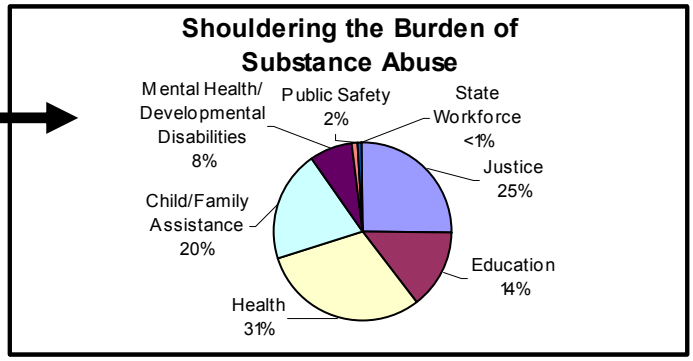
* Numbers may not add due to rounding.

Illinois

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$4,665,903.2***		***14.4***	***$363.62***
Justice	**1,434,599.9**	**1,156,812.4**		**3.6**	**90.15**
Adult Corrections	1,155,599.7	928,966.9	80.4		
Juvenile Justice	107,496.0	84,793.9	78.9		
Judiciary	171,504.1	143,051.5	83.4		
Education (Elementary/Secondary)	**5,769,174.2**	**666,976.5**	**11.6**	**2.1**	**51.98**
Health	**4,566,394.8**	**1,431,877.9**	**31.4**	**4.4**	**111.59**
Child/Family Assistance	**1,421,037.6**	**942,741.5**		**2.9**	**73.47**
Child Welfare	1,237,548.1	907,111.5	73.3		
Income Assistance	183,489.5	35,630.0	19.4		
Mental Health/Developmental Disabilities	**1,298,044.4**	**375,578.1**		**1.2**	**29.27**
Mental Health	507,119.6	278,650.4	54.9		
Developmental Disabilities	790,924.9	96,927.7	12.3		
Public Safety	**306,109.0**	**70,935.4**	**23.2**	**0.2**	**5.53**
State Workforce	**5,947,713.6**	**20,981.5**	**0.4**	**0.1**	**1.64**
Regulation/Compliance	***8,244.3***	***8,244.3***	***100.0***	***0.0***	***0.64***
Licensing and Control	5,138.1	5,138.1			
Collection of Taxes	3,106.2	3,106.2			
Prevention, Treatment and Research	***179,467.7***	***179,467.7***	***100.0***	***0.6***	***13.99***
Prevention	6,202.4	6,202.4			
Treatment	165,921.4	165,921.4			
Research	NA	NA			
Unspecified	7,343.9	7,343.9			
Total		***$4,853,615.1***		***15.0***	***$378.24***





Total State Budget	$32,442 M
• Elementary and Secondary Education	$5,769 M
• Substance Abuse and Addiction	$4,854 M
• Medicaid	$5,948 M
• Higher Education	$2,371 M
• Transportation	$3,070 M
Population	12.8 M

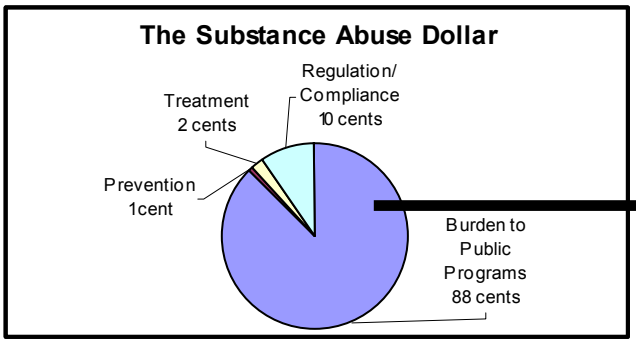
Tobacco and alcohol tax revenue total $803,711,000; $62.63 per capita

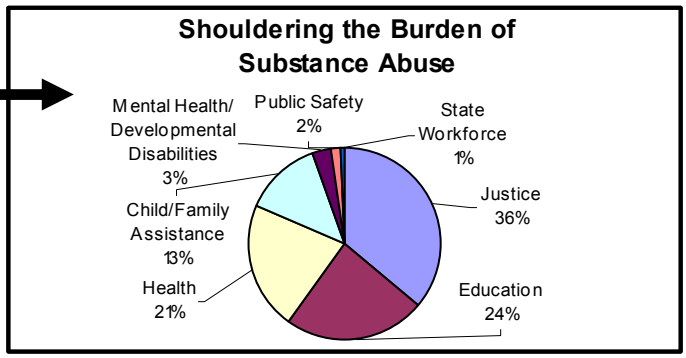
* Numbers may not add due to rounding.

Iowa

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$899,167.1***		***10.2***	***$301.52***
Justice	**407,189.7**	**321,955.9**		**3.7**	**107.96**
Adult Corrections	293,471.2	230,759.8	78.6		
Juvenile Justice	15,414.0	11,873.0	77.0		
Judiciary	98,304.5	79,323.1	80.7		
Education (Elementary/Secondary)	**2,050,297.2**	**215,335.7**	**10.5**	**2.4**	**72.21**
Health	**579,271.5**	**192,823.5**	**33.3**	**2.2**	**64.66**
Child/Family Assistance	**225,032.9**	**118,801.5**		**1.4**	**39.84**
Child Welfare	150,641.6	107,158.7	71.1		
Income Assistance	74,391.3	11,642.8	15.7		
Mental Health/Developmental Disabilities	**104,166.7**	**29,935.6**		**0.3**	**10.04**
Mental Health	40,873.4	21,362.4	52.3		
Developmental Disabilities	63,293.3	8,573.2	13.5		
Public Safety	**46,401.0**	**14,645.1**	**31.6**	**0.2**	**4.91**
State Workforce	**1,789,724.2**	**5,669.8**	**0.3**	**0.1**	**1.90**
Regulation/Compliance	***101,609.4***	***101,609.4***	***100.0***	***1.2***	***34.07***
Licensing and Control	313.1	313.1			
Collection of Taxes	147.3	147.3			
Liquor Store Expenses	101,149.0	101,149.0			
Prevention, Treatment and Research	***27,306.8***	***27,306.8***	***100.0***	***0.3***	***9.16***
Prevention	6,082.2	6,082.2			
Treatment	14,616.5	14,616.5			
Research	NA	NA			
Unspecified	6,608.1	6,608.1			
Total		***$1,028,083.3***		***11.7***	***$344.75***





Total State Budget	$8,792 M
• Elementary and Secondary Education	$2,050 M
• Substance Abuse and Addiction	$1,028 M
• Medicaid	$813 M
• Higher Education	$2,103 M
• Transportation	$1,080 M
Population	3.0 M

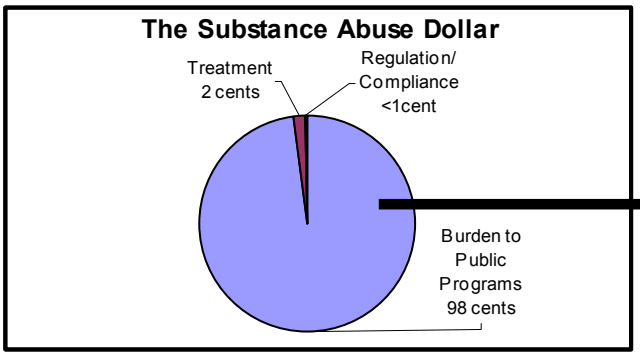
Tobacco and alcohol tax revenue total $110,139,000; $36.93 per capita.
Liquor store revenue total $149,120,000; $50.01 per capita.

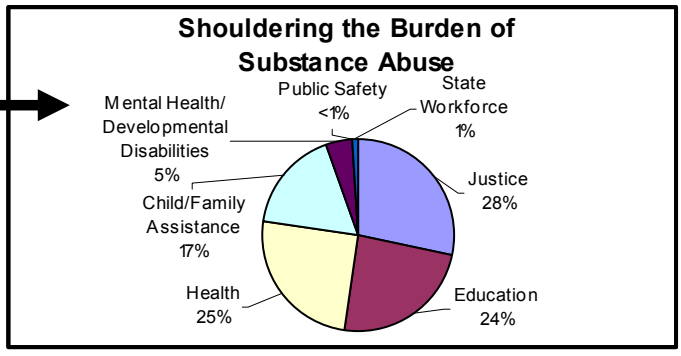
* Numbers may not add due to rounding.

Kansas

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,194,223.1***		***17.4***	***$432.05***
Justice	**412,537.6**	**332,034.1**		**4.8**	**120.12**
Adult Corrections	214,867.1	173,695.8	80.8		
Juvenile Justice	140,989.1	111,884.8	79.4		
Judiciary	56,681.4	46,453.5	82.0		
Education (Elementary/Secondary)	**2,387,225.0**	**283,101.1**	**11.9**	**4.1**	**102.42**
Health	**1,251,991.7**	**295,058.1**	**23.6**	**4.3**	**106.75**
Child/Family Assistance	**330,838.5**	**201,593.8**		**2.9**	**72.93**
Child Welfare	246,365.4	181,963.9	73.9		
Income Assistance	84,473.1	19,629.9	23.2		
Mental Health/Developmental Disabilities	**398,314.8**	**60,416.4**		**0.9**	**21.86**
Mental Health	65,652.3	36,542.1	55.7		
Developmental Disabilities	332,662.5	23,874.3	7.2		
Public Safety	**91,234.2**	**13,054.2**	**14.3**	**0.2**	**4.72**
State Workforce	**2,469,492.7**	**8,965.3**	**0.4**	**0.1**	**3.24**
Regulation/Compliance	***3,918.7***	***3,918.7***	***100.0***	***0.1***	***1.42***
Licensing and Control	1,959.4	1,959.4			
Collection of Taxes	1,959.4	1,959.4			
Prevention, Treatment and Research	***18,808.0***	***18,808.0***	***100.0***	***0.3***	***6.80***
Prevention	NA	NA			
Treatment	18,149.7	18,149.7			
Research	NA	NA			
Unspecified	658.3	658.3			
Total		***$1,216,949.8***		***17.7***	***$440.27***





Total State Budget	$6,878 M
• Elementary and Secondary Education	$2,387 M
• Substance Abuse and Addiction	$1,217
• Medicaid	$868 M
• Higher Education	$1,332 M
• Transportation	$691 M
Population	2.8 M

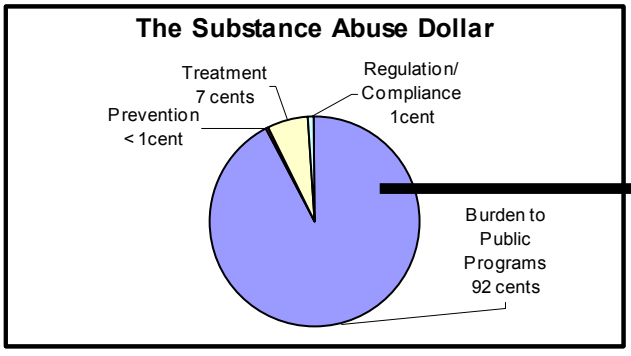
Tobacco and alcohol tax revenue total $214,222,000; $77.50 per capita.

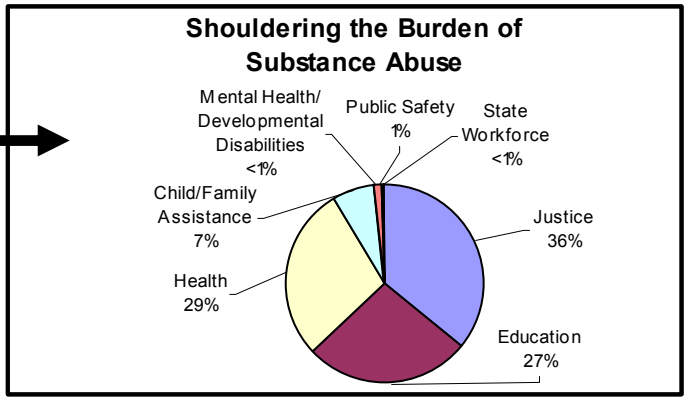
* Numbers may not add due to rounding.

Kentucky

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,280,766.4***		***9.8***	***$304.50***
Justice	**590,865.8**	**457,933.2**		**3.5**	**108.87**
Adult Corrections	257,694.3	202,430.5	78.6		
Juvenile Justice	111,619.3	85,887.3	76.9		
Judiciary	221,552.2	169,615.4	76.6		
Education (Elementary/Secondary)	**3,275,158.9**	**342,578.8**	**10.5**	**2.6**	**81.45**
Health	**1,344,527.1**	**369,494.7**	**27.5**	**2.8**	**87.85**
Child/Family Assistance	**177,961.8**	**90,303.3**		**0.7**	**21.47**
Child Welfare	106,043.5	75,334.6	71.0		
Income Assistance	71,918.3	14,968.7	20.8		
Mental Health/Developmental Disabilities	**1,645.3**	**138.8**		**0.0**	**0.03**
Mental Health	NA	NA	NA		
Developmental Disabilities	1,645.3	138.8	8.4		
Public Safety	**61,994.4**	**15,028.5**	**24.2**	**0.1**	**3.57**
State Workforce	**1,677,148.0**	**5,289.1**	**0.3**	**0.0**	**1.26**
Regulation/Compliance	***9,355.3***	***9,355.3***	***100.0***	***0.1***	***2.22***
Licensing and Control	4,557.6	4,557.6			
Collection of Taxes	4,797.7	4,797.7			
Prevention, Treatment and Research	***101,877.2***	***101,877.2***	***100.0***	***0.8***	***24.22***
Prevention	773.6	773.6			
Treatment	12,188.1	12,188.1			
Research	497.3	497.3			
Unspecified	88,418.2	88,418.2			
Total		***$1,391,998.8***		***10.7***	***$330.95***





Total State Budget	$13,022 M
• Elementary and Secondary Education	$3,275 M
• Substance Abuse and Addiction	$1,392 M
• Medicaid	$1,280 M
• Higher Education	$3,402 M
• Transportation	$1,057 M
Population	4.2 M

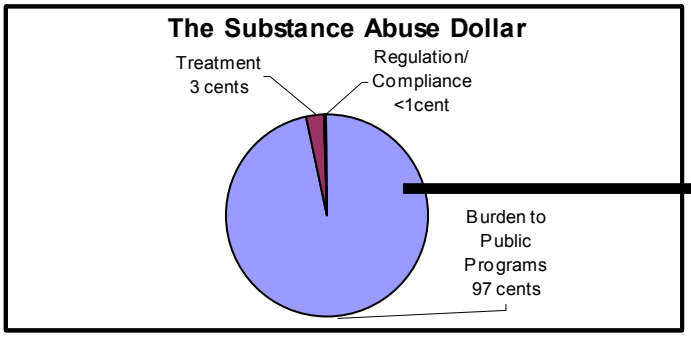
Tobacco and alcohol tax revenue total $119,478,000; $28.41 per capita.

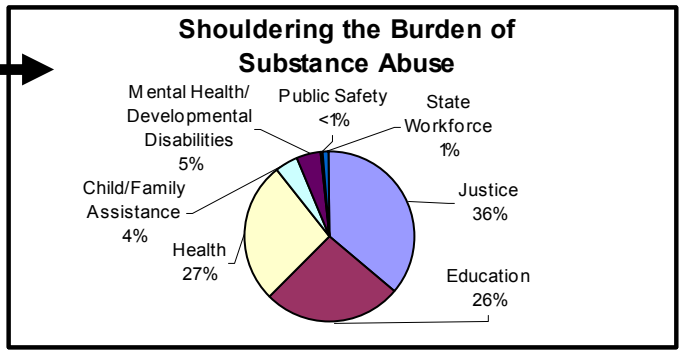
* Numbers may not add due to rounding.

Louisiana

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,375,626.8***		***17.0***	***$320.83***
Justice	**603,552.9**	**493,521.8**		**6.1**	**115.10**
Adult Corrections	387,412.2	315,377.5	81.4		
Juvenile Justice	117,427.0	93,891.8	80.0		
Judiciary	98,713.7	84,252.5	85.4		
Education (Elementary/Secondary)	**2,947,086.5**	**361,073.3**	**12.3**	**4.5**	**84.21**
Health	**1,338,019.5**	**374,212.8**	**28.0**	**4.6**	**87.27**
Child/Family Assistance	**85,109.0**	**58,483.7**		**0.7**	**13.64**
Child Welfare	75,277.7	56,133.5	74.6		
Income Assistance	9,831.3	2,350.2	23.9		
Mental Health/Developmental Disabilities	**142,616.8**	**70,912.5**		**0.9**	**16.54**
Mental Health	121,693.9	68,845.5	56.6		
Developmental Disabilities	20,922.9	2,067.1	9.9		
Public Safety	**1,163.0**	**1,069.8**	**92.0**	**0.0**	**0.25**
State Workforce	**4,341,108.5**	**16,352.9**	**0.4**	**0.2**	**3.81**
Regulation/Compliance	***4,600.0***	***4,600.0***	***100.0***	***0.1***	***1.07***
Licensing and Control	4,600.0	4,600.0			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***43,699.9***	***43,699.9***	***100.0***	***0.5***	***10.19***
Prevention	NA	NA			
Treatment	29,506.3	29,506.3			
Research	NA	NA			
Unspecified	14,193.5	14,193.5			
Total		***$1,423,926.6***		***17.6***	***$332.09***





Total State Budget	$8,071 M
• Elementary and Secondary Education	$2,947 M
• Substance Abuse and Addiction	$1,424 M
• Medicaid	$1,250 M
• Higher Education	$2,230 M
• Transportation	$950 M
Population	4.3 M

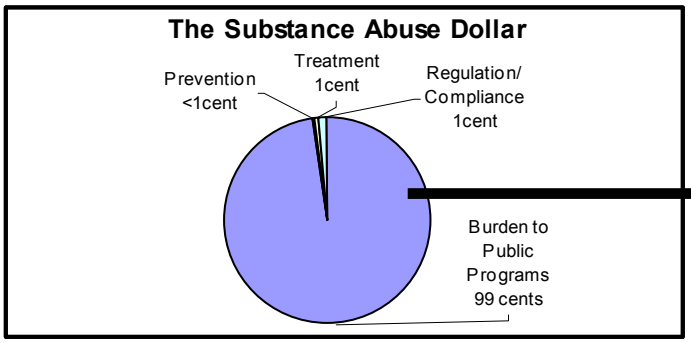
Tobacco and alcohol tax revenue total $160,177,000; $37.36 per capita

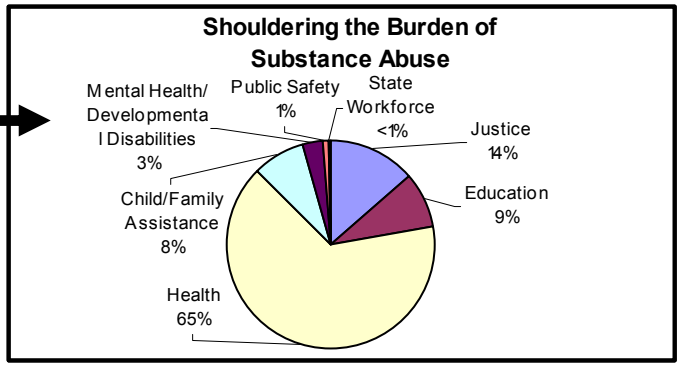
* Numbers may not add due to rounding.

Maine

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,180,020.6***		***26.9***	***$892.89***
Justice	**190,067.6**	**159,985.6**		**3.6**	**121.06**
Adult Corrections	86,103.2	71,955.9	83.6		
Juvenile Justice	44,576.4	36,665.2	82.3		
Judiciary	59,388.0	51,364.5	86.5		
Education (Elementary/Secondary)	**736,616.2**	**102,807.9**	**14.0**	**2.3**	**77.79**
Health	**2,396,426.2**	**769,802.3**	**32.1**	**17.6**	**582.49**
Child/Family Assistance	**193,722.7**	**93,907.6**		**2.1**	**71.06**
Child Welfare	83,275.0	64,376.1	77.3		
Income Assistance	110,447.7	29,531.5	26.7		
Mental Health/Developmental Disabilities	**82,004.6**	**38,807.2**		**0.9**	**29.36**
Mental Health	60,547.8	36,457.6	60.2		
Developmental Disabilities	21,456.7	2,349.6	11.0		
Public Safety	**49,757.8**	**11,293.9**	**22.7**	**0.3**	**8.55**
State Workforce	**781,051.9**	**3,416.0**	**0.4**	**0.1**	**2.58**
Regulation/Compliance	***6,482.0***	***6,482.0***	***100.0***	***0.1***	***4.90***
Licensing and Control	224.0	224.0			
Collection of Taxes	NA	NA			
Liquor Store Expenses	6,258.0	6,258.0			
Prevention, Treatment and Research	***8,452.5***	***8,452.5***	***100.0***	***0.2***	***6.40***
Prevention	981.1	981.1			
Treatment	7,022.3	7,022.3			
Research	449.0	449.0			
Total		***$1,194,955.0***		***27.3***	***$904.19***





Total State Budget	$4,384 M
• Elementary and Secondary Education	$737 M
• Substance Abuse and Addiction	$1,195 M
• Medicaid	$716 M
• Higher Education	$215 M
• Transportation	$302 M
Population	1.3 M

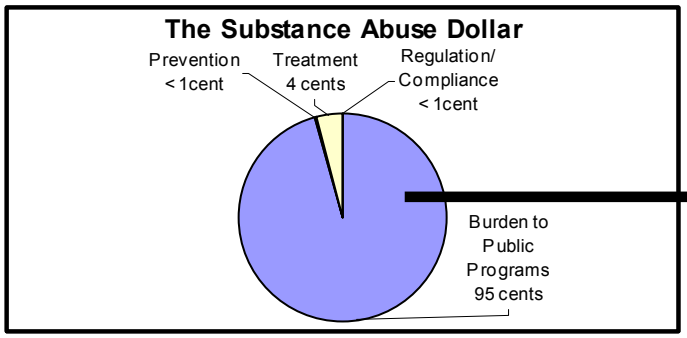
Tobacco and alcohol tax revenue total $104,648,000; $79.18 per capita
Liquor store revenue total $51,565,000; $39.02 per capita.

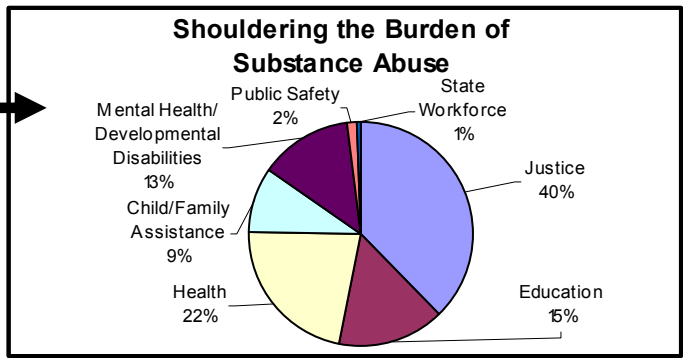
* Numbers may not add due to rounding.

Maryland

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,578,937.3***		***14.2***	***$459.23***
Justice	**1,303,735.4**	**1,018,524.5**		**5.6**	**181.37**
Adult Corrections	814,535.8	638,105.7	78.3		
Juvenile Justice	187,225.7	143,640.7	76.7		
Judiciary	301,973.8	236,778.2	78.4		
Education (Elementary/Secondary)	**3,666,056.3**	**379,128.1**	**10.3**	**2.1**	**67.51**
Health	**2,192,852.0**	**559,989.1**	**25.5**	**3.1**	**99.72**
Child/Family Assistance	**399,762.8**	**224,441.4**		**1.2**	**39.97**
Child Welfare	285,406.6	202,008.7	70.8		
Income Assistance	114,356.2	22,432.7	19.6		
Mental Health/Developmental Disabilities	**1,000,065.6**	**338,151.6**		**1.9**	**60.22**
Mental Health	585,612.2	303,546.3	51.8		
Developmental Disabilities	403,880.5	34,980.8	8.7		
Public Safety	**164,910.1**	**44,960.2**	**27.3**	**0.2**	**8.01**
State Workforce	**4,413,156.4**	**13,742.3**	**0.3**	**0.1**	**2.45**
Regulation/Compliance	***3,527.9***	***3,527.9***	***100.0***	***0.0***	***0.63***
Licensing and Control	NA	NA			
Collection of Taxes	3,527.9	3,527.9			
Prevention, Treatment and Research	***122,609.7***	***122,609.7***	***100.0***	***0.7***	***21.83***
Prevention	10,116.6	10,116.6			
Treatment	104,498.4	104,498.4			
Research	6,366.1	6,366.1			
Unspecified	1,628.6	1,628.6			
Total		***$2,705,074.9***		***14.9***	***$481.70***





Total State Budget	$18,167 M
• Elementary and Secondary Education	$3,666 M
• Substance Abuse and Addiction	$2,705 M
• Medicaid	$2,561 M
• Higher Education	$3,137 M
• Transportation	$2,484 M
Population	5.6 M

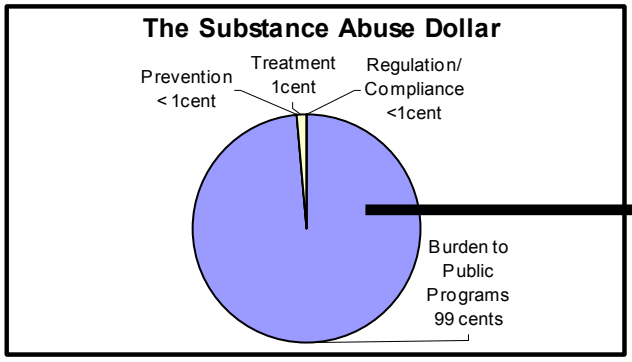
Tobacco and alcohol tax revenue total $303,147,000; $53.98 per capita

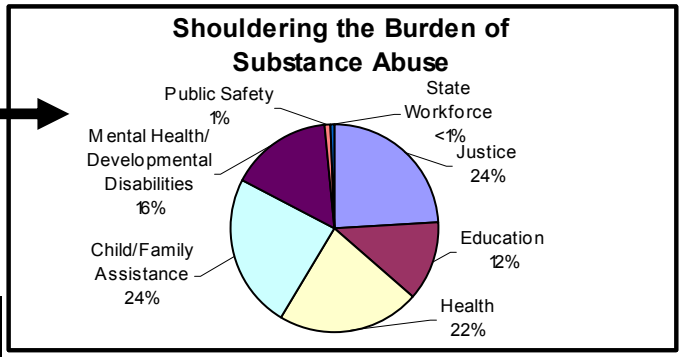
* Numbers may not add due to rounding.

Massachusetts

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$4,501,760.3***		***21.8***	***$699.34***
Justice	**1,304,197.3**	**1,084,198.9**		**5.3**	**168.43**
Adult Corrections	982,692.4	810,769.4	82.5		
Juvenile Justice	129,356.5	104,936.6	81.1		
Judiciary	192,148.4	168,492.9	87.7		
Education (Elementary/Secondary)	**4,226,058.8**	**552,493.1**	**13.1**	**2.7**	**85.83**
Health	**3,000,156.0**	**1,007,625.0**	**33.6**	**4.9**	**156.53**
Child/Family Assistance	**2,056,322.5**	**1,083,639.3**		**5.3**	**168.34**
Child Welfare	1,209,469.9	918,615.6	76.0		
Income Assistance	846,852.6	165,023.7	19.5		
Mental Health/Developmental Disabilities	**1,665,355.0**	**703,122.3**		**3.4**	**109.23**
Mental Health	1,066,560.0	622,750.7	58.4		
Developmental Disabilities	598,795.1	80,371.6	13.4		
Public Safety	**196,575.1**	**49,307.2**	**25.1**	**0.2**	**7.66**
State Workforce	**5,269,307.8**	**21,374.5**	**0.4**	**0.1**	**3.32**
Regulation/Compliance	***1,826.5***	***1,826.5***	***100.0***	***0.0***	***0.28***
Licensing and Control	1,826.5	1,826.5			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***66,042.2***	***66,042.2***	***100.0***	***0.3***	***10.26***
Prevention	32.2	32.2			
Treatment	52,947.3	52,947.3			
Research	NA	NA			
Unspecified	13,062.8	13,062.8			
Total		***$4,569,629.0***		***22.2***	***$709.88***





Total State Budget	$20,630 M
• Elementary and Secondary Education	$4,226 M
• Substance Abuse and Addiction	$4,570 M
• Medicaid	$2,999 M
• Higher Education	$915 M
• Transportation	$429 M
Population	6.4 M

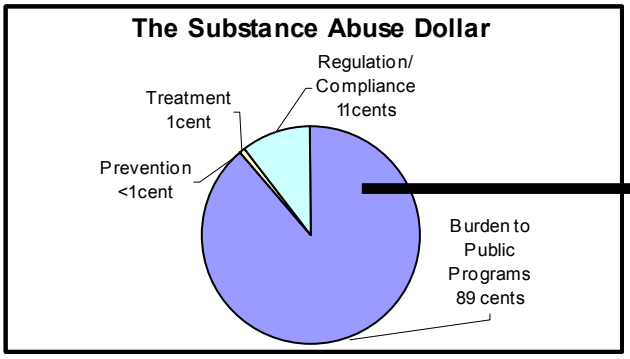
Tobacco and alcohol tax revenue total $492,888,000; $76.57 per capita.

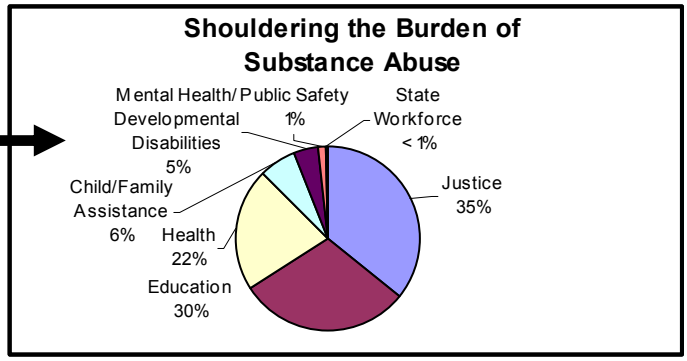
* Numbers may not add due to rounding.

Michigan

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$4,673,041.1***		***16.1***	***$462.88***
Justice	**2,015,069.5**	**1,647,953.5**		**5.7**	**163.23**
Adult Corrections	1,818,150.4	1,488,220.5	81.9		
Juvenile Justice	50,019.3	40,231.2	80.4		
Judiciary	146,899.8	119,501.8	81.4		
Education (Elementary/Secondary)	**11,119,065.4**	**1,398,360.2**	**12.6**	**4.8**	**138.51**
Health	**3,237,405.8**	**1,024,296.0**	**31.6**	**3.5**	**101.46**
Child/Family Assistance	**663,709.8**	**300,031.9**		**1.0**	**29.72**
Child Welfare	299,379.2	224,924.0	75.1		
Income Assistance	364,330.6	75,107.9	20.6		
Mental Health/Developmental Disabilities	**494,722.9**	**222,347.1**		**0.8**	**22.02**
Mental Health	360,646.6	206,665.4	57.3		
Developmental Disabilities	134,076.3	15,681.7	11.7		
Public Safety	**184,018.8**	**63,863.8**	**34.7**	**0.2**	**6.33**
State Workforce	**4,171,629.0**	**16,188.5**	**0.4**	**0.1**	**1.60**
Regulation/Compliance	***558,354.9***	***558,354.9***	***100.0***	***1.9***	***55.31***
Licensing and Control	993.9	993.9			
Collection of Taxes	200.0	200.0			
Liquor Store Expenses	557,161.0	557,161.0			
Prevention, Treatment and Research	***49,644.3***	***49,644.3***	***100.0***	***0.2***	***4.92***
Prevention	8,573.2	8,573.2			
Treatment	35,585.2	35,585.2			
Research	5,486.9	5,486.9			
Total		***$5,281,040.3***		***18.2***	***$523.10***





Total State Budget	$28,981 M
• Elementary and Secondary Education	$11,119 M
• Substance Abuse and Addiction	$5,281 M
• Medicaid	$3,743 M
• Higher Education	$2,151 M
• Transportation	$2,149 M
Population	10.1 M

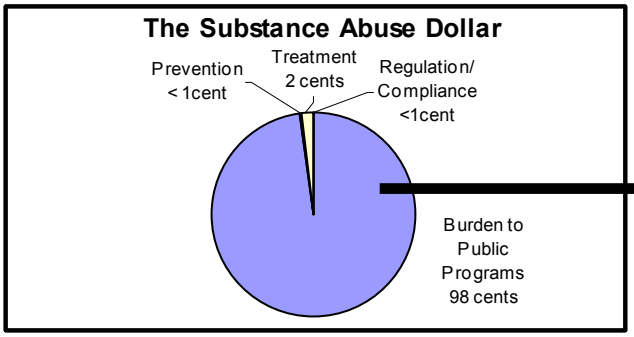
Tobacco and alcohol tax revenue total $1,330,759,000; $131.82 per capita.
Liquor store revenue total $688,927,000; $68.24 per capita.

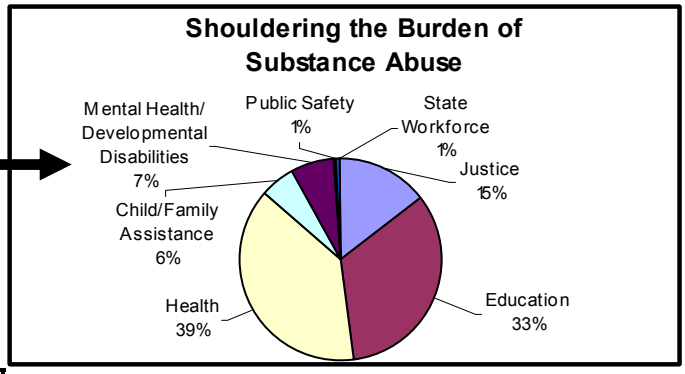
* Numbers may not add due to rounding.

Minnesota

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,774,049.8***		***14.9***	***$536.87***
Justice	**475,773.6**	**409.674.8**		**2.2**	**79.29**
Adult Corrections	226,527.6	190,877.7	84.3		
Juvenile Justice	9,271.4	7,694.3	83.0		
Judiciary	239,974.7	211,102.8	88.0		
Education (Elementary/Secondary)	**6,277,196.0**	**915,529.7**	**14.6**	**4.9**	**177.18**
Health	**3,086,416.9**	**1,069,725.2**	**34.7**	**5.8**	**207.03**
Child/Family Assistance	**346,344.1**	**159,307.7**		**0.9**	**30.83**
Child Welfare	140,419.0	109,798.9	78.2		
Income Assistance	205,925.1	49,508.8	24.0		
Mental Health/Developmental Disabilities	**301,741.9**	**185,379.9**		**1.0**	**35.88**
Mental Health	301,741.9	185,379.9	61.4		
Developmental Disabilities	NA	NA	NA		
Public Safety	**64,685.0**	**17,493.3**	**27.0**	**0.1**	**3.39**
State Workforce	**3,680,050.0**	**16,939.1**	**0.5**	**0.1**	**3.28**
Regulation/Compliance	***446.0***	***446.0***	***100.0***	***0.0***	***0.09***
Licensing and Control	446.0	446.0			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***66,192.7***	***66,192.7***	***100.0***	***0.4***	***12.81***
Prevention	7,880.0	7,880.0			
Treatment	55,675.7	55,675.7			
Research	NA	NA			
Unspecified	2,637.0	2,637.0			
Total		***$2,840,688.5***		***15.3***	***$549.76***





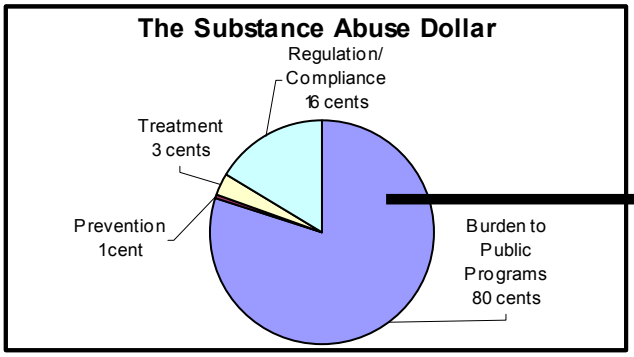
Total State Budget	$18,596 M
• Elementary and Secondary Education	$6,277 M
• Substance Abuse and Addiction	$2,841 M
• Medicaid	$2,533 M
• Higher Education	$2,225 M
• Transportation	$2,079 M
Population	5.2M

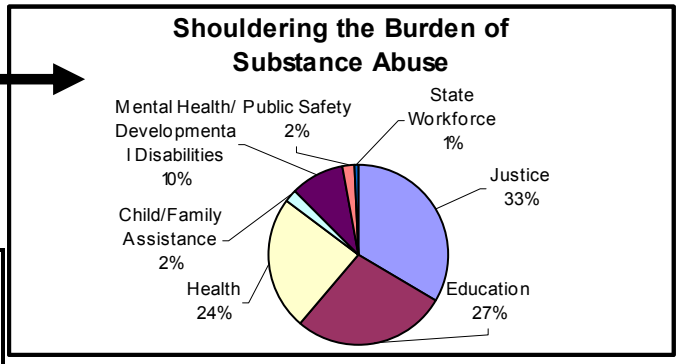
Tobacco and alcohol tax revenue total $243,218,000; $47.07 per capita.

* Numbers may not add due to rounding.

Mississippi
Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$811,911.6***		***11.2***	***$278.96***
Justice	**339,977.9**	**270,201.4**		**3.7**	**92.84**
Adult Corrections	277,145.7	220,013.0	79.4		
Juvenile Justice	17,514.9	13,630.5	77.8		
Judiciary	45,317.3	36,557.9	80.7		
Education (Elementary/Secondary)	**2,031,436.9**	**222,196.0**	**10.9**	**3.1**	**76.34**
Health	**742,836.5**	**195,304.5**	**26.3**	**2.7**	**67.10**
Child/Family Assistance	**39,910.6**	**17,807.1**		**0.2**	**6.12**
Child Welfare	18,183.9	13,103.3	72.1		
Income Assistance	21,726.7	4,703.9	21.7		
Mental Health/Developmental Disabilities	**181,416.7**	**84,647.2**		**1.2**	**29.08**
Mental Health	154,049.5	82,259.2	53.4		
Developmental Disabilities	27,367.2	2,388.0	8.7		
Public Safety	**47,516.6**	**16,310.7**	**34.3**	**0.2**	**5.60**
State Workforce	**1,642,515.2**	**5,444.7**	**0.3**	**0.1**	**1.87**
Regulation/Compliance	***165,110.4***	***165,110.4***	***100.0***	***2.3***	***56.73***
Licensing and Control	NA	NA			
Collection of Taxes	402.4	402.4			
Liquor Store Expenses	164,708.0	164,708.0			
Prevention, Treatment and Research	***37,256.6***	***37,256.6***	***100.0***	***0.5***	***12.80***
Prevention	7,079.4	7,079.4			
Treatment	29,325.4	29,325.4			
Research	NA	NA			
Unspecified	851.9	851.9			
Total		***$1,014,278.6***		***14.0***	***$348.48***





Total State Budget	$7,255 M
• Elementary and Secondary Education	$2,031 M
• Substance Abuse and Addiction	$1,014M
• Medicaid	$993 M
• Higher Education	$1,899 M
• Transportation	$532 M
Population	2.9 M

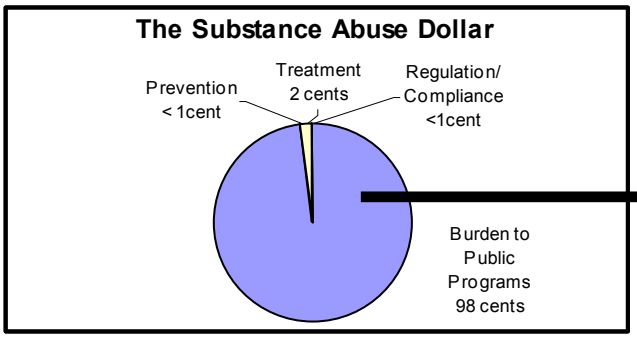
Tobacco and alcohol tax revenue total $95,890,000; $32.95 per capita.
Liquor store revenue total $203,005,000; $69.75 per capita.

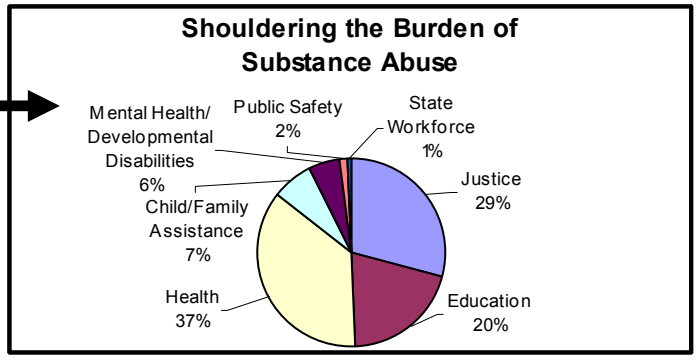
* Numbers may not add due to rounding.

Missouri

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,143,925.4***		***15.8***	***$366.94***
Justice	**764,416.2**	**618,694.7**		**4.6**	**105.89**
Adult Corrections	530,390.2	428,718.2	80.8		
Juvenile Justice	108,661.5	86,221.4	79.3		
Judiciary	125,364.6	103,755.1	82.8		
Education (Elementary/Secondary)	**3,610,279.7**	**427,948.6**	**11.9**	**3.2**	**73.24**
Health	**2,740,912.2**	**785,781.4**	**28.7**	**5.8**	**134.49**
Child/Family Assistance	**248,062.6**	**146,082.1**		**1.1**	**25.00**
Child Welfare	183,808.5	135,741.5	73.8		
Income Assistance	64,254.1	10,340.6	16.1		
Mental Health/Developmental Disabilities	**360,666.6**	**123,250.7**		**0.9**	**21.09**
Mental Health	191,745.7	106,701.4	55.6		
Developmental Disabilities	168,920.9	16,549.3	9.8		
Public Safety	**166,906.6**	**32,103.2**	**19.2**	**0.2**	**5.49**
State Workforce	**2,773,727.9**	**10,064.7**	**0.4**	**0.1**	**1.72**
Regulation/Compliance	***2,508.3***	***2,508.3***	***100.0***	***0.0***	***0.43***
Licensing and Control	2,318.6	2,318.6			
Collection of Taxes	189.7	189.7			
Prevention, Treatment and Research	***42,542.4***	***42,542.4***	**100.0**	***0.3***	***7.28***
Prevention	2,707.5	2,707.5			
Treatment	24,414.1	24,414.1			
Research	NA	NA			
Unspecified	15,420.8	15,420.8			
Total		***$2,188,976.1***		***16.1***	***$374.65***





Total State Budget	$13,563 M
• Elementary and Secondary Education	$3,610 M
• Substance Abuse and Addiction	$2,189 M
• Medicaid	$2,532 M
• Transportation	$1,700 M
• Higher Education	$985 M
Population	5.8 M

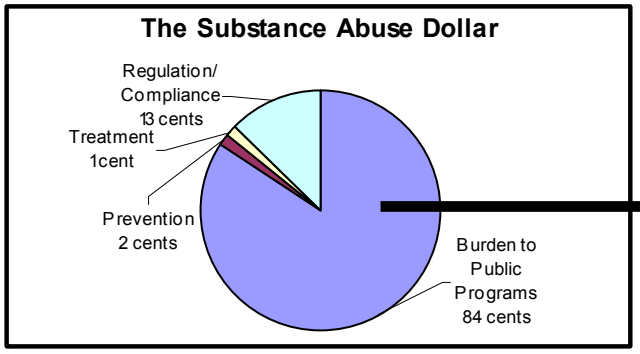
Tobacco and alcohol tax revenue total $138,589,000; $23.72 per capita.

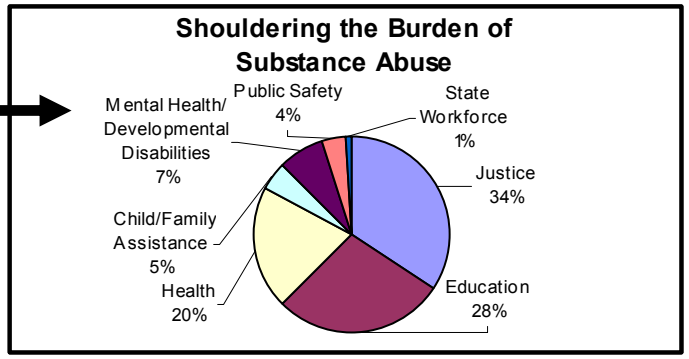
* Numbers may not add due to rounding.

Montana

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$307,875.7***		***12.6***	***$325.92***
Justice	**123,565.5**	**105,199.7**		**4.3**	**111.37**
Adult Corrections	85,955.3	73,229.6	85.2		
Juvenile Justice	7,512.7	6,309.4	84.0		
Judiciary	30,097.5	25,660.7	85.3		
Education (Elementary/Secondary)	**562,215.7**	**87,178.1**	**15.5**	**3.6**	**92.29**
Health	**185,704.8**	**62,400.1**	**33.6**	**2.5**	**66.06**
Child/Family Assistance	**28,070.5**	**14,722.2**		**0.6**	**15.59**
Child Welfare	13,490.8	10,711.4	79.4		
Income Assistance	14,579.7	4,010.8	27.5		
Mental Health/Developmental Disabilities	**60,359.4**	**22,378.9**		**0.9**	**23.69**
Mental Health	29,122.1	18,384.7	63.1		
Developmental Disabilities	31,237.3	3,994.1	12.8		
Public Safety	**50,225.3**	**13,100.7**	**26.1**	**0.5**	**13.87**
State Workforce	**585,600.0**	**2,896.0**	**0.5**	**0.1**	**3.07**
Regulation/Compliance	***47,076.6***	***47,076.6***	***100.0***	***1.9***	***49.84***
Licensing and Control	1,671.6	1,671.6			
Collection of Taxes	NA	NA			
Liquor Store Expenses	45,405.0	45,405.0			
Prevention, Treatment and Research	***10,696.4***	***10,696.4***	***100.0***	***0.4***	***11.32***
Prevention	5,883.5	5,883.5			
Treatment	4,512.9	4,512.9			
Research	300.0	300.0			
Total		***$365,648.7***		***14.9***	***$387.08***





Total State Budget	$2,449 M
• Elementary and Secondary Education	$562 M
• Substance Abuse and Addiction	$366 M
• Medicaid	$182 M
• Higher Education	$403 M
• Transportation	$246 M
Population	.95 M

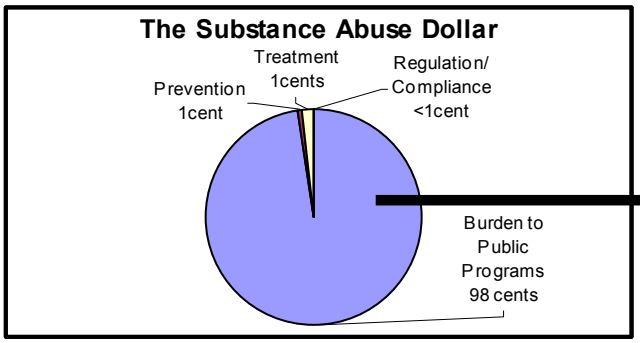
Tobacco and alcohol tax revenue total $82,954,000; $87.82 per capita.
Liquor store revenue total $52,094,000; $55.15 per capita.

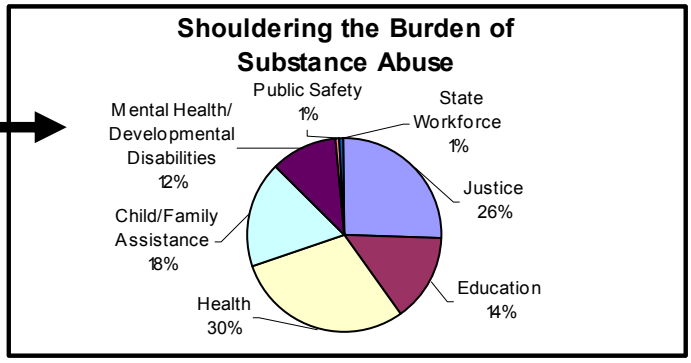
* Numbers may not add due to rounding.

Nebraska

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$615,726.8***		***12.0***	***$348.20***
Justice	**203,593.8**	**157,513.2**		**3.1**	**89.07**
Adult Corrections	133,580.3	104,439.2	78.2		
Juvenile Justice	20,990.5	16,069.7	76.6		
Judiciary	49,023.1	37,004.3	75.5		
Education (Elementary/Secondary)	**863,176.0**	**88,538.6**	**10.3**	**1.7**	**50.07**
Health	**582,203.7**	**182,365.9**	**31.3**	**3.6**	**103.13**
Child/Family Assistance	**182,173.5**	**108,688.6**		**2.1**	**61.46**
Child Welfare	146,188.7	103,195.0	70.6		
Income Assistance	35,984.8	5,493.7	15.3		
Mental Health/Developmental Disabilities	**154,118.2**	**70,591.4**		**1.4**	**39.92**
Mental Health	131,342.5	67,780.9	51.6		
Developmental Disabilities	22,775.7	2,810.5	12.3		
Public Safety	**19,402.1**	**4,877.6**	**25.1**	**0.1**	**2.76**
State Workforce	**1,021,313.4**	**3,151.5**	**0.3**	**0.1**	**1.78**
Regulation/Compliance	***934.2***	***934.2***	***100.0***	***0.0***	***0.53***
Licensing and Control	437.5	437.5			
Collection of Taxes	496.7	496.7			
Prevention, Treatment and Research	***12,523.3***	***12,523.3***	***100.0***	***0.2***	***7.08***
Prevention	3,020.0	3,020.0			
Treatment	7,786.3	7,786.3			
Research	NA	NA			
Unspecified	1,716.9	1,716.9			
Total		***$629,184.2***		***12.3***	***$355.81***





Total State Budget	$5,121 M
• Elementary and Secondary Education	$863 M
• Substance Abuse and Addiction	$629 M
• Medicaid	$557 M
• Higher Education	$1,469 M
• Transportation	$371 M
Population	1.8 M

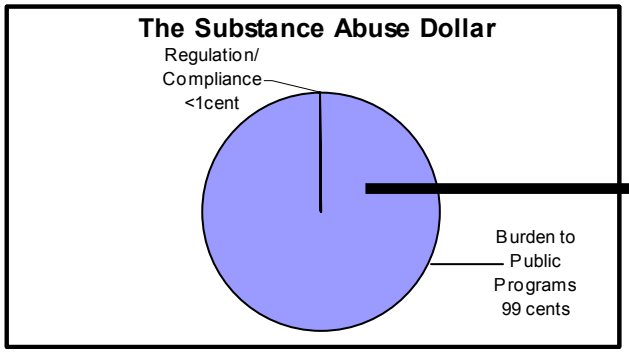
Tobacco and alcohol tax revenue total $95,538,000; $54.03 per capita.

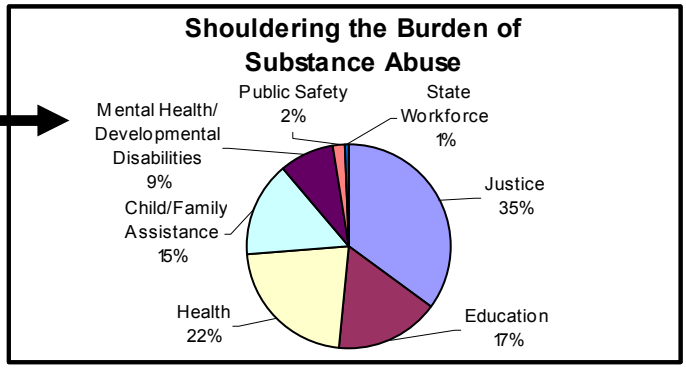
* Numbers may not add due to rounding.

Nevada

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita ($)
Burden Spending		***$757,361.2***		***14.9***	***$303.49***
Justice	**317,464.9**	**264,295.5**		**5.2**	**105.91**
Adult Corrections	275,362.9	229,676.9	83.4		
Juvenile Justice	188.4	154.6	82.1		
Judiciary	41,913.6	34,464.0	82.2		
Education (Elementary/Secondary)	**913,101.3**	**126,167.5**	**13.8**	**2.5**	**50.56**
Health	**472,000.0**	**168,006.0**	**35.6**	**3.3**	**67.32**
Child/Family Assistance	**170,785.3**	**114,523.8**		**2.3**	**45.89**
Child Welfare	139,955.8	107,906.5	77.1		
Income Assistance	30,829.5	6,617.3	21.5		
Mental Health/Developmental Disabilities	**148,599.8**	**65,468.2**		**1.3**	**26.23**
Mental Health	96,638.2	57,918.6	59.9		
Developmental Disabilities	51,961.6	7,549.5	14.5		
Public Safety	**52,622.6**	**14,213.9**	**27.0**	**0.3**	**5.70**
State Workforce	**1,083,994.0**	**4,686.2**	**0.4**	**0.1**	**1.88**
Regulation/Compliance	***411.7***	***411.7***	***100.0***	***0.0***	***0.16***
Licensing and Control	NA	NA			
Collection of Taxes	411.7	411.7			
Prevention, Treatment and Research	***4,342.5***	***4,342.5***	***100.0***	***0.1***	***1.74***
Prevention	NA	NA			
Treatment	NA	NA			
Research	NA	NA			
Unspecified	4,342.5	4,342.5			
Total		***$762,115.4***		***15.0***	***$305.39***





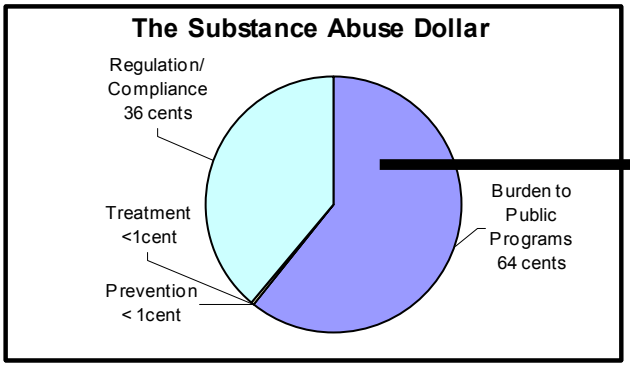
Total State Budget	$5,082 M
• Elementary and Secondary Education	$913 M
• Substance Abuse and Addiction	$762 M
• Medicaid	$460 M
• Higher Education	$627 M
• Transportation	$303 M
Population	2.5 M

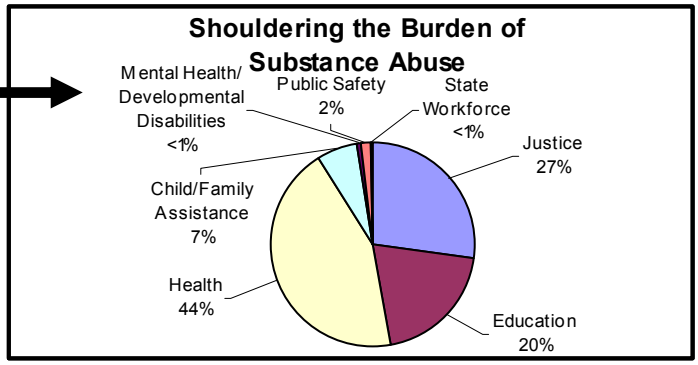
Tobacco and alcohol tax revenue total $172,969,000; $69.31 per capita.

* Numbers may not add due to rounding.

New Hampshire
Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita ($)
Burden Spending		***$535,844.6***		***18.3***	***$407.52***
Justice	**176,913.8**	**143,876.8**		**4.9**	**109.42**
Adult Corrections	74,080.8	60,276.0	81.4		
Juvenile Justice	30,264.6	24,185.7	79.9		
Judiciary	72,568.4	59,415.1	81.9		
Education (Elementary/Secondary)	**878,989.1**	**107,437.7**	**12.2**	**3.7**	**81.71**
Health	**864,373.4**	**237,663.8**	**27.5**	**8.1**	**180.75**
Child/Family Assistance	**73,605.6**	**35,306.4**		**1.2**	**26.85**
Child Welfare	38,390.3	28,607.4	74.5		
Income Assistance	35,215.3	6,699.0	19.0		
Mental Health/Developmental Disabilities	**910.0**	**499.9**		**<0.1**	**0.38**
Mental Health	880.0	497.3	56.5		
Developmental Disabilities	30.0	2.6	8.6		
Public Safety	**35,858.6**	**9,137.8**	**25.5**	**0.3**	**6.95**
State Workforce	**511,666.5**	**1,922.3**	**0.4**	**0.1**	**1.46**
Regulation/Compliance	***339,302.8***	***339,302.8***	***100.0***	***11.6***	***258.05***
Licensing and Control	2,368.8	2,368.8			
Collection of Taxes	NA	NA			
Liquor Store Expenses	336,934.0	336,934.0			
Prevention, Treatment and Research	***1,930.1***	***1,930.1***	***100.0***	***0.1***	***1.47***
Prevention	768.4	768.4			
Treatment	1,152.8	1,152.8			
Research	NA	NA			
Unspecified	8.9	8.9			
Total		***$877,077.5***		***30.0***	***$667.03***





Total State Budget	$2,928 M
• Elementary and Secondary Education	$879.0 M
• Substance Abuse and Addiction	$847 M
• Medicaid	$607 M
• Higher Education	$158 M
• Transportation	$264 M
Population	1.3 M

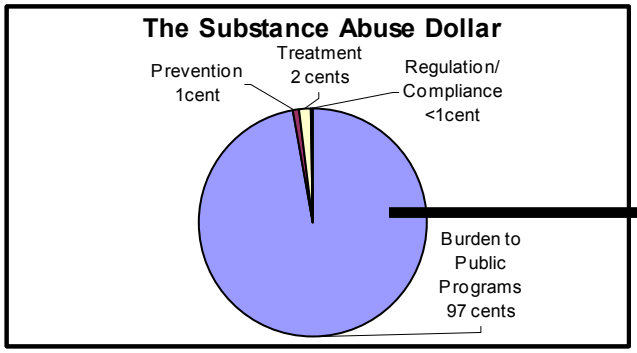
Tobacco and alcohol tax revenue total $113,962,000; $86.67 per capita.
Liquor store revenue total $401,000,000; $304.97 per capita.

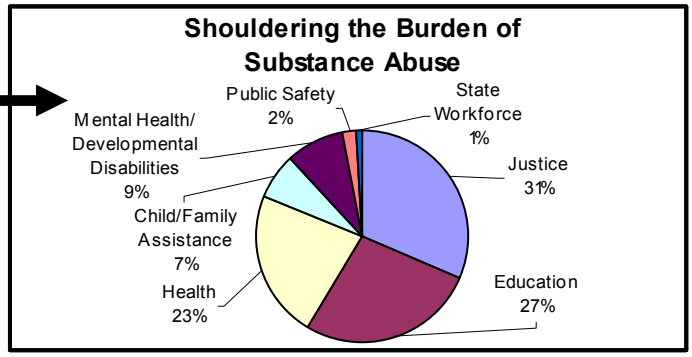
* Numbers may not add due to rounding.

New Jersey

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$3,779,957.2***		***11.7***	***$433.25***
Justice	**1,467,987.2**	**1,177,107.7**		**3.6**	**134.92**
Adult Corrections	975,215.0	785,693.0	80.6		
Juvenile Justice	206,891.0	163,586.4	79.1		
Judiciary	285,881.2	227,828.3	79.7		
Education (Elementary/Secondary)	**8,857,738.0**	**1,034,342.0**	**11.7**	**3.2**	**118.56**
Health	**3,424,631.0**	**852,408.6**	**24.9**	**2.6**	**97.70**
Child/Family Assistance	**668,682.4**	**264,851.0**		**0.8**	**30.36**
Child Welfare	259,585.0	190,847.0	73.5		
Income Assistance	409,097.4	74,004.1	18.1		
Mental Health/Developmental Disabilities	**1,281,604.0**	**339,673.5**		**1.1**	**38.93**
Mental Health	505,544.0	279,200.4	55.2		
Developmental Disabilities	776,060.0	60,473.2	7.8		
Public Safety	**342,779.0**	**84,346.3**	**24.6**	**0.3**	**9.67**
State Workforce	**7,631,852.3**	**27,228.0**	**0.4**	**0.1**	**3.12**
Regulation/Compliance	***8,813.0***	***8,813.0***	***100.0***	***0.0***	***1.01***
Licensing and Control	6,813.0	6,813.0			
Collection of Taxes	2,000.0	2,000.0			
Prevention, Treatment and Research	***101,867.0***	***101,867.0***	***100.0***	***0.3***	***11.68***
Prevention	28,802.0	28,802.0			
Treatment	71,406.0	71,406.0			
Research	NA	NA			
Unspecified	1,659.0	1,659.0			
Total		***$3,890,637.2***		***12.0***	***$445.94***





Total State Budget	$32,300 M
• Elementary and Secondary Education	$8,858 M
• Substance Abuse and Addiction	$3,891 M
• Medicaid	$3,772 M
• Higher Education	$3,081 M
• Transportation	$1,538 M
Population	8.7 M

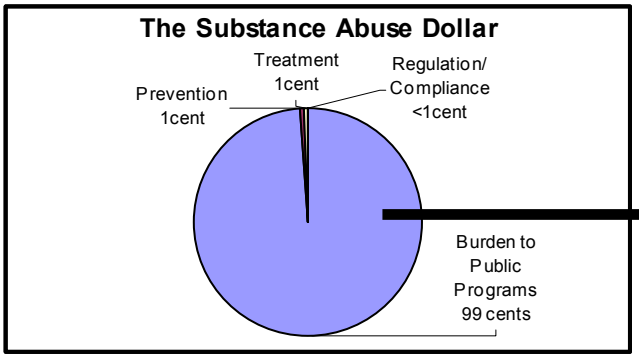
Tobacco and alcohol tax revenue total $899,501,000; $103.10 per capita.

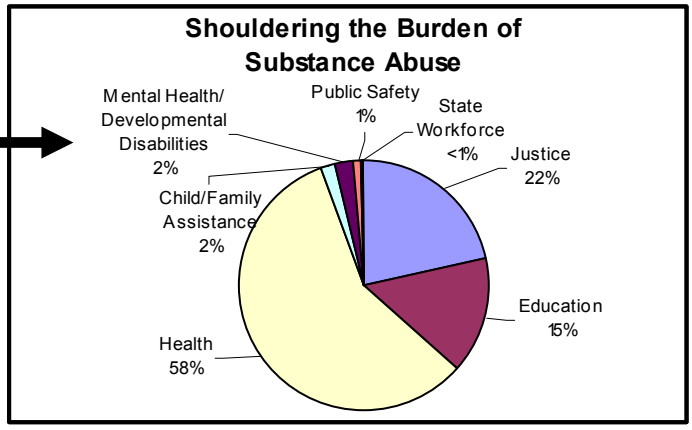
* Numbers may not add due to rounding.

New Mexico

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita ($)
Burden Spending		***$1,346,006.2***		***20.9***	***$688.64***
Justice	**375,387.5**	**291,309.9**		**4.5**	**149.04**
Adult Corrections	199,015.5	155,480.5	78.1		
Juvenile Justice	56,609.8	43,303.3	76.5		
Judiciary	119,762.2	92,526.1	77.3		
Education (Elementary/Secondary)	**1,974,906.4**	**201,936.6**	**10.2**	**3.1**	**103.31**
Health	**3,041,790.0**	**777,498.5**	**25.6**	**12.1**	**397.78**
Child/Family Assistance	**55,218.3**	**28,249.2**		**0.4**	**14.45**
Child Welfare	33,962.9	23,949.8	70.5		
Income Assistance	21,255.4	4,299.4	20.2		
Mental Health/Developmental Disabilities	**133,243.6**	**28,235.8**		**0.4**	**14.45**
Mental Health	40,360.7	20,793.3	51.5		
Developmental Disabilities	92,882.9	7,442.4	8.0		
Public Safety	**76,671.0**	**15,049.0**	**19.6**	**0.2**	**7.70**
State Workforce	**1,212,088.8**	**3,727.2**	**0.3**	**0.1**	**1.91**
Regulation/Compliance	***1,167.9***	***1,167.9***	***100.0***	***0.0***	***0.60***
Licensing and Control	848.5	848.5			
Collection of Taxes	319.4	319.4			
Prevention, Treatment and Research	***16,829.6***	***16,829.6***	***100.0***	***0.3***	***8.61***
Prevention	5,171.3	5,171.3			
Treatment	5,446.3	5,446.3			
Research	1,285.7	1,285.7			
Unspecified	4,926.3	4,926.3			
Total		***$1,364,003.7***		***21.2***	***$697.84***





Total State Budget	$6,439 M
• Elementary and Secondary Education	$1,975 M
• Substance Abuse and Addiction	$1,364 M
• Medicaid	$603 M
• Higher Education	$1,610 M
• Transportation	$544 M
Population	2.0 M

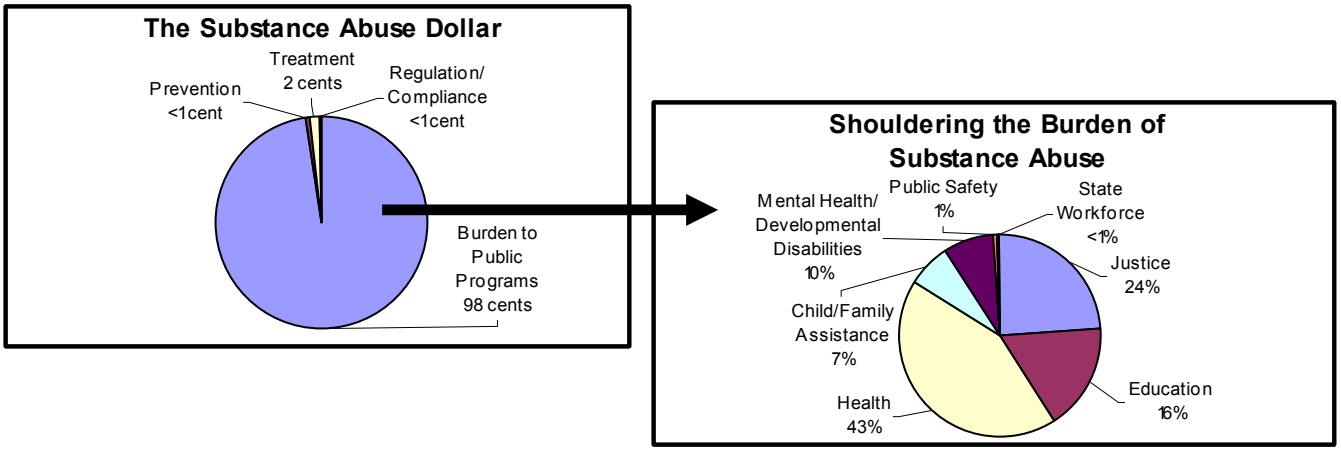
Tobacco and alcohol tax revenue total $83,104,000; $42.52 per capita.

* Numbers may not add due to rounding.

New York

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$13,131,778.1***		***21.1***	***$680.19***
Justice	**3,759,218.1**	**3,102,669.0**		**5.0**	**160.71**
Adult Corrections	2,770,658.0	2,284,269.2	82.4		
Juvenile Justice	245,338.7	198,867.8	81.1		
Judiciary	743,221.4	619,532.1	83.4		
Education (Elementary/Secondary)	**16,547,015.0**	**2,155,491.1**	**13.0**	**3.5**	**111.65**
Health	**19,057,416.8**	**5,581,196.0**	**29.3**	**9.0**	**289.09**
Child/Family Assistance	**2,382,629.1**	**897,594.5**		**1.4**	**46.49**
Child Welfare	880,150.5	667,824.4	75.9		
Income Assistance	1,502,478.6	229,770.2	15.3		
Mental Health/Developmental Disabilities	**3,336,415.9**	**1,247,211.8**		**2.0**	**64.60**
Mental Health	1,891,654.7	1,102,607.8	58.3		
Developmental Disabilities	1,444,761.2	144,604.0	10.0		
Public Safety	**484,778.0**	**94,166.1**	**19.4**	**0.2**	**4.88**
State Workforce	**13,231,000.0**	**53,449.4**	**0.4**	**0.1**	**2.77**
Regulation/Compliance	***21,720.0***	***21,720.0***	***100.0***	***0.0***	***1.13***
Licensing and Control	14,720.0	14,720.0			
Collection of Taxes	7,000.0	7,000.0			
Prevention, Treatment and Research	***287,641.0***	***287,641.0***	***100.0***	***0.5***	***14.90***
Prevention	49,577.0	49,577.0			
Treatment	238,063.9	238,063.9			
Research	NA	NA			
Total		***$13,441,139.0***		***21.6***	***$696.21***



Total State Budget	$62,180 M
• Elementary and Secondary Education	$16,547 M
• Substance Abuse and Addiction	$13,441 M
• Medicaid	$9,577 M
• Higher Education	$6,458 M
• Transportation	$2,613 M
Population	19.3 M

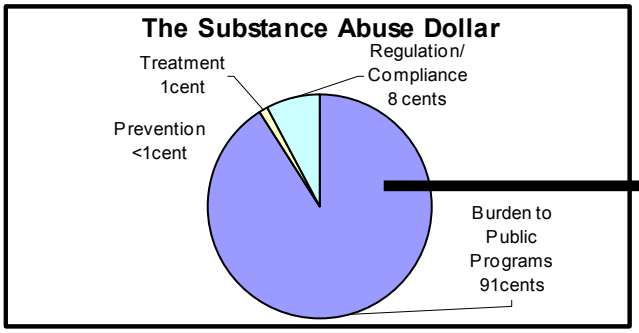
Tobacco and alcohol tax revenue total $1,160,559,000; $60.11 per capita.

* Numbers may not add due to rounding.

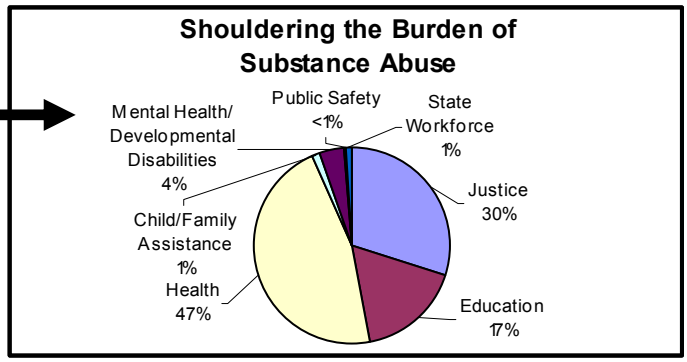
North Carolina

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita ($)
Burden Spending		***$4,226,952.3***		***17.6***	***$477.27***
Justice	**1,579,153.1**	**1,255,524.6**		**5.2**	**141.76**
Adult Corrections	1,122,759.8	889,826.0	79.3		
Juvenile Justice	138,215.8	107,370.3	77.7		
Judiciary	318,177.6	258,328.2	81.2		
Education (Elementary/Secondary)	**6,630,000.0**	**720,005.0**	**10.9**	**3.0**	**81.30**
Health	**8,348,626.3**	**1,966,500.6**	**23.6**	**8.2**	**222.04**
Child/Family Assistance	**157,071.1**	**55,914.7**		**0.2**	**6.31**
Child Welfare	71,112.5	51,128.1	71.9		
Income Assistance	85,958.6	4,786.6	5.6		
Mental Health/Developmental Disabilities	**445,869.6**	**175,706.4**		**0.7**	**19.84**
Mental Health	313,653.8	166,856.9	53.2		
Developmental Disabilities	132,215.8	8,849.5	6.7		
Public Safety	**147,939.3**	**19,844.4**	**13.4**	**0.1**	**2.24**
State Workforce	**10,174,087.0**	**33,456.6**	**0.3**	**0.1**	**3.78**
Regulation/Compliance	***363,945.0***	***363,945.0***	***100.0***	***1.5***	***41.09***
Licensing and Control	NA	NA			
Collection of Taxes	NA	NA			
Liquor Store Expenses	363,945.0	363,945.0			
Prevention, Treatment and Research	***45,637.3***	***45,637.3***	***100.0***	***0.2***	***5.15***
Prevention	750.0	750.0			
Treatment	35,279.4	35,279.4			
Research	NA	NA			
Unspecified	9,607.9	9,607.9			
Total		***$4,636,534.6***		***19.3***	***$523.52***



Total State Budget	$24,074 M
• Elementary and Secondary Education	$6,630 M
• Substance Abuse and Addiction	$4,646 M
• Medicaid	$2,881 M
• Transportation	$2,613 M
• Higher Education	$4,295 M
Population	8.9 M



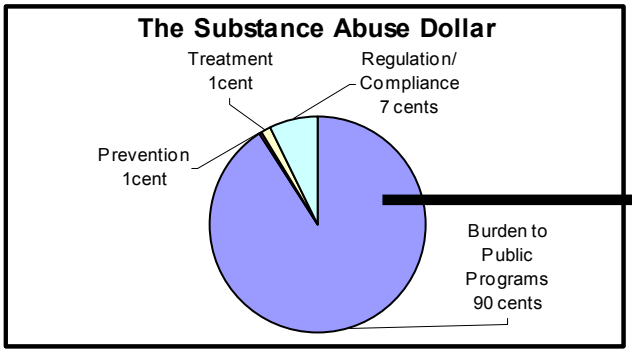
Tobacco and alcohol tax revenue total $263,527,000; $29.76 per capita.
Liquor store revenue total $437,908,000; $49.44 per capita.

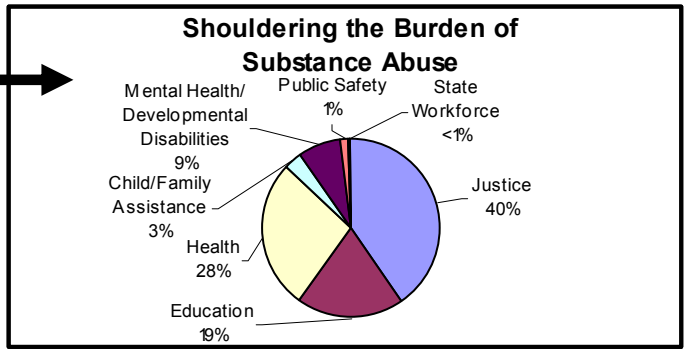
* Numbers may not add due to rounding.

Ohio

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$4,864,834.2***		***11.8***	***$423.84***
Justice	**2,407,913.8**	**1,948,433.2**		**4.7**	**169.75**
Adult Corrections	1,969,526.7	1,597,102.4	81.1		
Juvenile Justice	254,499.6	202,641.8	79.6		
Judiciary	183,887.6	148,689.0	80.9		
Education (Elementary/Secondary)	**7,634,676.4**	**918,525.0**	**12.0**	**2.2**	**80.02**
Health	**4,372,063.1**	**1,347,296.2**	**30.8**	**3.3**	**117.38**
Child/Family Assistance	**463,803.4**	**155,864.7**		**0.4**	**13.58**
Child Welfare	97,549.9	72,356.4	74.2		
Income Assistance	366,253.5	83,508.3	22.8		
Mental Health/Developmental Disabilities	**1,081,220.3**	**413,708.6**		**1.0**	**36.04**
Mental Health	652,492.9	365,808.3	56.1		
Developmental Disabilities	428,727.4	47,900.2	11.2		
Public Safety	**282,729.4**	**70,016.1**	**24.8**	**0.2**	**6.10**
State Workforce	**2,978,377.5**	**10,990.4**	**0.4**	**0.0**	**0.96**
Regulation/Compliance	***395,457.9***	***395,457.9***	***100.0***	***1.0***	***34.45***
Licensing and Control	6,932.4	6,932.4			
Collection of Taxes	1,218.5	1,218.5			
Liquor Store Expenses	387,307.0	387,307.0			
Prevention, Treatment and Research	***118,772.2***	***118,772.2***	***100.0***	***0.3***	***10.34***
Prevention	20,707.9	20,707.9			
Treatment	54,237.9	54,237.9			
Research	17,876.7	17,876.7			
Unspecified	25,899.7	25,899.7			
Total		***$5,379,014.3***		***13.0***	***$468.64***





Total State Budget	$41,309 M
• Elementary and Secondary Education	$7,635 M
• Substance Abuse and Addiction	$5,379 M
• Medicaid	$10,772 M
• Higher Education	$2,452 M
• Transportation	$2,728 M
Population	11.5 M

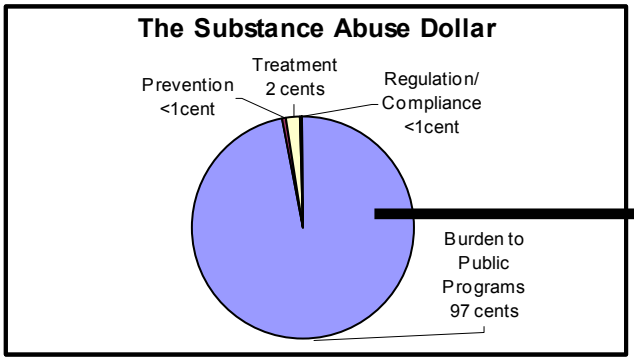
Tobacco and alcohol tax revenue total $669,031,000; $58.29 per capita.
Liquor store revenue total $617,668,000; $53.81 per capita.

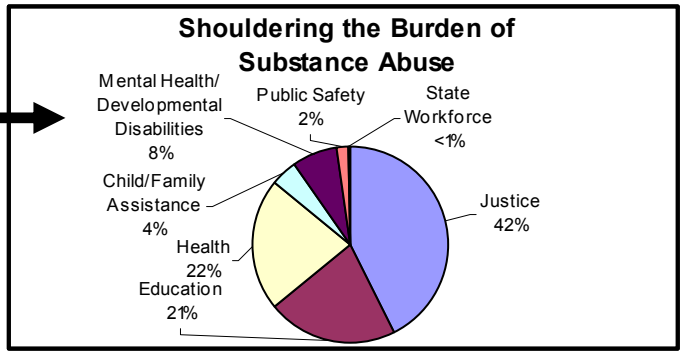
* Numbers may not add due to rounding.

Oklahoma

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$998,920.9***		***11.8***	***$279.09***
Justice	**541,375.6**	**422,983.3**		**5.0**	**118.18**
Adult Corrections	410,167.0	323,062.7	78.8		
Juvenile Justice	92,858.2	71,655.8	77.2		
Judiciary	38,350.5	28,264.8	73.7		
Education (Elementary/Secondary)	**2,009,000.0**	**212,496.2**	**10.6**	**2.5**	**59.37**
Health	**884,873.2**	**221,718.9**	**25.1**	**2.6**	**61.95**
Child/Family Assistance	**104,446.0**	**44,240.2**		**0.5**	**12.36**
Child Welfare	44,326.2	31,603.2	71.3		
Income Assistance	60,119.7	12,636.9	21.0		
Mental Health/Developmental Disabilities	**227,287.7**	**76,187.4**		**0.9**	**21.29**
Mental Health	131,932.7	69,214.4	52.5		
Developmental Disabilities	95,355.0	6,973.0	7.3		
Public Safety	**73,655.9**	**18,065.8**	**24.5**	**0.2**	**5.05**
State Workforce	**1,011,331.9**	**3,229.2**	**0.3**	**0.0**	**0.90**
Regulation/Compliance	***4,053.8***	***4,053.8***	***100.0***	***0.0***	***1.13***
Licensing and Control	1,931.3	1,931.3			
Collection of Taxes	2,122.6	2,122.6			
Prevention, Treatment and Research	***23,579.3***	***23,579.3***	***100.0***	***0.3***	***6.59***
Prevention	4,103.5	4,103.5			
Treatment	18,431.8	18,431.8			
Research	211.1	211.1			
Unspecified	833.0	833.0			
Total		***$1,026,554.1***		***12.2***	***$286.81***





Total State Budget	$8,448 M
• Elementary and Secondary Education	$2,009 M
• Substance Abuse and Addiction	$1,027 M
• Medicaid	$866 M
• Higher Education	$2,081 M
• Transportation	$572 M
Population	3.6M

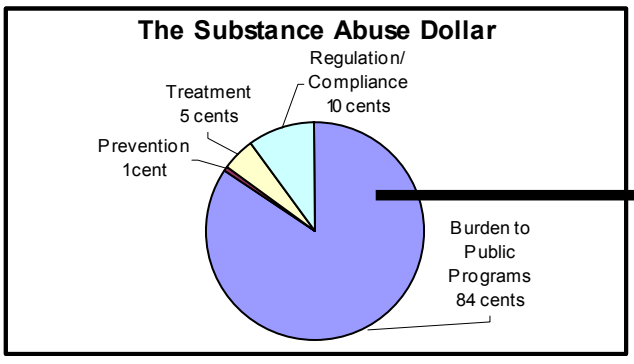
Tobacco and alcohol tax revenue total $198,749,000; $55.53 per capita.

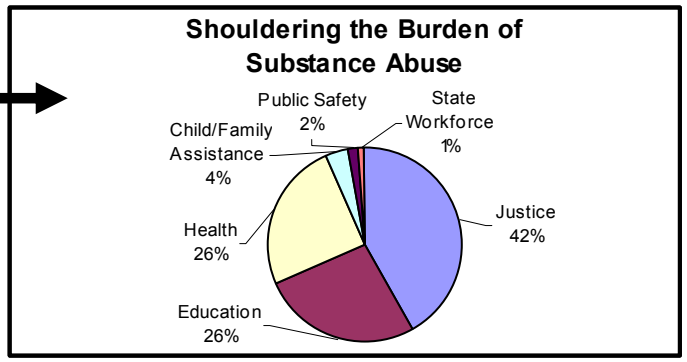
* Numbers may not add due to rounding.

Oregon

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,461,714.9***		***9.5***	***394.98***
Justice	**720,077.3**	**610,665.0**		**4.0**	**165.01**
Adult Corrections	557,805.7	475,019.0	85.2		
Juvenile Justice	121,211.4	101,750.4	83.9		
Judiciary	41,060.2	33,895.6	82.6		
Education (Elementary/Secondary)	**2,488,000.0**	**384,853.9**	**15.5**	**2.5**	**103.99**
Health	**1,250,000.0**	**374,063.0**	**29.9**	**2.4**	**101.08**
Child/Family Assistance	**71,071.9**	**51,879.3**		**0.3**	**14.02**
Child Welfare	62,071.9	49,254.5	79.4		
Income Assistance	9,000.0	2,624.8	29.2		
Mental Health/Developmental Disabilities	**NA**	**NA**		**NA**	**NA**
Mental Health	NA	NA	NA		
Developmental Disabilities	NA	NA	NA		
Public Safety	**146,924.1**	**29,650.4**	**20.2**	**0.2**	**8.01**
State Workforce	**2,150,267.3**	**10,603.3**	**0.5**	**0.1**	**2.87**
Regulation/Compliance	***174,316.1***	***174,316.1***	***100.0***	***1.1***	***47.10***
Licensing and Control	19,167.1	19,167.1			
Collection of Taxes	NA	NA			
Liquor Store Expenses	155,149.0	155,149.0			
Prevention, Treatment and Research	***96,221.0***	***96,221.0***	***100.0***	***0.6***	***26.00***
Prevention	9,830.6	9,830.6			
Treatment	82,340.3	82,340.3			
Research	NA	NA			
Unspecified	4,050.1	4,050.1			
Total		***$1,732,251.9***		***11.3***	***$468.08***





Total State Budget	$15,340 M
• Elementary and Secondary Education	$2,488 M
• Substance Abuse and Addiction	$1,732 M
• Medicaid	$1,225 M
• Higher Education	$2,361 M
• Transportation	$1,601 M
Population	3.7 M

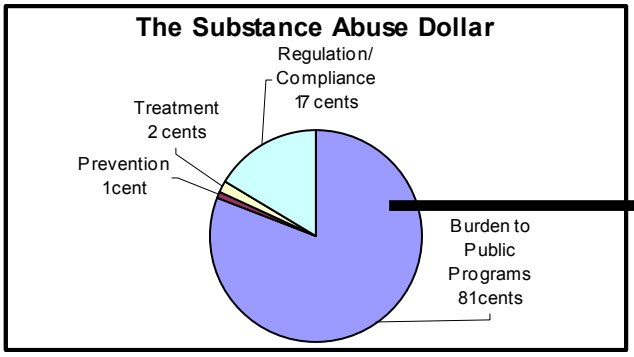
Tobacco and alcohol tax revenue total $257,301,000; $69.53 per capita.
Liquor store revenue total $309,649,000; $83.67 per capita.

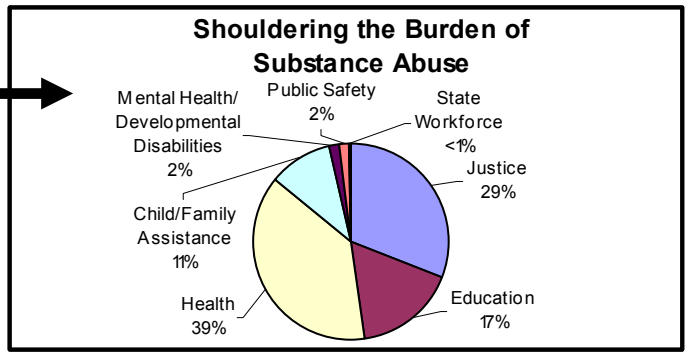
* Numbers may not add due to rounding.

Pennsylvania

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$5,344,357.7***		***15.9***	***$429.59***
Justice	**1,955,408.9**	**1,572,366.4**		**4.7**	**126.39**
Adult Corrections	1,409,585.4	1,141,889.6	81.0		
Juvenile Justice	94,188.9	74,915.1	79.5		
Judiciary	451,634.5	355,561.7	78.7		
Education (Elementary/Secondary)	**7,694,150.0**	**921,353.7**	**12.0**	**2.7**	**74.06**
Health	**6,955,317.1**	**2,086,122.9**	**30.0**	**6.2**	**167.69**
Child/Family Assistance	**1,222,291.8**	**566,571.3**		**1.7**	**45.54**
Child Welfare	624,449.3	462,540.1	74.1		
Income Assistance	597,842.5	104,031.3	17.4		
Mental Health/Developmental Disabilities	**776,519.2**	**85,655.7**		**0.3**	**6.89**
Mental Health	9,958.0	5,569.7	55.9		
Developmental Disabilities	766,561.2	80,086.0	10.4		
Public Safety	**328,297.0**	**94,025.0**	**28.6**	**0.3**	**7.56**
State Workforce	**4,975,462.6**	**18,262.6**	**0.4**	**0.1**	**1.47**
Regulation/Compliance	***1,102,435.6***	***1,102,435.6***	***100.0***	***3.3***	***88.62***
Licensing and Control	1,044.6	1,044.6			
Collection of Taxes	19,884.0	19,884.0			
Liquor Store Expenses	1,081,507.0	1,081,507.0			
Prevention, Treatment and Research	***188,216.1***	***188,216.1***	***100.0***	***0.6***	***15.13***
Prevention	51,727.3	51,727.3			
Treatment	87,582.3	87,582.3			
Research	NA	NA			
Unspecified	48,906.5	48,906.5			
Total		***$6,635,009.3***		***19.8***	***$533.33***





Total State Budget	$33,589 M
• Elementary and Secondary Education	$7,694 M
• Substance Abuse and Addiction	$6,635 M
• Medicaid	$7,518 M
• Higher Education	$1,913 M
• Transportation	$3,221 M
Population	12.4 M

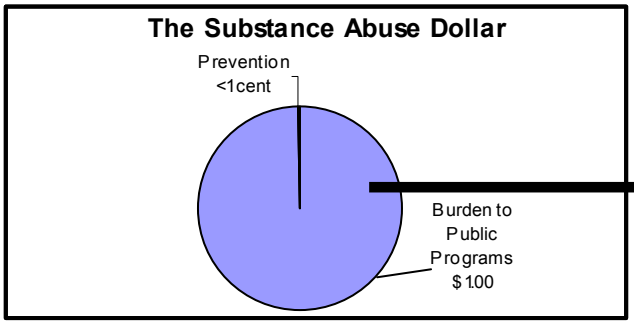
Tobacco and alcohol tax revenue total $1,267,917,000; $101.92 per capita
Liquor store revenue total $1,171,179,000; $94.14 per capita.

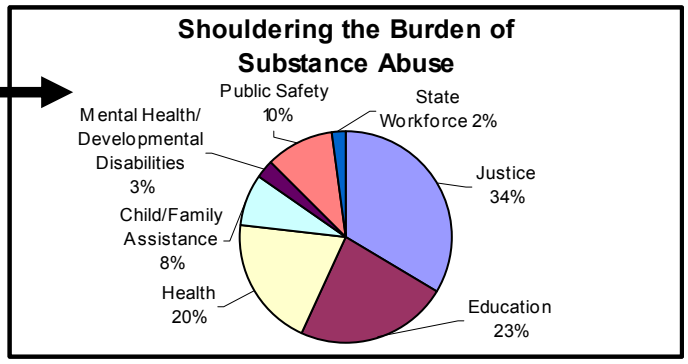
* Numbers may not add due to rounding.

Puerto Rico

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$1,261,117.5***		***14.2***	***$321.12***
Justice	**522,103.0**	**423,461.0**		**4.8**	**107.83**
Adult Corrections	432,733.0	352,051.1	81.4		
Juvenile Justice	89,370.0	71,409.9	79.9		
Judiciary	NA	NA	NA		
Education (Elementary/Secondary)	**2,382,651.0**	**291,059.8**	**12.2**	**3.3**	**74.11**
Health	**938,640.0**	**253,352.6**	**27.0**	**2.8**	**64.51**
Child/Family Assistance	**148,777.8**	**99,624.6**		**1.1**	**25.37**
Child Welfare	126,626.4	94,342.7	74.5		
Income Assistance	22,151.5	5,281.9	23.8		
Mental Health/Developmental Disabilities	**90,395.5**	**37,538.2**		**0.4**	**9.56**
Mental Health	60,730.0	34,306.4	56.5		
Developmental Disabilities	29,665.5	3,231.8	10.9		
Public Safety	**605,056.0**	**126,386.5**	**20.9**	**1.4**	**32.18**
State Workforce	**7,909,334.0**	**29,694.8**	**0.4**	**0.3**	**7.56**
Regulation/Compliance	***NA***	***NA***	***NA***	***NA***	***NA***
Licensing and Control	NA	NA			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***2,497.0***	***2,497.0***	***100.0***	***<0.1***	***.64***
Prevention	2,497.0	2,497.0			
Treatment	NA	NA			
Research	NA	NA			
Total		***$1,263,614.5***		***14.2***	***$321.76***





Total State Budget	$8,908 M
• Elementary and Secondary Education	$2,383 M
• Substance Abuse and Addiction	$1,264 M
• Medicaid	$NA M
• Higher Education	$NA M
• Transportation	$NA M
Population	3.9 M

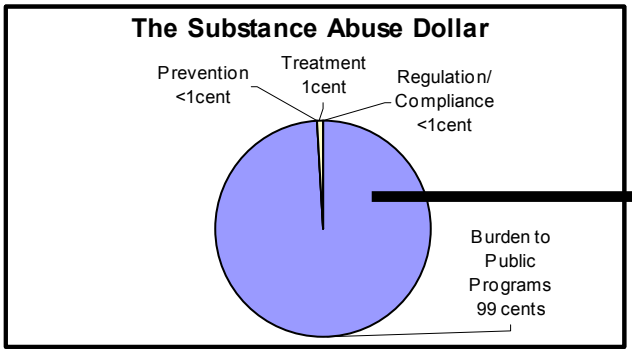
Tobacco and alcohol tax revenue total $NA; $NA per capita.

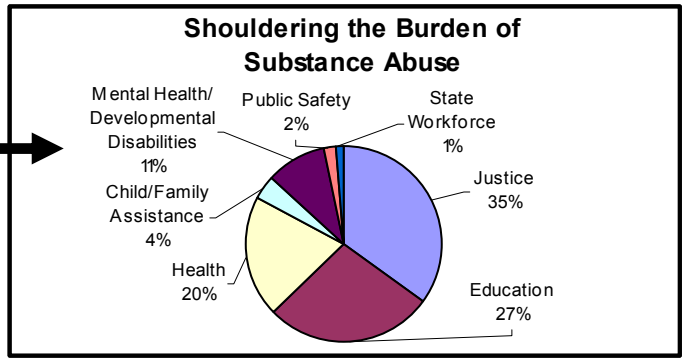
* Numbers may not add due to rounding.

South Carolina

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$934,172.7***		***8.5***	***$216.18***
Justice	**410,107.7**	**324,912.0**		**2.9**	**75.19**
Adult Corrections	295,568.7	233,049.2	78.8		
Juvenile Justice	69,664.4	53,819.6	77.3		
Judiciary	44,874.5	38,043.2	84.8		
Education (Elementary/Secondary)	**2,410,258.2**	**256,087.4**	**10.6**	**2.3**	**59.26**
Health	**678,824.2**	**184,382.4**	**27.2**	**1.7**	**42.67**
Child/Family Assistance	**85,444.5**	**39,194.9**		**0.4**	**9.07**
Child Welfare	49,068.9	35,035.1	71.4		
Income Assistance	36,375.5	4,159.8	11.4		
Mental Health/Developmental Disabilities	**302,721.1**	**99,467.2**		**0.9**	**23.02**
Mental Health	165,895.1	87,239.8	52.6		
Developmental Disabilities	136,826.0	12,227.4	8.9		
Public Safety	**76,746.4**	**17,628.3**	**23.0**	**0.2**	**4.08**
State Workforce	**3,895,315.1**	**12,500.4**	**0.3**	**0.1**	**2.89**
Regulation/Compliance	***614.3***	***614.3***	***100.0***	***0.0***	***0.14***
Licensing and Control	305.0	305.0			
Collection of Taxes	309.4	309.4			
Prevention, Treatment and Research	***6,022.2***	***6,022.2***	***100.0***	***0.1***	***1.39***
Prevention	9.9	9.9			
Treatment	4,493.4	4,493.4			
Research	28.1	28.1			
Unspecified	1,490.7	1,490.7			
Total		***$940,809.2***		***8.5***	***$217.72***





Total State Budget	$11,053 M
• Elementary and Secondary Education	$2,410 M
• Substance Abuse and Addiction	$941 M
• Medicaid	$1,294 M
• Higher Education	$2,803 M
• Transportation	$1,394 M
Population	4.3 M

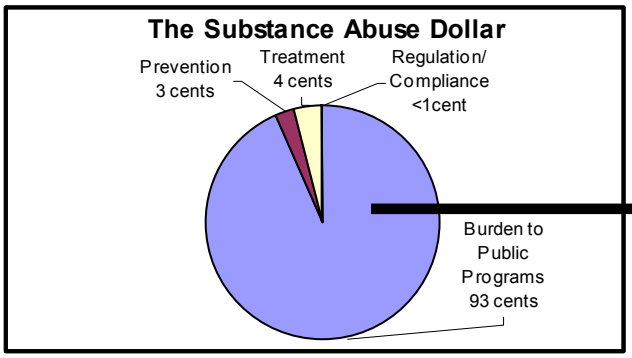
Tobacco and alcohol tax revenue total $171,437,000; $39.67 per capita.

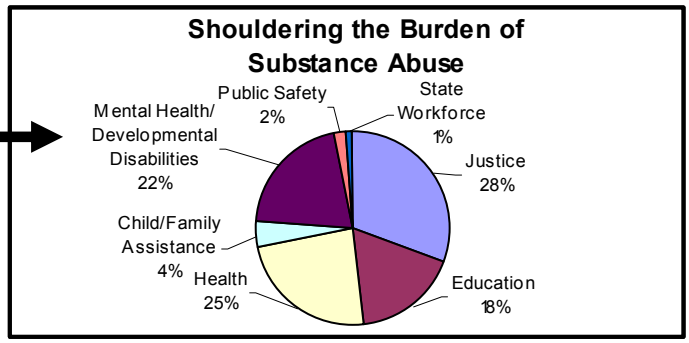
* Numbers may not add due to rounding.

South Dakota

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$180,017.7***		***8.1***	***$230.23***
Justice	**65,502.2**	**51,038.3**		**2.3**	**65.27**
Adult Corrections	45,306.3	34,900.3	77.0		
Juvenile Justice	NA	NA	NA		
Judiciary	20,195.9	16,138.0	79.9		
Education (Elementary/Secondary)	**333,317.4**	**32,206.6**	**9.7**	**1.5**	**41.19**
Health	**153,369.4**	**44,010.3**	**28.7**	**2.0**	**56.29**
Child/Family Assistance	**15,284.7**	**7,822.7**		**0.4**	**10.00**
Child Welfare	9,755.3	6,750.1	69.2		
Income Assistance	5,529.4	1,072.6	19.4		
Mental Health/Developmental Disabilities	**156,905.4**	**39,457.5**		**1.8**	**50.46**
Mental Health	58,549.0	29,244.1	50.0		
Developmental Disabilities	98,356.4	10,213.4	10.4		
Public Safety	**16,512.7**	**3,305.1**	**20.0**	**0.2**	**4.23**
State Workforce	**646,665.9**	**2,177.2**	**0.3**	**0.1**	**2.78**
Regulation/Compliance	***140.1***	***140.1***	***100.0***	***0.0***	***0.18***
Licensing and Control	NA	NA			
Collection of Taxes	140.1	140.1			
Prevention, Treatment and Research	***13,143.8***	***13,143.8***	***100.0***	***0.6***	***16.81***
Prevention	4,266.2	4,266.2			
Treatment	6,294.3	6,294.3			
Research	303.2	303.2			
Unspecified	2,280.1	2,280.1			
Total		***$193,301.6***		***8.7***	***$247.21***





Total State Budget	$2,219 M
• Elementary and Secondary Education	$333 M
• Substance Abuse and Addiction	$200 M
• Medicaid	$204 M
• Transportation	$195 M
• Higher Education	$529 M
Population	.78 M

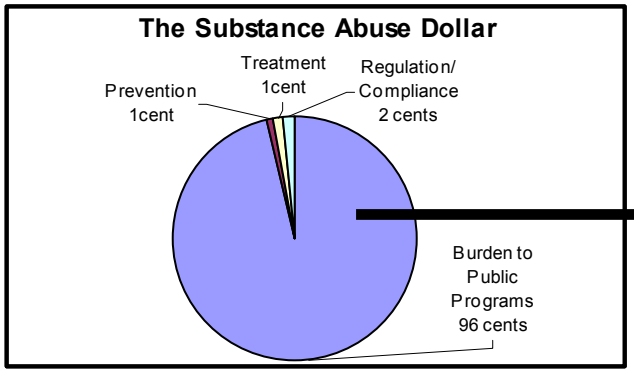
Tobacco and alcohol tax revenue total $40,787,000; $52.16 per capita.

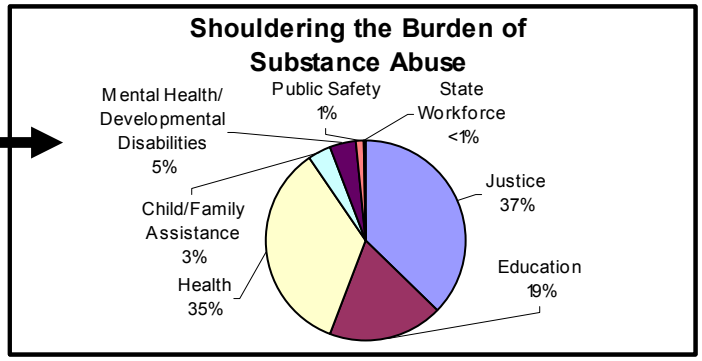
* Numbers may not add due to rounding.

Texas

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$6,399,871.5***		***15.8***	***$272.24***
Justice	**3,022,605.4**	**2,379,800.4**		**5.9**	**101.23**
Adult Corrections	2,343,922.6	1,853,567.4	79.1		
Juvenile Justice	248,476.3	192,569.0	77.5		
Judiciary	430,206.5	333,664.0	77.6		
Education (Elementary/Secondary)	**11,026,895.9**	**1,186,300.6**	**10.8**	**2.9**	**50.46**
Health	**7,706,364.9**	**2,230,158.7**	**28.9**	**5.5**	**94.87**
Child/Family Assistance	**367,344.8**	**217,755.3**		**0.5**	**9.26**
Child Welfare	276,828.6	198,442.1	71.7		
Income Assistance	90,516.2	19,313.2	21.3		
Mental Health/Developmental Disabilities	**543,006.8**	**287,431.6**		**0.7**	**12.23**
Mental Health	542,979.7	287,428.6	52.9		
Developmental Disabilities	27.1	3.0	11.0		
Public Safety	**241,608.5**	**77,160.9**	**31.9**	**0.2**	**3.28**
State Workforce	**6,534,606.7**	**21,264.0**	**0.3**	**0.1**	**0.90**
Regulation/Compliance	***115,296.3***	***115,296.3***	***100.0***	***0.3***	***4.90***
Licensing and Control	34,433.5	34,433.5			
Collection of Taxes	80,862.9	80,862.9			
Prevention, Treatment and Research	***126,583.0***	***126,583.0***	***100.0***	***0.3***	***5.38***
Prevention	14,409.0	14,409.0			
Treatment	16,812.3	16,812.3			
Research	2,252.8	2,252.8			
Unspecified	93,108.9	93,108.9			
Total		***$6,641,750.8***		***16.4***	***$282.53***





Total State Budget	$40,481 M
• Elementary and Secondary Education	$11,027 M
• Substance Abuse and Addiction	$6,642 M
• Medicaid	$7,147 M
• Higher Education	$7,506 M
• Transportation	$2,639 M
Population	23.5 M

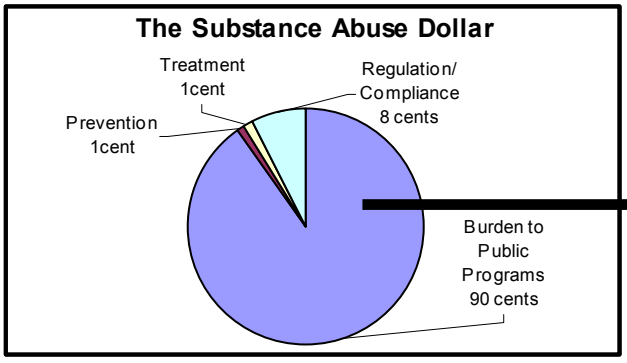
Tobacco and alcohol tax revenue total $1,225,746,000; $52.14 per capita.

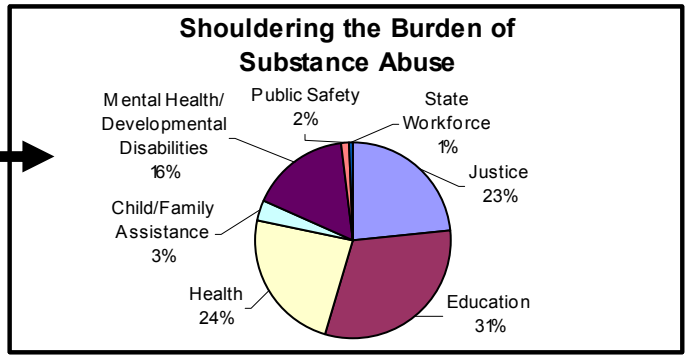
* Numbers may not add due to rounding.

Vermont

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$485,869.0***		***18.4***	***$778.75***
Justice	**136,109.8**	**113,908.5**		**4.3**	**182.57**
Adult Corrections	100,992.8	84,699.7	83.9		
Juvenile Justice	171.4	141.5	82.6		
Judiciary	34,945.6	29,067.3	83.2		
Education (Elementary/Secondary)	**1,066,091.3**	**151,610.6**	**14.2**	**5.7**	**243.00**
Health	**362,530.1**	**114,669.8**	**31.6**	**4.3**	**183.79**
Child/Family Assistance	**46,025.0**	**16,096.3**		**0.6**	**25.80**
Child Welfare	12,566.4	9,762.4	77.7		
Income Assistance	33,458.6	6,333.9	18.9		
Mental Health/Developmental Disabilities	**191,634.4**	**79,719.4**		**3.0**	**127.77**
Mental Health	117,504.5	71,366.4	60.7		
Developmental Disabilities	74,429.9	8,353.0	11.2		
Public Safety	**28,724.9**	**7,437.4**	**25.9**	**0.3**	**11.92**
State Workforce	**543,000.0**	**2,427.0**	**0.4**	**0.1**	**3.89**
Regulation/Compliance	***40,948.0***	***40,948.0***	***100.0***	***1.5***	***65.63***
Licensing and Control	4,054.0	4,054.0			
Collection of Taxes	72.0	72.0			
Liquor Store Expenses	36,822.0	36,822.0			
Prevention, Treatment and Research	***11,895.6***	***11,895.6***	***100.0***	***0.4***	***19.07***
Prevention	3,213.6	3,213.6			
Treatment	4,479.6	4,479.6			
Research	561.7	561.7			
Unspecified	3,640.7	3,640.7			
Total		***$538,712.6***		***20.4***	***$863.45***





Total State Budget	$2,645 M
• Elementary and Secondary Education	$1,066 M
• Substance Abuse and Addiction	$539 M
• Medicaid	$330 M
• Higher Education	$115 M
• Transportation	$187 M
Population	.62 M

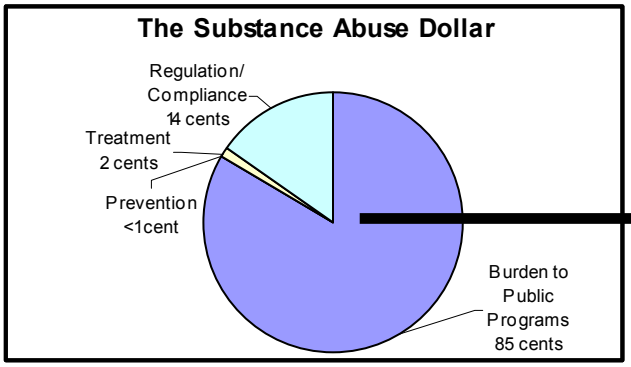
Tobacco and alcohol tax revenue total $66,238,000; $106.17 per capita.
Liquor store revenue total $37,759,000; $60.52 per capita.

* Numbers may not add due to rounding.

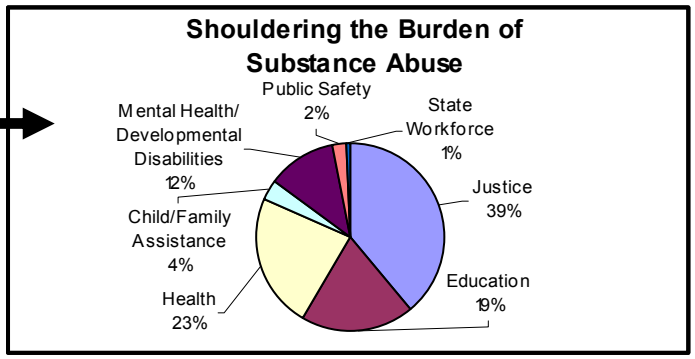
Virginia

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,378,551.1***		***9.4***	***$311.21***
Justice	**1,197,310.0**	**924,390.1**		**3.7**	**120.95**
Adult Corrections	765,993.9	587,771.2	76.7		
Juvenile Justice	204,186.0	153,205.0	75.0		
Judiciary	227,130.1	183,413.9	80.8		
Education (Elementary/Secondary)	**4,852,667.0**	**461,816.7**	**9.5**	**1.8**	**60.42**
Health	**2,148,769.5**	**554,214.5**	**25.8**	**2.2**	**72.51**
Child/Family Assistance	**253,527.8**	**87,359.9**		**0.3**	**11.43**
Child Welfare	85,357.8	58,756.0	68.8		
Income Assistance	168,170.0	28,604.0	17.0		
Mental Health/Developmental Disabilities	**963,714.4**	**274,756.4**		**1.1**	**35.95**
Mental Health	469,737.6	232,651.5	49.5		
Developmental Disabilities	493,976.8	42,104.8	8.5		
Public Safety	**169,759.8**	**57,627.9**	**33.9**	**0.2**	**7.54**
State Workforce	**6,473,255.8**	**18,385.6**	**0.3**	**0.1**	**2.41**
Regulation/Compliance	***378,919.7***	***378,919.7***	***100.0***	***1.5***	***49.58***
Licensing and Control	12,288.7	12,288.7			
Collection of Taxes	NA	NA			
Liquor Store Expenses	366,631.0	366,631.0			
Prevention, Treatment and Research	***43,195.9***	***43,195.9***	***100.0***	***0.2***	***5.65***
Prevention	600.0	600.0			
Treatment	39,610.7	39,610.7			
Research	NA	NA			
Unspecified	2,985.2	2,985.2			
Total		***$2,800,666.7***		***11.1***	***$366.44***



Total State Budget	$25,214 M
• Elementary and Secondary Education	$4,853 M
• Substance Abuse and Addiction	$2,801 M
• Medicaid	$2,218 M
• Higher Education	$3,262 M
• Transportation	$2,861 M
Population	7.6 M



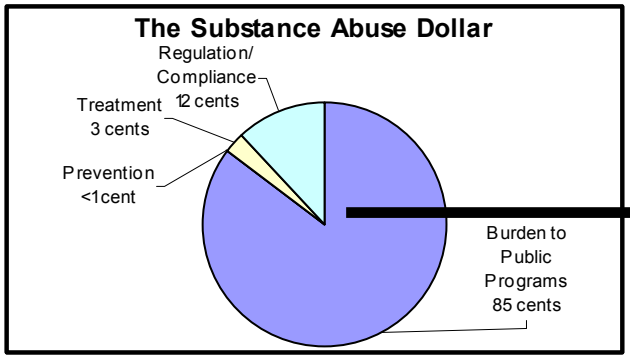
Tobacco and alcohol tax revenue total $255,217,000; $33.39 per capita
Liquor store revenue total $439,340,000; $57.48 per capita.

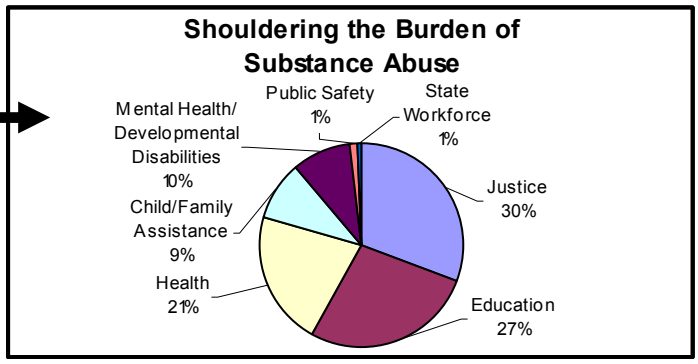
* Numbers may not add due to rounding.

Washington

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,746,056.4***		***13.4***	***$429.35***
Justice	**1,011,937.4**	**834,477.4**		**4.1**	**130.47**
Adult Corrections	875,488.5	722,810.4	82.6		
Juvenile Justice	88,868.2	72,144.4	81.2		
Judiciary	47,580.7	39,522.5	83.1		
Education (Elementary/Secondary)	**5,646,597.0**	**740,699.3**	**13.1**	**3.6**	**115.81**
Health	**2,231,719.0**	**582,122.1**	**26.1**	**2.8**	**91.02**
Child/Family Assistance	**534,369.5**	**255,496.3**		**1.2**	**39.95**
Child Welfare	245,032.0	186,279.9	76.0		
Income Assistance	289,337.5	69,216.4	23.9		
Mental Health/Developmental Disabilities	**1,155,183.3**	**282,771.3**		**1.4**	**44.21**
Mental Health	372,777.9	218,011.4	58.5		
Developmental Disabilities	782,405.4	64,759.9	8.3		
Public Safety	**198,712.8**	**36,498.3**	**18.4**	**0.2**	**5.71**
State Workforce	**3,435,992.7**	**13,991.8**	**0.4**	**0.1**	**2.19**
Regulation/Compliance	***381,127.4***	***381,127.4***	***100.0***	***1.9***	***59.59***
Licensing and Control	NA	NA			
Collection of Taxes	1,888.4	1,888.4			
Liquor Store Expenses	379,239.0	379,239.0			
Prevention, Treatment and Research	***90,571.6***	***90,571.6***	***100.0***	***0.4***	***14.16***
Prevention	3,308.0	3,308.0			
Treatment	77,473.0	77,473.0			
Research	NA	NA			
Unspecified	9,790.6	9,790.6			
Total		***$3,217,755.5***		***15.6***	***$503.10***





Total State Budget	$20,562 M
• Elementary and Secondary Education	$5,647 M
• Substance Abuse and Addiction	$3,218 M
• Medicaid	$3,003 M
• Higher Education	$4,465 M
• Transportation	$1,532 M
Population	6.4 M

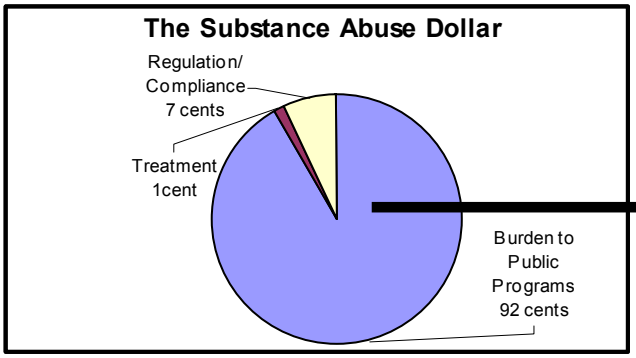
Tobacco and alcohol tax revenue total $553,440,000; $86.53 per capita
Liquor store revenue total $465,896,000; $72.84 per capita.

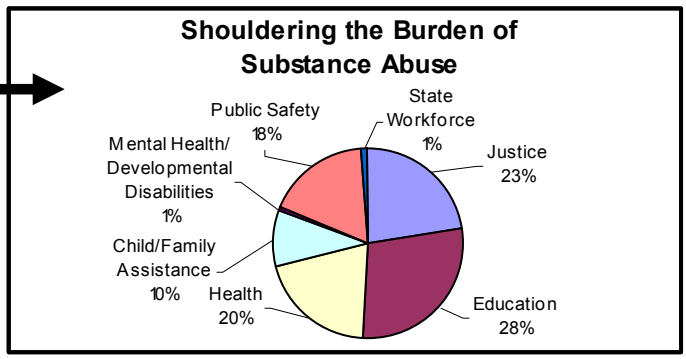
* Numbers may not add due to rounding.

West Virginia

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$704,810.2***		***5.0***	***$387.58***
Justice	**204,220.8**	**161,103.1**		**1.2**	**88.59**
Adult Corrections	122,963.0	95,785.4	77.9		
Juvenile Justice	33,287.9	25,383.9	76.3		
Judiciary	47,970.0	39,933.8	83.2		
Education (Elementary/Secondary)	**1,945,819.1**	**196,610.3**	**10.1**	**1.4**	**108.12**
Health	**543,946.9**	**140,764.5**	**25.9**	**1.0**	**77.41**
Child/Family Assistance	**131,356.2**	**67,528.2**		**0.5**	**37.13**
Child Welfare	81,935.0	57,552.4	70.2		
Income Assistance	49,421.2	9,975.7	20.2		
Mental Health/Developmental Disabilities	**41,732.2**	**6,629.3**		**0.0**	**3.65**
Mental Health	7,900.3	4,044.0	51.2		
Developmental Disabilities	33,831.9	2,585.3	7.6		
Public Safety	**825,696.0**	**125,175.2**	**15.2**	**0.9**	**68.84**
State Workforce	**2,306,505.5**	**6,999.5**	**0.3**	**0.1**	**3.85**
Regulation/Compliance	***53,171.9***	***53,171.9***	***100.0***	***0.4***	***29.24***
Licensing and Control	NA	NA			
Collection of Taxes	304.9	304.9			
Liquor Store Expenses	52,867.0	52,867.0			
Prevention, Treatment and Research	***10,203.8***	***10,203.8***	***100.0***	***0.1***	***5.61***
Prevention	NA	NA			
Treatment	7,410.5	7,410.5			
Research	NA	NA			
Unspecified	2,793.2	2,793.2			
Total		***$768,185.8***		***5.5***	***$422.44***





Total State Budget	$13,976 M
• Elementary and Secondary Education	$1,946 M
• Substance Abuse and Addiction	$768 M
• Medicaid	$527 M
• Higher Education	$1,214 M
• Transportation	$537 M
Population	1.8 M

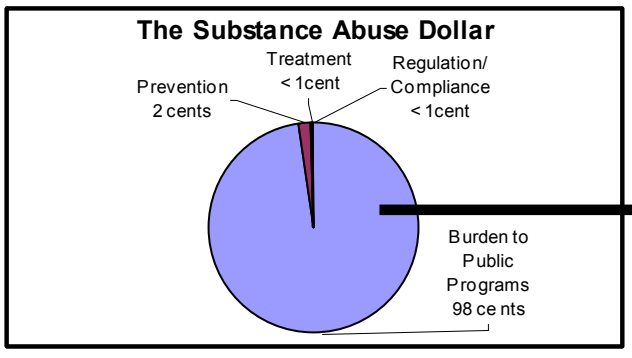
Tobacco and alcohol tax revenue total $111,471,000; $61.30 per capita
Liquor store revenue total $61,804,000; $33.99 per capita.

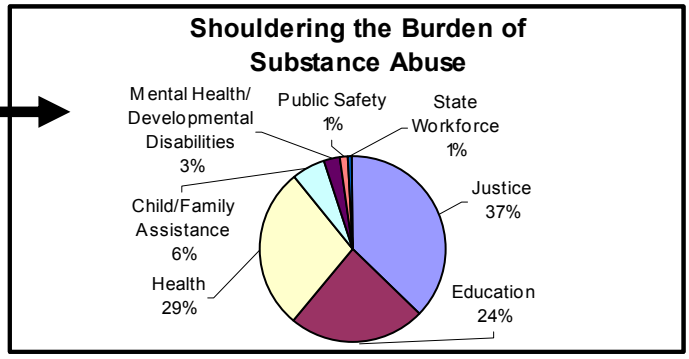
* Numbers may not add due to rounding.

Wisconsin

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$2,384,352.8***		***9.6***	***$429.11***
Justice	**1,102,948.8**	**886,854.5**		**3.6**	**159.61**
Adult Corrections	851,006.1	683,487.0	80.3		
Juvenile Justice	130,703.4	102,999.1	78.8		
Judiciary	121,239.3	100,368.3	82.8		
Education (Elementary/Secondary)	**4,867,100.0**	**560,386.6**	**11.5**	**2.3**	**100.85**
Health	**1,875,449.4**	**680,472.1**	**36.3**	**2.7**	**122.46**
Child/Family Assistance	**475,283.0**	**137,740.6**		**0.6**	**24.79**
Child Welfare	114,542.2	83,854.4	73.2		
Income Assistance	360,740.8	53,886.1	14.9		
Mental Health/Developmental Disabilities	**121,866.3**	**66,822.9**		**0.3**	**12.03**
Mental Health	121,866.3	66,822.9	54.8		
Developmental Disabilities	NA	NA	NA		
Public Safety	**77,344.1**	**31,291.5**	**40.5**	**0.1**	**5.63**
State Workforce	**5,919,151.8**	**20,784.6**	**0.4**	**0.1**	**3.74**
Regulation/Compliance	***1,146.7***	***1,146.7***	***100.0***	***0.0***	***0.21***
Licensing and Control	NA	NA			
Collection of Taxes	1,146.7	1,146.7			
Prevention, Treatment and Research	***51,767.8***	***51,767.8***	***100.0***	***0.2***	***9.32***
Prevention	13,392.3	13,392.3			
Treatment	2,306.2	2,306.2			
Research	NA	NA			
Unspecified	36,069.3	36,069.3			
Total		***$2,437,267.3***		***9.8***	***$438.63***





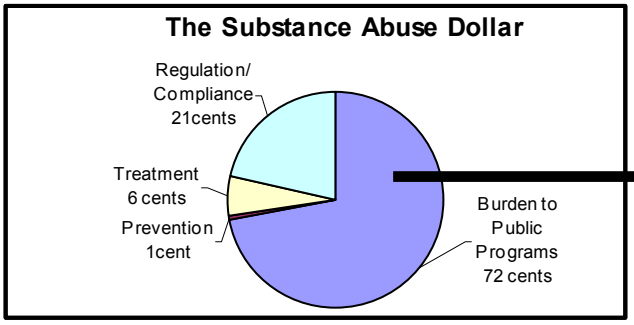
Total State Budget	$24,891 M
• Elementary and Secondary Education	$4,867 M
• Substance Abuse and Addiction	$2,437 M
• Medicaid	$1,766 M
• Higher Education	$3,177 M
• Transportation	$1,340 M
Population	5.6 M

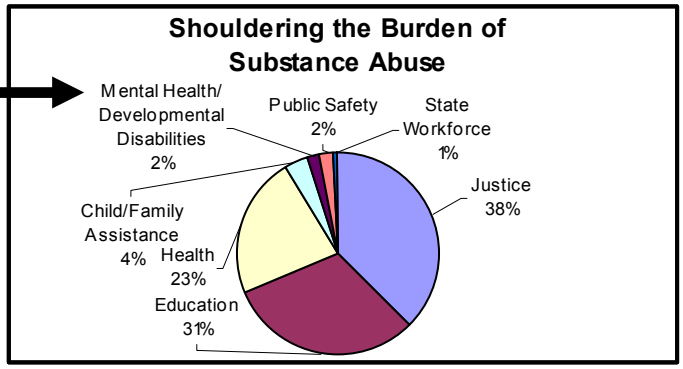
Tobacco and alcohol tax revenue total $359,443,000; $64.69 per capita.

* Numbers may not add due to rounding.

Wyoming
Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$177,097.7***		***4.3***	***$343.88***
Justice	**84,980.7**	**66,478.1**		**1.6**	**129.08**
Adult Corrections	45,566.4	36,125.9	79.3		
Juvenile Justice	9,064.2	7,044.1	77.7		
Judiciary	30,350.1	23,308.1	76.8		
Education (Elementary/Secondary)	**500,833.2**	**54,473.4**	**10.9**	**1.3**	**105.77**
Health	**158,137.3**	**40,902.7**	**25.9**	**1.0**	**79.42**
Child/Family Assistance	**15,464.9**	**6,263.9**		**0.2**	**12.16**
Child Welfare	5,965.1	4,290.9	71.9		
Income Assistance	9,499.8	1,973.0	20.8		
Mental Health/Developmental Disabilities	**51,260.9**	**4,098.1**		**0.1**	**7.96**
Mental Health	52.2	27.8	53.2		
Developmental Disabilities	51,208.7	4,070.3	7.9		
Public Safety	**20,313.3**	**3,885.7**	**19.1**	**0.1**	**7.55**
State Workforce	**302,272.2**	**995.7**	**0.3**	**<0.1**	**1.93**
Regulation/Compliance	***52,445.8***	***52,445.8***	***100.0***	***1.3***	***101.84***
Licensing and Control	39.3	39.3			
Collection of Taxes	10.5	10.5			
Liquor Store Expenses	52,396.0	52,396.0			
Prevention, Treatment and Research	***17,005.4***	***17,005.4***	***100.0***	***0.4***	***33.02***
Prevention	1,416.1	1,416.1			
Treatment	12,312.5	12,312.5			
Research	248.1	248.1			
Unspecified	3,028.8	3,028.8			
Total		***$246,548.9***		***6.0***	***$478.73***





Total State Budget	$4,134 M
• Elementary and Secondary Education	$501 M
• Substance Abuse and Addiction	$247 M
• Medicaid	$142 M
• Transportation	$801 M
• Higher Education	$278 M
Population	.52 M

Tobacco and alcohol tax revenue total $28,357,000; $55.06 per capita.
Liquor store revenue total $60,042,000; $116.59 per capita.

* Numbers may not add due to rounding.

Appendix E
Total Local Government Spending on the Burden of Substance Abuse* (2005)

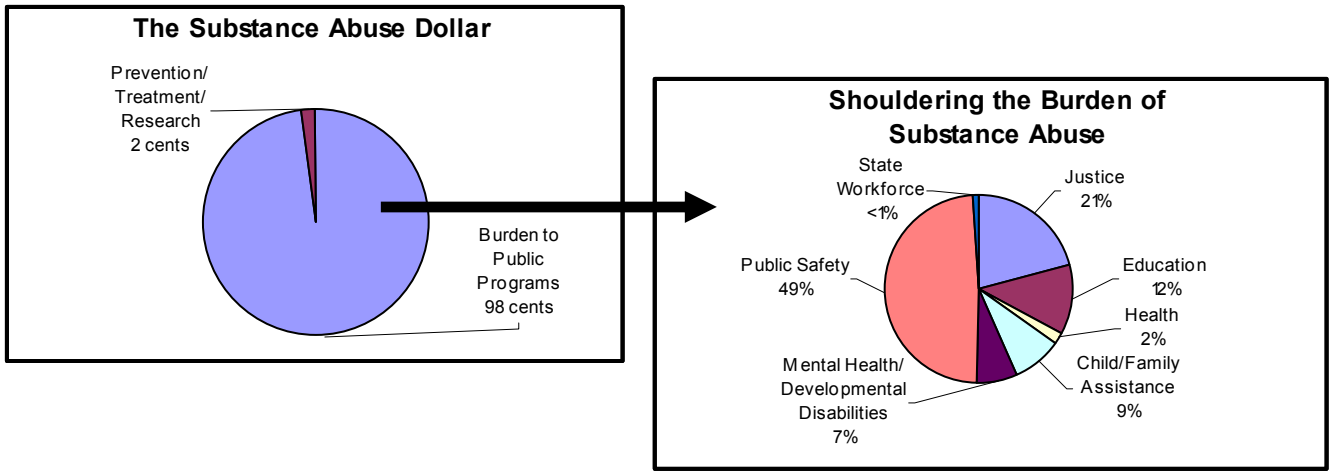
	Local Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of Local Budget	Per Capita
Burden Spending		***$93,335,231.1***		***8.9***	***$307.71***
Justice	**39,101,569.7**	**27,271,343.2**		**2.6**	**89.91**
Corrections	20,737,092.5	17,678,128.8	85.2		
Judiciary	18,364,477.2	9,593,214.4	52.2		
Education (Elementary/Secondary)	**190,183,700.7**	**22,785,756.7**	**12.0**	**2.2**	**75.12**
Health	**72,473,003.6**	**21,481,824.2**		**2.1**	**70.82**
Hospitals†	45,913,770.8	13,609,365.0	29.6		
Health‡	26,559,232.7	7,872,459.3	29.6		
Child/Family Assistance	**32,615,418.5**	**7,646,943.4**		**0.7**	**25.21**
Cash Assistance Payments	6,943,730.4	1,628,012.6	23.4		
Vendor Payments§	2,553,072.1	598,588.0	23.4		
Other Cash Assistance**	23,118,616.0	5,420,342.8	23.4		
Public Safety	**64,711,925.2**	**12,767,544.4**	**19.7**	**1.2**	**42.09**
Local Workforce	**376,241,970.0**	**1,381,819.2**		**0.1**	**4.56**
Regulation/Compliance	***439,538.0***	***439,538.0***		***<0.04***	***1.45***
Licensing/Control	NA	NA			
Collection of Taxes	NA	NA			
Liquor Store Expenses††	439,538.0	439,538.0			
Prevention, Treatment, Research	***NA***	***NA***	***NA***	***NA***	***NA***
Total		***$93,774,769.1***		***9.0***	***$309.15***

Tobacco and alcohol tax revenue total $812,330,000.
Liquor store revenues total $433,935,000.00

* Numbers may not add due to rounding. Categories of spending do not exactly track with federal, state and local case study data due to data limitations. Spending on burden only; no comparable data available for prevention, treatment, research or alcohol and tobacco licensing and control or collection of taxes.
† General health (medical payments, upkeep and capital outlays on city/county hospitals).
‡ Community health care, general health care activities.
§ Cash outlays for food, clothing, home heat, etc. for those receiving public assistance.
** Local public cash payments to individuals contingent upon their need (e.g., local general assistance).
†† Montgomery County, MD only.

Combined Charlotte and Mecklenburg County, NC
Summary of Spending on Substance Abuse and Addiction (2005)*

	Local Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of Local Budget	Per Capita
Burden Spending		***$235,098.3***		***10.6***	***$338.05***
Justice	**60,031.0**	**48,824.2**		**2.2**	**70.20**
Adult Corrections	53,150.0	43,342.5	81.6		
Juvenile Justice	2,824.0	2,153.5	76.3		
Judiciary	4,056.9	3,328.1	82.0		
Education (Elementary/Secondary)	**269,830.0**	**27,869.3**	**10.3**	**1.3**	**40.07**
Health	**16,332.7**	**3,933.4**	**24.1**	**0.2**	**5.66**
Child/Family Assistance	**38,813.6**	**21,365.3**		**1.0**	**30.72**
Child Welfare	19,629.6	13,888.0	70.8		
Income Assistance	NA	NA	NA		
Mental Health/Developmental Disabilities	**36,367.5**	**16,483.3**		**0.7**	**23.70**
Mental Health	31,160.4	16,140.7	51.8		
Developmental Disabilities	5,207.1	342.6	6.6		
Public Safety	**878,162.0**	**115,544.6**	**13.2**	**5.2**	**166.14**
Local Workforce	**346,762.6**	**1,078.3**	**0.3**	**<0.1**	**1.55**
Regulation/Compliance	***NA***	***NA***	***NA***	***NA***	***NA***
Licensing and Control	NA	NA			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***5,197.3***	***5,197.3***	***100.0***	***0.2***	***7.47***
Total		***$240,295.6***		***10.8***	***$345.52***



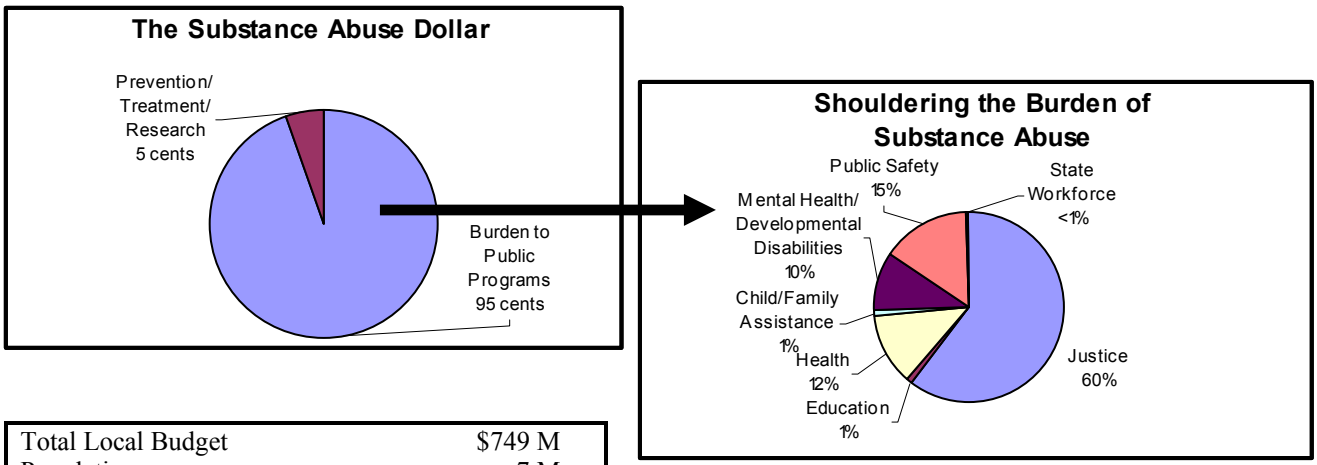
Total Local Budget	$2,226 M
Population	.7 M

* Numbers may not add due to rounding.

Multnomah County, OR

Summary of Local Spending on Substance Abuse and Addiction (2005)*

	Local Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of Local Budget	Per Capita
Burden Spending		***$116,092.5***		***15.5***	***$165.48***
Justice	**81,006.1**	**69,823.2**		**9.3**	**99.53**
Adult Corrections	63,377.3	55,089.7	86.9		
Juvenile Justice	16,882.4	13,987.1	82.9		
Judiciary (Drug Court)	746.4	746.4	100.0		
Education (Elementary/Secondary)	**8,597.0**	**1,269.5**	**14.8**	**0.2**	**1.81**
Health	**45,878.5**	**14,057.0**	**30.6**	**1.9**	**20.04**
Child/Family Assistance	**1,453.0**	**1,139.8**		**0.2**	**1.62**
Child Welfare	1,453.0	1,139.8	78.4		
Income Assistance	NA	NA	NA		
Mental Health/Developmental Disabilities	**20,778.3**	**11,894.6**		**1.6**	**16.95**
Mental Health	18,946.3	11,704.9	61.8		
Developmental Disabilities	1,832.0	189.7	10.4		
Public Safety	**88,733.2**	**17,719.5**	**20.0**	**2.4**	**25.26**
Local Workforce	**40,443.6**	**188.9**	**0.5**	**0.0**	**0.27**
Regulation/Compliance	***NA***	***NA***	***NA***	***NA***	***NA***
Licensing and Control	NA	NA			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research	***6,446.7***	***6,446.7***	***100.0***	***0.9***	***9.19***
Prevention	NA	NA			
Treatment	6,446.7	6,446.7			
Research	NA	NA			
Total		***$122,539.2***		***16.4***	***$174.67***



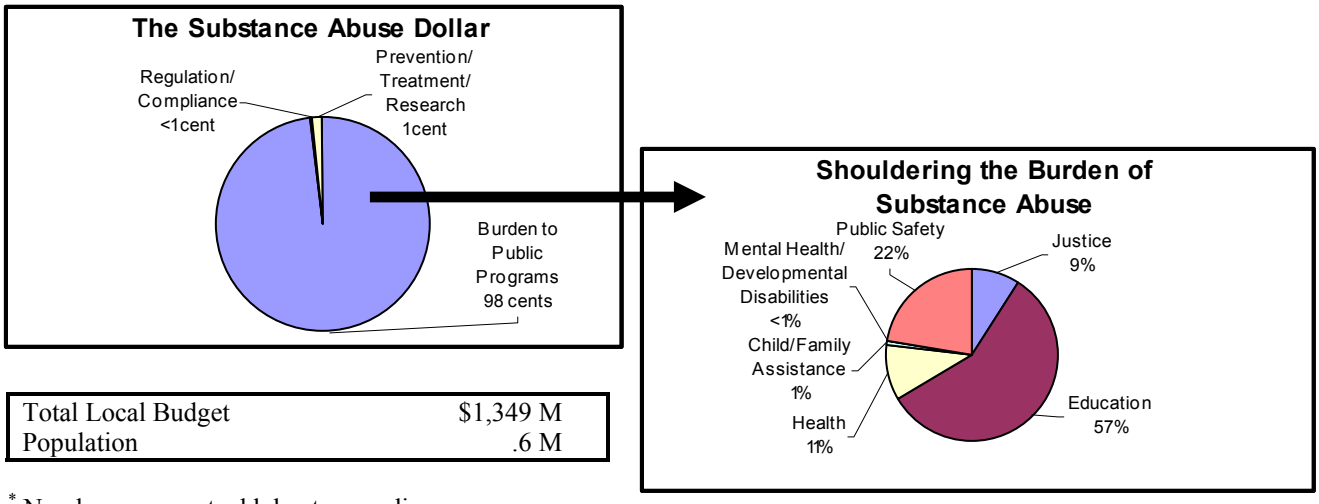
Total Local Budget	$749 M
Population	.7 M

* Numbers may not add due to rounding.

Nashville, TN

Summary of Local Spending on Substance Abuse and Addiction (2005)*

	Local Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of Local Budget	Per Capita
Burden Spending		***$104,043.2***		***7.7***	***$189.48***
Justice	**10,546.0**	**9,313.9**		**0.7**	**16.96**
Adult Corrections	3,800.0	3,178.6	83.7		
Juvenile Justice	125.0	98.5	78.8		
Judiciary	6,621.0	6,036.8	82.2		
Education (Elementary/Secondary)	**507,939.7**	**59,747.0**	**11.8**	**4.4**	**108.81**
Health	**42,850.8**	**11,007.2**	**25.7**	**0.8**	**20.05**
Child/Family Assistance	**2,346.6**	**541.4**		**<0.1**	**0.99**
Child Welfare	NA	NA	NA		
Income Assistance	2,346.6	541.4	23.1		
Mental Health/Developmental Disabilities	**653.8**	**72.9**		**<0.1**	**0.13**
Mental Health	53.8	29.8	55.4		
Developmental Disabilities	600.0	43.0	7.2		
Public Safety	**163,360.2**	**23,360.8**	**14.3**	**1.7**	**42.54**
Local Workforce	**NA**	**NA**	**NA**	**NA**	**NA**
Regulation/Compliance	***270.0***	***270.0***	***100.0***	***0.0***	***0.49***
Licensing and Control	130.0	130.0			
Collection of Taxes	140.0	140.0			
Prevention, Treatment and Research	***1,508.5***	***1,508.5***	***100.0***	***0.1***	***2.75***
Prevention	93.8	93.8			
Treatment	76.0	76.0			
Research	13.4	13.4			
Unspecified PTR	1,325.4	1,325.4			
Total		***$105,821.7***		***7.8***	***$192.71***



Total Local Budget	$1,349 M
Population	.6 M

* Numbers may not add due to rounding.

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NOTE: The 2005 Federal spending by agency budget function data was used for Social Security, National Defense, Income Security, Medicare and Other Health; CASA's analysis of Federal budget data for purposes of this study was used for Substance Abuse and Addiction spending.
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INDIANA
CENTER FOR HEALTH POLICY
RESEARCH FOR A HEALTHIER INDIANA
AUGUST 2008

Prescription Drug Abuse Is a Growing Problem in Indiana

When taken under the supervision of a physician, prescription drugs can be lifesaving, but when abused, they can be as life-threatening as illicit drugs. Prescription drugs are the second most commonly abused category of drugs, less common than marijuana, but more common than cocaine, heroin, methamphetamine, and other drugs.[1] The nonmedical or recreational use of prescription medications is a serious public health concern in the United States.

Although many prescription drugs have the potential for abuse, some are more often misused than others. The three prescription drug classes that are most commonly abused are:

1. opioids, which are generally prescribed to treat pain (pain relievers),
2. central nervous system (CNS) depressants, used to treat anxiety and sleep disorders (sedatives and tranquilizers), and
3. stimulants, prescribed to treat the sleep disorder narcolepsy, obesity, and attention-deficit hyperactivity disorder (ADHD).[2]

Table 1 shows the three major prescription drug classes that are most often abused and their most common trademark names.

Table 1: Major Classes of Prescription Drugs and Their Most Common Medications (Trademark Names are Shown in Parenthesis)

Opioids	Central Nervous System (CNS) Depressants	Stimulants
Oxycodone (OxyContin, Percodan, Percocet)	*Barbiturates*	Dextroamphetamine (Dexedrine and Adderall)
Propoxyphene (Darvon)	Mephobarbital (Mebaral)	Methylphenidate (Ritalin and Concerta)
Hydrocodone (Vicodin, Lortab, Lorcet)	Pentobarbital sodium (Nembutal)	
Hydromorphone (Dilaudid)	*Benzodiazepines*	
Meperidine (Demerol)	Diazepam (Valium)	
Diphenoxylate (Lomotil)	Chlordiazepoxide hydrochloride (Librium)	
Morphine (Kadian, Avinza, MS Contin)	Alprazolam (Xanax)	
Codeine	Triazolam (Halcion)	
Fentanyl (Duragesic)	Estazolam (ProSom)	
Methadone	Clonazepam (Klonopin)	
	Lorazepam (Ativan)	

Source: National Institute on Drug Abuse. (2005). *Prescription drugs: Abuse and addiction.* Research Report Series

According to the 2006 Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), the most recent report available, more than one-fifth (20.3%) of the respondents ages 12 and older reported that they had abused psychotherapeutics[3] at least once in their life; 6.6 percent reported abusing them in the past year, and 2.8 percent reported abusing them in the past month.

Pain relievers are the prescription drug category most widely abused. The rate of nonmedical pain reliever use increased significantly from 2002 to 2006—from 12.6 percent to 13.6 percent for lifetime use, from 4.7 percent to 5.1 percent for past-year use, and from 1.9 percent to 2.1 percent for past-month use. When asked where they obtained the drugs, over half of the nonmedical users of prescription medication said they received them most recently "from a friend or relative for free."[4]

Adolescents ages 12 to 17 who had used stimulants nonmedically in the past year were more likely in that same period to have used other illicit drugs, to have participated in other delinquent behaviors, and to have experienced a major depressive episode than youths who did not use.[5]

The misuse of prescription medications can have serious consequences, similar to the problems associated with illicit drug use. In 2005, approximately 600,000 visits to U.S. emergency departments involved the nonmedical use of prescription or over-the-counter (OTC) pharmaceuticals or dietary supplements. More than half of these visits (55%) involved the use of multiple drugs.[6] Substance abuse treatment data for publicly-funded services show that in 2005, prescription drug abuse was reported at admission in more than 200,000 treatment episodes.[7] The nonmedical use of psychotherapeutics is also associated with legal consequences. During 2005, approximately 346,000 arrests were made in the United States for possession or sale/manufacture of dangerous non-narcotic drugs, including barbiturates (CNS depressants) and Benzedrine (a stimulant).[8]

Prescription Drug Abuse Epidemiology in Indiana

The prevalence of nonmedical (recreational) prescription drug use among Hoosiers 12 years and older is 20.7 percent for lifetime use, 7.6 percent for past-year use, and 2.7 percent for past-month use. Prevalence rates are based on annual averages from 2002 through 2004, the most recent estimates available from the National Survey on Drug Use and Health.

Most misuse of psychotherapeutics involves pain relievers (see Table 2). And nonmedical use of psychotherapeutics is highest among young people—17.8 percent of 18- to 25-year-olds reported past-year use, followed by 12- to 17-year-olds with 9.5 percent; and lowest among adults age 26 and older with 5.4 percent reporting past-year use. The rate of past-year prescription drug abuse of Hoosiers ages 18 to 25 (17.8%) is significantly higher than rates among their U.S. counterparts (14.5%), but comparisons between Indiana and the nation across other age groups show no statistical differences.[9]

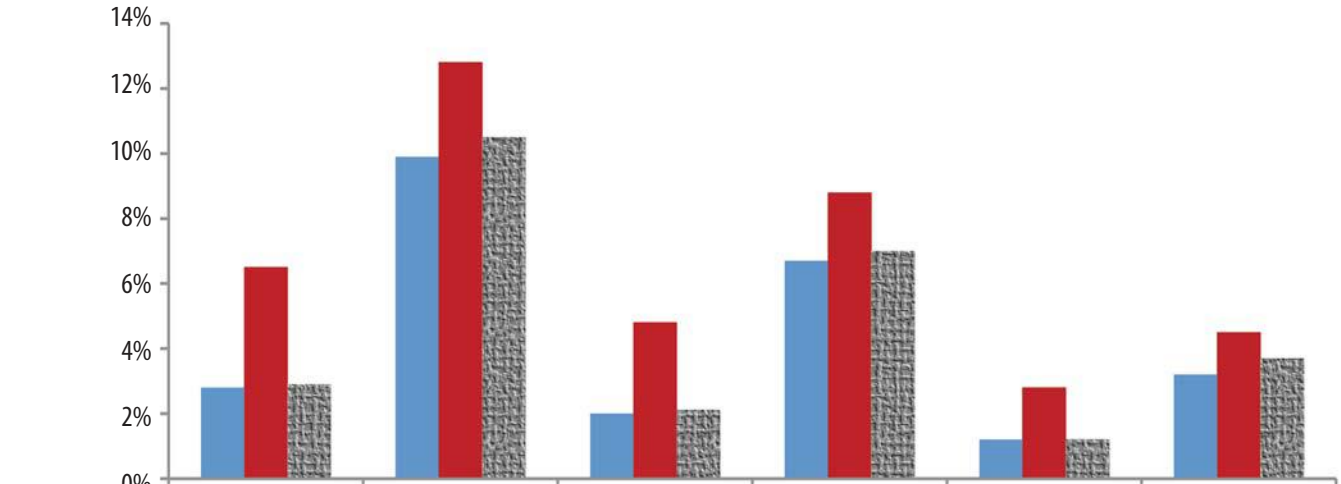
Oxycodone (OxyContin, Percodan, and Percocet) is one of the most widely prescribed pain relievers. Purchase and consumption of this opioid have increased dramatically in

Table 2: Numbers and Percentages of Indiana Residents 12 Years and Older Reporting Nonmedical Use of Psychotherapeutics

Type of Rx Drug	Lifetime Use	Past-Year Use	Past-Month Use
All psychotherapeutics	1,048,000	383,000	138,000
	20.7%	7.6%	2.7%
Pain relievers	756,000	306,000	102,000
	15.0%	6.1%	2.0%
Tranquilizers	460,000	142,000	39,000
	9.1%	2.8%	0.8%
Stimulants	420,000	84,000	38,000
	8.3%	1.7%	0.8%
Sedatives	197,000	20,000	7,000
	3.9%	0.4%	0.1%

Source: Based on annual averages from 2002 through 2004 from theSubstance Abuse and Mental Health Services Administration and Office of Applied Studies. (2008). *National Survey on Drug Use and Health*, retrieved June 2, 2008, from https://nsduhweb.rti.org/

Figure 1: Prevalence Rates of Ritalin, Tranquilizers, and Narcotics Use among Indiana Middle and High School Students, 2007



	Lifetime Use		Annual Use		Monthly Use	
	Middle School	High School	Middle School	High School	Middle School	High School
Ritalin	2.8%	9.9%	2.0%	6.7%	1.2%	3.2%
Tranquilzers	6.5%	12.8%	4.8%	8.8%	2.8%	4.5%
Narcotics	2.9%	10.5%	2.1%	7.0%	1.2%	3.7%

Source: Indiana Prevention Resource Center. (2008). *Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents.* Institute for Drug Abuse Prevention, Indiana University Bloomington.

Indiana. Data from the U.S. Drug Enforcement Administration show that in 2002, more than 29 million dosage units of oxycodone were purchased by Hoosier retail registrants (pharmacies, hospitals, and practitioners). This number is projected to rise to nearly 54 million for 2007—a rate of 8.5 dosage units per Indiana resident[10] and an 86 percent increase from 2002 to 2007.

The Indiana Prevention Resource Center used the annual Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents (ATOD) Survey to collect information on substance use, gambling behaviors, and risk and protective factors among Indiana students in middle school (grades 6 through 8) and high school (grades 9 through 12). Patterns of non-prescribed recreational use of Ritalin (a stimulant), tranquilizers, and narcotics are much higher for the older students, i.e., prevalence for lifetime, annual, and monthly use of these substances is significantly higher among high school students than middle school students.[11] Figure 1 shows 2007 prevalence rates among students.

CONSEQUENCES OF PRESCRIPTION DRUG MISUSE AND ABUSE

Individuals abuse prescription medications for many reasons. The effects of intentional abuse differ by type of drug, but generally, people use pain relievers and other psychopharmaceuticals because they believe the myth that these drugs provide a medically safe high. The types of prescription drugs most likely to be abused and their effects include:[12]

- **Opioids** (pain relievers, narcotics) alleviate pain; they also can induce drowsiness and mediate a feeling of pleasure, resulting in the initial euphoria that is often experienced during use.
- **CNS depressants** (sedatives, tranquilizers) increase activity of the neurotransmitter gamma-aminobutyric acid (GABA) in the brain; GABA decreases brain activity and produces a drowsy or calming effect.
- **Stimulants** (amphetamines) increase levels of norepinephrine and dopamine in the brain and body, resulting in an increase

in alertness, attention, and energy. The increase in dopamine is also associated with a sense of euphoria.

Medical and Health Consequences

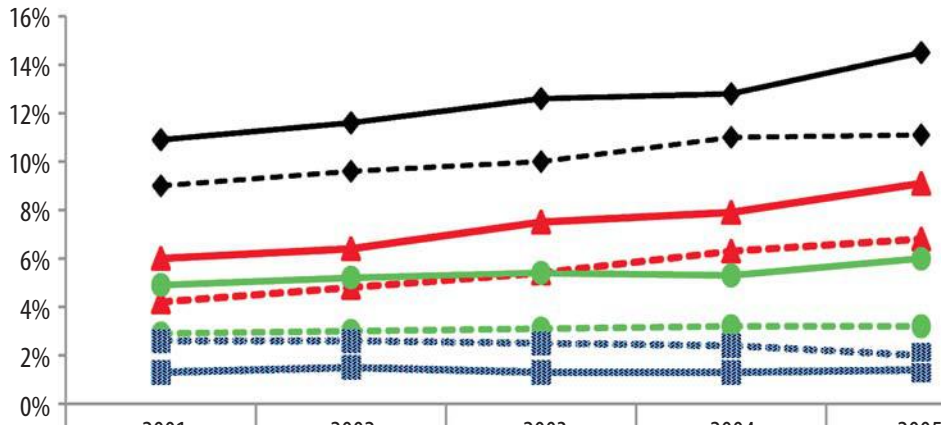
The health consequences of prescription drug abuse differ by type of drug. Stimulants can elevate blood pressure, increase heart rate and respiration, cause sleeping difficulties, and elicit paranoia. Their continued abuse, or even one high dose, can cause irregular heartbeat, heart failure, and seizures. Painkillers and CNS depressants can cause depressed respiration and even death. Also, CNS depressants can induce seizures when a reduction in their chronic use triggers a sudden rebound in brain activity.

One particularly dangerous type of abuse occurs when young people indiscriminately mix and share prescription drugs and other substances (polysubstance abuse), for example, by combining psychotherapeutics with alcohol and/or other drugs. This practice often includes the use of opiate analgesics, the most frequently prescribed medication with more than 100 million prescriptions written every year. This risky practice is likely to contribute to the growing trend of drug abuse-related emergency room visits involving prescribed narcotics.[13] In 2005, nearly 108 million visits to emergency departments (ED) were recorded in the United States, and approximately 1.5 million of these visits involved drug misuse or abuse.

A close look at substance-attributable ED visits shows that

- 27 percent of visits involved pharmaceuticals[14] only;
- 10 percent involved alcohol with pharmaceuticals;

Figure 2: Percentage of Indiana and U.S. Residents in Publicly-Funded Substance Abuse Treatment Who Reported Prescription Drug Abuse at the Time of Admission, by Drug Category and Year



	2001	2002	2003	2004	2005
Indiana all Rx drugs	10.9%	11.6%	12.6%	12.8%	14.5%
U.S. all Rx drugs	9.0%	9.6%	10.0%	11.0%	11.1%
Indiana pain reliever	6.0%	6.4%	7.5%	7.9%	9.1%
U.S. pain reliever	4.2%	4.8%	5.4%	6.3%	6.8%
Indiana sedative/tranquilizers	4.9%	5.2%	5.4%	5.3%	6.0%
U.S. sedative/tranquilizers	2.9%	3.0%	3.1%	3.2%	3.2%
Indiana stimulants	1.3%	1.5%	1.3%	1.3%	1.4%
U.S. stimulants	2.6%	2.6%	2.5%	2.4%	2.0%

Source: Substance Abuse and Mental Health Data Archive. (2008). *Treatment Episode Data Set (TEDS) Series*. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- 8 percent involved illicit drugs with pharmaceuticals; and
- 4 percent involved illicit drugs with both pharmaceuticals and alcohol.[15]

The number of drug-related ED visits remained stable from 2004 to 2005, and no significant changes were detected for ED visits attributable to major illicit drugs or alcohol. However, ED visits related to nonmedical use of prescription drugs, OTC pharmaceuticals, or dietary supplements increased 21 percent from 2004 to 2005. The majority of drug-related suicide attempts involved pharmaceuticals.[16]

Opiates, CNS depressants, and stimulants are highly addictive, especially if abused repeatedly, at high doses, and/or by susceptible individuals.[17] According to 2005 data from the Treatment Episode Data Set (a national database of information about individuals at or below the 200 percent of the federal poverty level who receive publicly-funded substance abuse services), overall prescription drug abuse is significantly higher in Indiana (14.5%) than the nation (11.0%). This holds true for pain reliever use (IN: 9.1%; U.S.: 6.8%) and sedative/tranquilizer use (IN: 6.0%; U.S.: 3.2%); however, stimulant use is greater among the U.S. population (IN: 1.4%; U.S. 2.1%). Moreover, overall prescription drug abuse in Indiana has increased significantly over the years, from roughly 11 percent in 2001 to nearly 15 percent in 2005 (see Figure 2). The percentage of individuals in treatment dependent on prescription drugs is also higher for Indiana (6.7%) than for U.S. residents (5.3%), and rates increased significantly among Hoosiers from 4.8 percent in 2001 to 6.7 percent in 2005.[18]

Drug-Related Mortality

Drug-related mortality statistics include two types of deaths from substance abuse, classified as accidental drug overdoses and fatal medication errors.

Accidental drug overdose is a concern for those who abuse prescription drugs. The mortality rates from unintentional drug overdoses (not including alcohol) have risen steadily since the early 1970s, and have reached historic highs in the past ten years. The increase from 1999 to 2004 was driven largely by opioid analgesics (prescription painkillers), with a smaller contribution from cocaine, but essentially no contribution from heroin. The number of deaths in the narcotics category nationally that involved prescription opioid analgesics increased from 2,900 in 1999 to at least 7,500 in 2004—an increase of 160 percent. By 2004, deaths from opioid painkillers numbered more than the total of deaths involving heroin and cocaine in this category.[19] In Indiana, the number of drug-induced deaths (including deaths from all drugs) increased from 245 in 1999 to 665 in 2005—an increase of over 170 percent.[20]

Fatal medication errors (FMEs) include deaths due to accidental drug overdoses and due to the wrong drug given or taken in error. FMEs can result from either prescription or over-the-counter (OTC) medications, but they do not include accidental overdoses from street drugs and alcohol, suicides and homicides by poisoning, and deaths caused by adverse effects of pharmaceuticals. A study published this year[21] revealed that the overall death rate for FMEs increased by 360.5% between 1983 and 2004. The researchers noted a particularly steep increase (3,196%) in incidents of FMEs occurring at home in combination with alcohol and/or street drugs. A possible conclusion of these findings is that the consumption of medication at home together with the use of multiple substances (polysubstance abuse) increases the risk of FMEs.

Legal/Criminal Consequences

Various federal agencies are involved in the enforcement of crimes associated with prescription drug diversion. The Food and Drug Administration's (FDA) Office of Criminal Investigation together with the U.S. Drug Enforcement Administration (DEA) investigates the illegal sale, use, and diversion of controlled substances, including illegal sales over the Internet. The FDA and U.S. Customs and Border Protection conduct spot examinations of mail and courier shipments to check for foreign drugs being sent to U.S. consumers. Additionally, the Department of Justice prosecutes doctors and pharmacies who illegally distribute via the Internet.[22]

The Uniform Crime Reporting (UCR) system is a national database maintained by the FBI that is used to track the number of arrests of property and violent crimes as well as drug-related crimes throughout the United States. Data are submitted by law enforcement agencies and available at the county level. A limitation of the data set is that states are not required to submit their information, so reporting levels vary.

To estimate missing arrest data, the FBI uses a statistical algorithm.[23] Based on UCR estimates, the number of arrests for possession of dangerous non-narcotic drugs (barbiturates and Benzedrine) in Indiana increased from 1,617 in 1999 to 2,620 in 2005—a 62 percent increase. Similarly, arrests for sale/manufacture of these substances rose from 316 in 1999 to 746 in 2005—a 136 percent increase (see Figure 3). A comparison of Indiana and U.S. arrest rates for possession and sale/manufacture of dangerous non-narcotics reveals a significant increase in rates on the national and state levels over the years and substantially higher rates in the United States than Indiana (see Figure 4).[24]

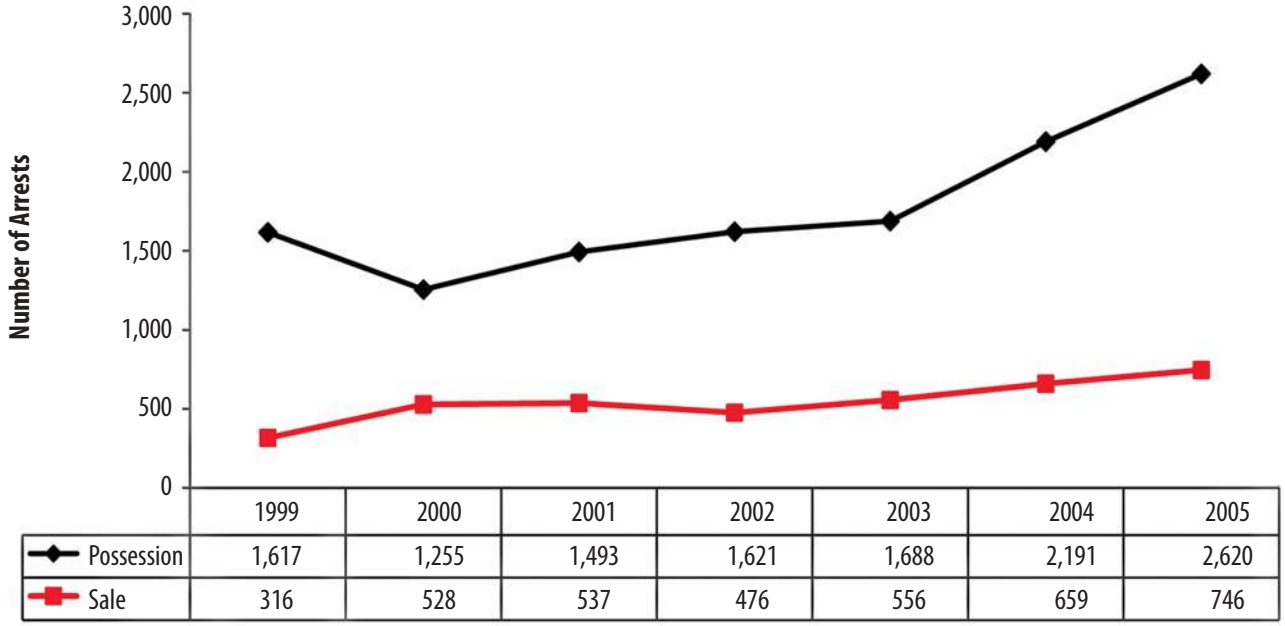
RISK FACTORS AND VULNERABLE POPULATIONS

Researchers have shown that people with certain characteristics are more or less likely to abuse prescription drugs. Simoni-Wastila and Strickler[25] found that in the general population, being female, being in poor or fair health, and drinking alcohol daily are risk factors for nonmedical prescription drug use. On the other hand, those who are young (25 or younger) and have full-time employment are less likely to engage in problem use.

Analyses from the 2005 Indiana Treatment Episode Data Set,[26] the most recent statistics now available, show that:

- Whites are most likely to report prescription drug abuse at the time of treatment admission compared to Blacks and other races (odds ratio = 2.1; $P < 0.001$).
- Women are more likely than men to report prescription drug abuse at the time of treatment admission (odds ratio = 1.8; $P < 0.001$).
- Adults ages 18 to 34 are more likely than any other age group to report prescription drug abuse at the time of treatment admission (odds ratio = 1.4; $P < 0.001$).
- Individuals who abuse prescription drugs are more likely to engage in polysubstance abuse (odds ratio = 4.6; $P < 0.001$).

Figure 3: Number of Arrests for Possession and Sale/Manufacture of Dangerous Non-Narcotic Drugs in Indiana (Uniform Crime Reports, 1999-2005)

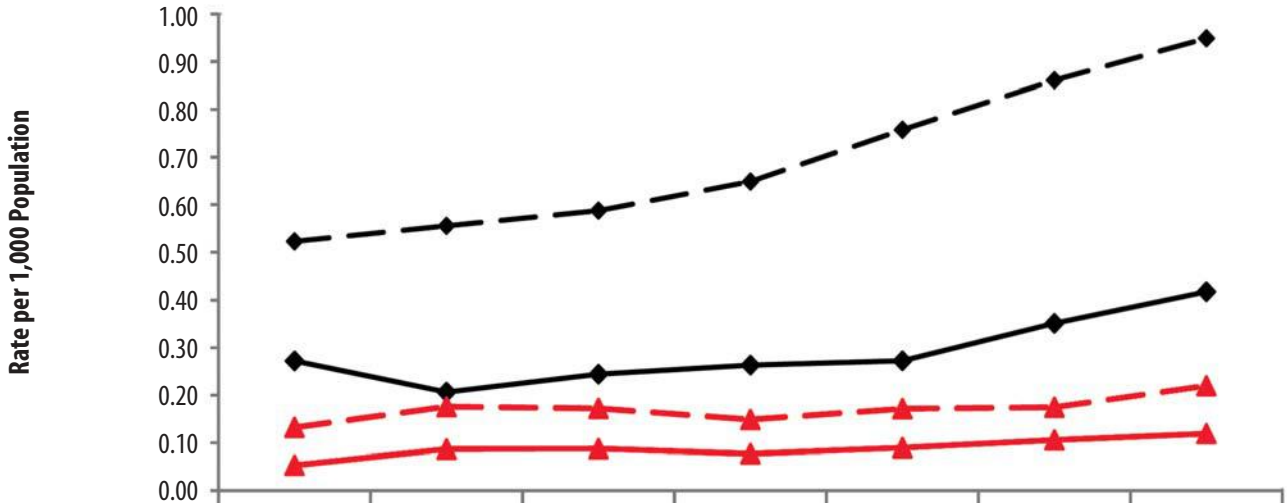


	1999	2000	2001	2002	2003	2004	2005
Possession	1,617	1,255	1,493	1,621	1,688	2,191	2,620
Sale	316	528	537	476	556	659	746

Source: National Archive of Criminal Justice Data, *Uniform Crime Reporting Program*. (n.d.). Federal Bureau of Investigation.

The elderly (65 and older) are also vulnerable to prescription drug misuse and abuse. Older people are more likely to be prescribed long-term and multiple prescriptions and this can lead to unintentional misuse. In addition, many older adults also use over-the-counter (OTC) medicines and dietary supplements regularly. Prescription and OTC drug abuse can have more adverse health consequences for the elderly because of high rates of comorbid illnesses, changes in drug metabolism with age, and the potential for drug interactions. For example, older people who take benzodiazepines are at an increased risk for cognitive impairment associated with the drug, sometimes leading to falls (causing hip and thigh fractures) and vehicle accidents.[27]

Figure 4: Arrest Rates, per 1,000 Population, for Possession and Sale/Manufacture of Dangerous Non-Narcotic Drugs in Indiana and the United States (Uniform Crime Reports, 1999-2005)



	1999	2000	2001	2002	2003	2004	2005
Indiana Possession	0.27	0.21	0.24	0.26	0.27	0.35	0.42
U.S. Possession	0.52	0.56	0.59	0.65	0.76	0.86	0.95
Indiana Sale	0.05	0.09	0.09	0.08	0.09	0.11	0.12
U.S. Sale	0.13	0.18	0.17	0.15	0.17	0.17	0.22

Source: National Archive of Criminal Justice Data. (n.d.). *Uniform Crime Reporting Program.* Federal Bureau of Investigation.

THOUGHTS FOR POLICYMAKERS

The Indiana General Assembly passed legislation in the mid-1990s that requires collection of information about controlled substances through the Central Repository for Controlled Substances Data program. Initially, Indiana's prescription drug monitoring program required pharmacies to report only on schedule II controlled substances. In 2004, due to a grant and legislative action (IC 35-48-7), the Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT) program was created, expanding reporting requirements to include schedule II through V controlled substances[28] (see box below for additional information).[29]

Indiana Tracks Prescription Drugs Through the INSPECT Program

The INSPECT program continues to be funded in part by the Harold Rogers Prescription Drug Monitoring Training and Technical Assistance Program. This federal grant program was created by the Department of Justice Appropriations Act, 2002 (Public Law 107-77) and received fiscal year 2008 funding under the Consolidated Appropriations Act, 2008 (Public Law 110-161).[30] Additional funding is provided by the state, derived from a percentage of controlled substance licensing fees. Each time a controlled substance is dispensed, the dispenser is required to submit the following information to INSPECT:[31]

A. the recipient's name,
B. the recipient's or the recipient representative's identification number or the identification number or phrase designated by the central repository,
C. the recipient's date of birth,
D. the national drug code number of the controlled substance dispensed,
E. date the controlled substance is dispensed,
F. quantity of the controlled substance dispensed,
G. number of days of supply dispensed,
H. the dispenser's U.S. Drug Enforcement Agency registration number,
I. the prescriber's U.S. Drug Enforcement Agency registration number, and
J. the patient's address, including city, state and ZIP code.

In spite of these expanded monitoring efforts, the nonmedical use of addictive prescription drugs continues to rise. This increase is, at least in part, fueled by the fact that there is relatively little stigma associated with these pharmaceuticals, even when taken recreationally, because they are legally manufactured for a legitimate medical purpose. Prescription drug abusers frequently feel a false sense of security—since doctors can and do prescribe these drugs, many users believe that they cannot be as harmful as conventional street drugs such as heroin or cocaine.

Prescription medicines are widely available and easily accessible, and this is a key factor in abuse rates. They are often illegally acquired through a parent's medicine cabinet, friends' prescriptions, "doctor shopping," and the Internet.

Unfortunately, the Internet has become one of the fastest growing methods for obtaining controlled pharmaceuticals, but it is important to note that not all pharmacies that provide online services are illegitimate. The National Association of Boards of Pharmacy has established a registry of online pharmacies that operate in a legal and medically sound fashion and meet certain criteria. However, some online "pharmacies" do illegally sell controlled substances to the public beyond the bounds of what is safe and legal.[32]

> *"The legal or licensed [Internet] pharmacies do submit data [to the INSPECT program]. The illegal [Internet] pharmacies are just that–'illegal.' They are not licensed. They are not requiring prescriptions. They are not operating within any normal guidelines. The laws attempting to govern this practice are very difficult to enforce. They hide their location so they don't get busted."*
>
> DONNA S. WALL, INDIANA STATE BOARD OF PHARMACY (E-MAIL CORRESPONDENCE, 7/15/2008)[33]

To target all the factors that play a role in prescription drug abuse, effective policy interventions should include comprehensive strategies and address at least the following four areas.

Laws and enforcement—Tighter control of online pharmacies and Internet drug sales would decrease availability of prescription pharmaceuticals without limiting access to individuals who have a legitimate medical need for these substances. Additionally, laws comparable to the social host liability laws for alcohol and the teen party ordinances could be implemented to place greater responsibility on adults. Under social host liability laws, adults who provide alcohol to a person under the age of 21 can be held liable if that minor is killed or injured or kills or injures another person. Teen party ordinances make it illegal to host a party where underage drinking occurs; under this law, the offense is the hosting of the party *itself* and adults can be arrested if they allow a drinking party to occur with their knowledge. Similar versions of these laws focusing on prescription pharmaceuticals would encourage adults who legitimately use such medications to monitor their supply more carefully.

Community norms—Increased awareness among the public of the potential risks of prescription medication misuse (e.g., risks of dependency, addiction, potential overdose, and medical and legal consequences) will help change community norms and defy the myth of medically-safe recreational drug use. Public education targeting parents, grandparents, and youth should be used to inform the public about the dangers of prescription drug abuse and the methods that users may employ to obtain drugs (such as "doctor-shopping," taking pills from family's or friends' prescriptions, and online pharmacies).

Support for health care providers—More education and support services should be available to health care professionals to help them identify drug-seeking behaviors in patients and address treatment needs. The INSPECT database is a valuable tool for providers to query patients' prescription drug history and screen for potential problems. Dissemination of information about drug treatments, interventions, and facilities will also make it easier for providers to refer clients to the right programs.

Polysubstance abuse—Prescription drug abuse is associated with polysubstance abuse (the use of two or more substances). Hoosiers in treatment who use prescription drugs are more likely to be multiple-substances users.[34] Also, a study done at a Midwestern university suggests that most nonmedical users of prescription pharmaceuticals are polydrug users and should be screened for potential drug abuse or dependence.[35]

Prescription drug abuse poses a unique challenge due to the need to balance prevention and law enforcement strategies with legitimate access to drugs for medical purposes. Policymakers must carefully consider policy initiatives that may impact the legitimate needs of those in severe pain. Pain management has emerged as a critical clinical concern and is often essential during recovery from severe illness and surgical procedures.[36/37]

Notes

[1]Office of National Drug Control Policy. (n.d.). *Prescription drugs.* Retrieved June 2, 2008, from http://www.whitehousedrugpolicy.gov/drugfact/prescrptn_drgs/index.html

[2]National Institute on Drug Abuse, National Institutes of Health. (July 2001, Revised August 2005). *Prescription drugs: Abuse and addiction.* NIH Publication Number 05-4881. Retrieved July 30, 2008, from the NIDA Web site from http://www.nida.nih.gov/PDF/RRPrescription.pdf

[3]Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives, but does not include over-the-counter drugs. Source: Substance Abuse and Mental Health Services Administration and Office of Applied Studies. (2008). *National Survey on Drug Use and Health.* Retrieved June 2, 2008, from https://nsduhweb.rti.org/

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The Indiana University Center for Health Policy is a nonpartisan applied research organization and part of the Indiana University Public Policy Institute. CHP researchers work on critical public health policy issues and issues that affect the quality of health care delivery and access to health care. The mission of CHP is to collaborate with state and local government and public and private healthcare organizations in policy and program development, program evaluation, and applied research on critical health policy-related issues.

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Authors: **Eric R. Wright**, PhD, director, Indiana University Center for Health Policy, and professor, School of Public and Environmental Affairs, and chair of the Indiana State Epidemiology and Outcomes Workgroup, and **Marion Greene**, research coordinator, Center for Health Policy. **Editor: Marilyn Michael Yurk**, Indiana University Public Policy Institute.

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Exhibit A - New York Secure Prescription Program

Exhibit B - LEGISLATIVE AUTHORITY

IC 25-26-13-4 Powers and duties of board; prescription drug form program (Relevant Sections)

Sec. 4. (a) The board may:

…

(1) promulgate rules and regulations under IC 4-22-2 for implementing and enforcing this chapter;

…

(4) regulate the sale of drugs and devices in the state of Indiana;

…

(d) The board shall adopt rules and procedures, in consultation with the medical licensing board, concerning the electronic transmission of prescriptions. The rules adopted under this subsection must address the following:

(1) Privacy protection for the practitioner and the practitioner's patient.

(2) Security of the electronic transmission.

(3) A process for approving electronic data intermediaries for the electronic transmission of prescriptions.

(4) Use of a practitioner's United States Drug Enforcement Agency registration number.

(5) Protection of the practitioner from identity theft or fraudulent use of the practitioner's prescribing authority.

(e) The governor may direct the board to develop:

(1) a prescription drug program that includes the establishment of criteria to eliminate or significantly reduce prescription fraud; and

(2) a standard format for an official tamper resistant prescription drug form for prescriptions (as defined in IC 16-42-19-7(1)).

The board may adopt rules under IC 4-22-2 necessary to implement this subsection.

(f) The standard format for a prescription drug form described in subsection (e)(2) must include the following:

(1) A counterfeit protection bar code with human readable representation of the data in the bar code.

(2) A thermochromic mark on the front and the back of the prescription that:

(A) is at least one-fourth (1/4) of one (1) inch in height and width; and

(B) changes from blue to clear when exposed to heat.

(g) The board may contract with a supplier to implement and manage the prescription drug program described in subsection (e). The supplier must:

(1) have been audited by a third party auditor using the SAS 70 audit or an equivalent audit for at least the three (3) previous years; and

(2) be audited by a third party auditor using the SAS 70 audit or an equivalent audit throughout the duration of the contract;

in order to be considered to implement and manage the program.

As added by Acts 1977, P.L.276, SEC.1. Amended by Acts 1981, P.L.222, SEC.186; P.L.75-1992, SEC.20; P.L.2-1993, SEC.145; P.L.177-1997, SEC.5; P.L.212-2005, SEC.22; P.L.204-2005, SEC.15; P.L.182-2009(ss), SEC.371.

Exhibit C - PDMP Best Practices

Exhibit D - IMPACT OF PRESCRIPTION DRUG ABUSE IN INDIANA

Exhibit E - Additional Information