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Final Report of the COMMISSION TO STUDY ALLOCATIONS OF THE FUND FOR A HEALTHY MAINE

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Executive Summary

The Commission to Study the Allocations of the Fund for a Healthy Maine (herein referred to as "the Commission") was authorized by Resolve 2011, chapter 112.[1] The resolve that was presented to the Legislature by the Government Oversight Committee was in response to a report from the Office of Program Evaluation and Government Accountability (OPEGA). The OPEGA report stated that ten years had passed since the Fund for a Healthy Maine law had been enacted but that since that time the programs receiving allocations from the fund had remained largely stable without a comprehensive examination of whether the structure of allocations was still appropriate. In Resolve 2011, chapter 112, the Commission was directed to review the alignment of allocations from the Fund for a Healthy Maine and report its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services.

Members of the Commission met three times in November 2011 to conduct a review of the Fund for a Healthy Maine. The following recommendations were made unanimously by members of the Commission except where it is stated otherwise.

1. **Change the Fund for a Healthy Maine to a separate fund.** Amend the Fund for a Healthy Maine law to change the Fund for a Healthy Maine from a group of programs within Other Special Revenue Funds to a separate fund. Maintain current law on revenues paid into the fund.

2. **Include health promotion and prevention and overweight and obesity to the list of health purposes for the Fund for a Healthy Maine.** Amend the Fund for a Healthy Maine law to broaden "health-related purposes" to "prevention and health promotion purposes." Also amend the list of prevention and health promotion purposes to include overweight and obesity prevention, education and treatment activities.

3. **Require separate accounts and annual reporting about the use of Fund for a Healthy Maine funds.** Amend the Fund for a Healthy Maine law to require contractors, vendors and state agencies receiving funding from the Fund for a Healthy Maine to maintain money received from the Fund for a Healthy Maine in separate accounts and to provide a description of how Fund for a Healthy Maine funds for the prior state fiscal year were targeted to the prevention and health promotion purposes specified in the law. Require the Commissioner of Administrative and Financial Services to compile reports and forward information to the Legislature annually.

4. **Require Health and Human Services Committee review of Fund for a Healthy Maine legislation.** Amend the Fund for a Healthy Maine law to require review by the joint standing committee having jurisdiction over health and human services matters of all legislative proposals that affect the Fund for a Healthy Maine that have majority

[1] See Appendix A for Resolve 2011, chapter 112 and Appendix B for the Commission membership.

support in the committee to which the legislation was referred. This mirrors the provision currently in Joint Rule 317. This recommendation was adopted by a majority vote of 9 to 3. The minority supported continuing to impose review requirements under Joint Rule 317.

5. Require study commission review of Fund for a Healthy Maine allocations every four years. Amend the Fund for a Healthy Maine statute to require the Legislature to establish a study commission to review allocations of the Fund for a Healthy Maine beginning in 2015 and every four years thereafter. The composition and duties of the commission would mirror the current commission under Resolve 2011, chapter 112.

6. Recommendations regarding separate program accounts. Direct the Commissioner of Administrative and Financial Services to review program structure for the programs of the Fund for a Healthy Maine and to recommend a new program structure, including a program for overweight and obesity prevention, education and treatment, beginning in state fiscal year 2014-2015. Funding for the new overweight and obesity program is from funding currently provided for this purpose under existing programs.

7. Issue a statement of support for funding continued enforcement by the Office of the Attorney General. Include in the recommendations of the Commission a statement of support for continued funding for the Office of the Attorney General from the Fund for a Healthy Maine to enable the office to continue diligent enforcement of the tobacco master settlement agreement in accordance with the requirements of Title 22, chapter 263, subchapters 3 and 4.

8. Issue a statement of support for investments in public health and prevention and for the original intent of the funding. Include in the recommendations of the Commission a statement that the Commission recognizes the importance of investments in public health and prevention and believes that the original intent of the funding should be maintained and efforts should be made to eliminate health disparities. The statement will also include the following: "Access to adequate health coverage and support for building relationships with health care providers and the health care system are critical to the individual's ability to access important prevention, education and treatment resources related to smoking and tobacco, overweight and obesity, prenatal and young children's care, child care, health care, prescription drugs, dental and oral health care, substance abuse, school health and nutrition programs and counseling on ways to improve individual health behaviors."

Two proposals were discussed by the Commission and received support from a minority of members.

1. Shift Fund for a Healthy Maine funding from family planning services to the child care subsidy program and consider a Medicaid State Plan amendment for family planning services with enhanced federal financial participation. Deallocate

$401,430 from FHM-Family Planning for state fiscal year 2012-2013, reallocate that funding to FHM-Purchased Social Services program for the child care subsidy program to enable the program to maximize matching federal block grant funds. In conjunction with the shift of funding, encourage the Appropriations and Financial Affairs Committee to consider a family planning Medicaid State Plan amendment. The family planning Medicaid expansion would expand access to family planning services to females up to 200% of the federal poverty level while taking advantage of the enhanced 9 to 1 federal match rate, which will make up for the lost Fund for a Healthy Maine funding. This proposal was supported by 4 members of the Commission and opposed by 8 members.

2. Raise tobacco and alcohol taxes and direct the revenues to prevention, education and treatment services. Raise tobacco and alcohol taxes to help to meet the costs of addiction, directing revenues from the increased taxes to the General Fund to support substance abuse prevention, education and treatment services. This proposal was supported by 4 members of the Commission and opposed by 5 members. Two members abstained from voting.

I. INTRODUCTION

Tobacco Master Settlement

In November 1998, 46 states and six United States territories and the nation's four largest tobacco manufacturers finalized the tobacco master settlement agreement in settlement of litigation to collect health related expenses caused by smoking tobacco. Under the terms of the settlement the participating tobacco manufacturers agreed to make annual payments to the states and territories in perpetuity, to curtail or cease certain tobacco marketing practices and to dissolve certain tobacco industry groups. As part of the agreement the states settled their lawsuits against the tobacco manufacturers and agreed to protect the manufacturers against private rights of action based on harm caused by tobacco. In furtherance of its obligations under the agreement Maine enacted two laws regarding the agreement, the responsibilities of the State and the obligations of tobacco manufacturers and distributors in Title 22, Maine Revised Statutes, chapter 263, subchapters 3 and 4.

Payments to the State of Maine under the tobacco settlement agreement began in state fiscal year 2000, continue through this time and are expected to continue indefinitely. By law, revenues are deposited into the Fund for a Healthy Maine to be used for a set of health-related purposes that are listed in the law. The State Treasurer provides oversight of revenues, while the State Budget Officer oversees the balance in the fund and the levels of expenditures from the fund. The Legislature approves expenditures from the fund, through allocations approved in budget bills and other bills.

Fund for a Healthy Maine

Title 22, Maine Revised Statutes, section 1511 establishes the Fund for a Healthy Maine. The law authorizes deposits into the fund from the settlement of the tobacco litigation in *State of Maine versus Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134,* from other sources and from interest earned and investment income on balances in the fund. In accordance with the law, since state fiscal year 2000, revenues from the tobacco settlement have been deposited into the Fund for a Healthy Maine, which is designated as an Other Special Revenue fund, where the revenues have been held in the State Treasurer's Cash Pool. In addition, beginning in state fiscal year 2006, certain revenues from slot machine operations in the state have been deposited into the Fund for a Healthy Maine pursuant to Title 8, Maine Revised Statutes, section 1036, subsection 2, paragraph E. As required by Title 22, section 1511, subsection 2, paragraph C and subsection 3-A, investment earnings have been credited back to the Fund for a Healthy Maine and unexpended funds allocated for a particular purpose but not spent or encumbered by the end of the state fiscal year have lapsed back to the fund.

Expenditures from the Fund for a Healthy Maine are made by authorization of the Legislature in budget bills and other bills. Because the fund is an Other Special Revenue fund, expenditures are made through spending decisions called allocations. Allocations from the Fund for a Healthy Maine are subject to four provisions in the law.

- Title 22 Maine Revised Statutes section 1511, subsection 4 requires allocations to be used to supplement, not supplant, appropriations from the General Fund.

- Subsection 5 requires specific legislative approval to change the source of funding for a program or activity funded from the Fund for a Healthy Maine.
- Subsection 6 limits the purposes for which allocations may be made to a list of eight health-related purposes:

  A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State;

  B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;

  C. Child care for children up to 15 years of age, including after-school care;

  D. Health care for children and adults, maximizing to the extent possible federal matching funds;

  E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds;

  F. Dental and oral health care to low-income persons who lack adequate dental coverage;

  G. Substance abuse prevention and treatment; and

  H. Comprehensive school health and nutrition programs, including school-based health centers.
- Subsection 12, requires that beginning in state fiscal year 2009, the State Budget Officer review programs receiving funds and adjust downwards funding in the All Other line category if actual revenue collections for the Fund for a Healthy Maine for the fiscal year are less than allocations approved by the Legislature. The State Budget Officer is required to calculate reductions for all programs with All Other allocations in proportion to the All Other allocations of all funded programs. Following the recommendation of the State Budget Officer and approval by the Governor, the allocations of all programs with All Other allocations must then be reduced by financial order. The law requires the State Budget Officer to report by May 15th each year on allocation adjustments made under the law to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services.

As required by Title 22 Maine Revised Statutes section 1511, subsection 8, the Treasurer of State reports on the Fund for a Healthy Maine each December to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services. The report summarizes activity in all accounts and funds related to the Fund for a Healthy Maine and reviews tobacco settlement payments, deposits, transfers, earnings and fund balances; the State's eligibility for tobacco settlement payments; the payment formula and revenue projections; and estimated future tobacco settlement payments.

The Legislature's Office of Fiscal and Program Review maintains a website that provides information on the tobacco settlement funds. The site provides information on fund balance status reports, pie charts on budgeted uses, revenues and expenditure tables, current revenue projections, allocations and uses by program and allocations and uses history. The site also contains links to reports on allocations to programs within the Department of Health and Human Services. The address is: *http://www.maine.gov/legis/ofpr/tobacco_settlement_funds/index.htm*

Review of the Fund for a Healthy Maine, Public Law 2007, chapter 629, Part H

Public Law 2007, chapter 629, Part H from the 123rd Legislature directed the Joint Standing Committee on Health and Human Services to meet during the 2008 interim to review the structure, accountability and appropriate level of legislative and independent oversight of the Fund for a Healthy Maine. The Joint Standing Committee on Health and Human Services met during the 2008 interim as directed. The Committee completed its work and issued a report in December 2008 to the Joint Standing Committee on Appropriations and Financial Affairs that includes the following recommendations.

1. The Joint Standing Committee on Health and Human Services recommended that the committee request the Government Oversight Committee to authorize the OPEGA to review the efficacy, efficiency and accountability of the programs and expenditures funded from the Fund for a Healthy Maine and compare the degree to which preventive health is prioritized in the expenditure of tobacco settlement dollars in Maine and other states. On October 2nd, 2008 Senator Joseph Brannigan and Representative Anne Perry, co-chairs of the committee, sent a letter to Beth Ashcroft, Director of the OPEGA requesting the reviews recommended by the Committee. In response to this letter the OPEGA performed a review, entitled "Fund for a Healthy Maine Programs – Frameworks Adequate for Ensuring Cost-Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved."[2] See below.

2. The Joint Standing Committee on Health and Human Services recommended that the 124th Legislature establish a Fund for a Healthy Maine subcommittee, consisting of three members of the Joint Standing Committee on Health and Human Services and two members of the Joint Standing Committee on Appropriations and Financial Affairs. The subcommittee would jointly discuss all budget proposals and work together to begin fiscal planning for the eventual end to the portion of the tobacco settlement payments designated as "strategic contribution payments." The Joint Standing Committee on Appropriations and Financial Affairs of the 124th Legislature considered this recommendation and the Legislature did not establish a subcommittee.

3. The Joint Standing Committee on Health and Human Services recommended that a new Joint Rule be established for the 124th Legislature to provide for review of all proposed Fund for a Healthy Maine allocations and deallocations and all proposed changes in the law governing the fund and its governing statutes. On January 15th 2009, the House of Representatives and Senate, as recommended and adopted by the Joint Select Committee on Joint Rules, adopted a new rule, Joint Rule 317. Joint Rule 317 requires the committee having jurisdiction over a proposal that affects the Fund for a Healthy Maine or funding from the fund to hold a public hearing on the proposal and to determine the level of support for the proposal within the committee of jurisdiction. If a majority of the Committee supports the proposal the Committee must refer the proposal

[2] The report is available on the OPEGA website at:
http://www.maine.gov/legis/opega/reports/FFHM/FFHM%20Report.pdf

to the Joint Standing Committee on Health and Human Services for review, evaluation and a report back to the Joint Standing Committee on Appropriations and Financial Affairs.

Office of Program Evaluation and Governmental Accountability Reports

As requested in the letter from Senator Joseph Brannigan and Representative Anne Perry, co-chairs of the Health and Human Services Committee, the Government Oversight Committee authorized the OPEGA to conduct reviews of state prioritization of preventive health and the efficacy, efficiency and accountability of the programs and expenditures funded from the Fund for a Healthy Maine. OPEGA performed two reviews and issued two reports to the Government Oversight Committee as described below.

In performing the first review requested by the Government Oversight Committee, OPEGA utilized past studies conducted by the U.S. Government Accountability Office and received survey responses from 33 states that receive tobacco master settlement agreement funds. The first report, "Fund for a Healthy Maine Programs: A Comparison of Maine's Allocations to Other States and a Summary of Programs," was completed by OPEGA and presented to the Government Oversight Committee in March 2009.[3] This first report includes an inventory of programs funded from the Fund for a Healthy Maine, lists their State budget account numbers and the agencies responsible for the programs and describes the program activities. The report includes a comparison of spending on preventive health services and concludes with the following statements: "Maine has consistently prioritized preventive health services more than other states ... allocating 99.8% in 2005 and 99.7% in 2009. In 2005, the other 33 states reviewed allocated an average of 54% of their TMSA funds to preventive health services and an average of just 45% in 2009. Nine of the 33 states reviewed allocated none of their settlement funds to preventive health services in 2009."

The second review undertaken by OPEGA for the Government Oversight Committee studied the efficacy, efficiency and accountability of programs and expenditures funded from the Fund for a Healthy Maine, and resulted in the report entitled "Fund for a Healthy Maine Programs – Frameworks Adequate for Ensuring Cost Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved" which was released in October 2009.[4] In this report, OPEGA focused on whether existing managerial and oversight systems are adequate to help ensure that activities funded by the Fund for a Healthy Maine are cost-effective and carried out economically and efficiently and have sufficient transparency and accountability. In performing the review for this report OPEGA reviewed in depth four programs funded from the Fund for a Healthy Maine: Community/School Grants; Public Health Infrastructure; Tobacco Prevention and Control; and Substance Abuse. OPEGA concluded that the programs do have defined purposes and stated goals for activities that generally align with the program purposes and that responsible agency managers are working to maximize effectiveness, that performance

[3] The report is available on the OPEGA website at:
http://www.maine.gov/legis/opega/GOC/GOC_meetings/Current_handouts/2-27-09/2-26%20Info%20Brief%20FFAHM-Tab%202%20.pdf

[4] The report is available on the OPEGA website at:
http://www.maine.gov/legis/opega/reports/FFHM/FFHM%20Report.pdf

measures are used and that frameworks for managing cost-effectiveness are reasonably adequate. OPEGA noted that meaningful conversations about cost-effectiveness are challenged by reluctance to deviate from the original funding agreement, inability to place responsibility for the Fund for a Healthy Maine in one State entity, lack of activity level financial and performance data, unclear budgetary descriptions and lack of alignment between budgetary programs and their activities and financial and performance information. The OPEGA recommendations in the October 2009 report include the following:

1. Allocations of Fund for a Healthy Maine funds should be reviewed in the context of the changing health environment and goals. This could include assessment by the Legislature of existing allocations and establishment of a structure to periodically reassess allocations.
2. Budgetary programs should be better aligned with the state's health goals, efforts and related performance information. This could include moving out of Community/School Grants the following expenditures: school nutrition/breakfast, tobacco enforcement and local public health liaisons.
3. Budget descriptions should be updated and more specific. This could include providing guidance to State agencies on program descriptions that are complete, accurate and up-to-date.
4. Costs for major activities within budgetary programs should be tracked within the State's accounting system. This could include development of a coordinated sub-account structure to assign costs at the activity level.

Establishment of the Commission to Study Allocations of the Fund for a Healthy Maine
During the First Regular Session of the 125th Legislature, the Health and Human Services Committee heard and considered L.D. 1558, Resolve to Study Allocations of the Fund for a Healthy Maine, which was reported by Representative Meredith Strang Burgess for the Government Oversight Committee. The Committee recommended several changes to the resolve and it was finally passed by the Legislature and signed by the Governor as Resolve 2011, chapter 112. The resolve established the Commission to Study Allocations of the Fund for a Healthy Maine, a 13-member study commission that was directed to review the alignment of allocations from the Fund for a Healthy Maine and report its findings and recommendations, including suggested legislation to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services by December 7, 2011. In performing its duties the Commission was directed to gather information and data from public and private entities as necessary to:

1. Identify or review the State's current public health care and preventive health priorities and goals;
2. Identify or review strategies for addressing priorities and goals and potential effectiveness of those strategies;
3. Assess the level of resources needed to properly pursue the strategies identified above;
4. Make recommendations for how Fund for a Healthy Maine funds should be allocated to most effectively support the State's current public health and preventive health priorities, goals and strategies; and

5. Make recommendations for processes to be used to ensure that Fund for a Healthy Maine allocations stay aligned with the State's health priorities and goals.

II. COMMISSION PROCESS

The Commission to Study the Allocations of the Fund for a Healthy Maine was authorized to hold six meetings. However, as the resolve authorizing the study was not an emergency and some appointments were made in mid-October, it was determined by the chairs of the Commission that the Commission would meet for three full days.

Meeting One

The first meeting took place on November 4, 2011. The Commission reviewed the resolve and the Fund for a Healthy Maine law in Title 22, Maine Revised Statutes, section 1511. Christopher Nolan, of the Office of Fiscal and Program Review, briefed the Commission on the revenues and allocations of the Fund for a Healthy Maine for state fiscal years 2012 and 2013 and provided a historical perspective for spending since the fund was enacted in 2000. The Commission determined that for programs that are paid for in multiple accounts (for example, Family Planning and the Head Start program), they would need to examine all funding sources for those programs in order to determine the proportion of a program that the Fund for a Healthy Maine money represents.

The Commission was briefed by Christopher Taub, Assistant Attorney General regarding the legal background of the tobacco master settlement agreement and current litigation. Mr. Taub explained that states are currently litigating with participating manufacturers as to whether states were diligently enforcing the escrow accounts in 2003. On the day that Mr. Taub briefed the Commission, the companies still contested that Maine was not diligent (12 states had been acknowledged as diligent). Beginning in May 2012, those states contested as not diligent will participate in arbitration with the tobacco manufacturers. If Maine is found not diligent, the state could potentially lose the entire payment for a calendar year depending on how many states are found non-diligent (the fewer states, the greater the burden per state). The next payment is due in April 2012, and there will not be a decision in the litigation before that date.

The Office of the Attorney General was allocated $111,840 in state fiscal year 2012 and $119,687 in state fiscal year 2013 from the Fund for a Healthy Maine to enable an Assistant Attorney General to do the work related to the tobacco master settlement agreement. In addition, a paralegal is employed to work on tobacco master settlement agreement issues, with that position funded from the General Fund. Mr. Taub stated that the tobacco master settlement agreement does not restrict the use of settlement money but that during arbitration, states were being asked how much is spent on enforcement. The companies argue that the states are not diligently enforcing the agreement and should forfeit their rights to payments under the agreement.

The resolve establishing the Commission requires the Commission to identify or review the State's current public health care and preventive health priorities and goals in order to determine

whether the allocation of Fund for a Healthy Maine money aligns with those priorities and goals. The Department of Health and Human Services (herein referred to as DHHS) gave an overview to the Commission regarding the state public health care and preventive health priorities and goals and the department's role and strategy. Bonnie Smith, Deputy Commissioner in DHHS, outlined a pilot project with MaineGeneral that will be expanded to all hospitals in which the department worked with 30 high cost emergency department users and saved $100,000 by giving more appropriate care. The department also outlined wellness programs for older adults that have resulted in reductions in health care expenditures. Keith Wilson, Contract and Compliance Manager for Child and Family Services in DHHS, outlined prevention programs for children including an after school program for 12 to 15 year olds, home visiting, Head Start, Early Head Start and child care. Geoffrey Miller, Associate Director for the Office of Substance Abuse in DHHS, outlined the substance abuse prevention, treatment and intervention services budget and programs funded by the Fund for a Healthy Maine.

Dr. Sheila Pinette, Director of the Department of Health and Human Services, Maine Center for Disease Control and Prevention (CDC), and a Commission member, outlined the philosophy behind the allocations of Fund for a Healthy Maine funds including recouping Medicaid costs of treating tobacco-related illness and reducing the burden of tobacco use. Maine CDC strategic priorities support the funding decisions for state and local level interventions and provide leadership to ensure healthy conditions in which to live. Dr. Pinette outlined the leading causes of death and the preventable causes of death in Maine in 2007. She also outlined the priorities and goals outlined in Healthy Maine 2010 and Healthy People 2020. Dr. Pinette described the six winnable health battles outlined by Tom Freidman of the U.S. CDC, including tobacco use as the number one battle. An extract of this presentation is included as Appendix C. Dr. Pinette explained that the CDC's work is based on public health models incorporating national priorities. She also briefly outlined the programs that received Fund for a Healthy Maine funds including the divisions of local public health, the nine public health districts in Maine and the role of the 27 local Healthy Maine Partnerships. Fund for a Healthy Maine funds are also used for tobacco use prevention, cessation and treatment, programs to combat obesity, oral health, school based health care, family planning services and immunization programs.

The Commission also took public comment at the end of the first meeting. Testimony was given by representatives of the Maine Public Health Association, Friends of the Fund for Healthy Maine, the American Heart Association, the American Lung Association of New England, the Maine Children's Alliance, the Maine Head Start Directors Association and the American Cancer Society.

Meeting Two

The second meeting of the Commission took place on November 17, 2011. At this meeting, the Commission was briefed on the specific allocations from the Fund for a Healthy Maine accounts. Shirrin Blaisdell from the Department of Administrative and Financial Services briefed the Commission on the allocations from the Fund for a Healthy Maine accounts outside of Department of Health and Human Services. Non-DHHS accounts are in the Office of the Attorney General, the Department of Education, the Department of Public Safety, the Finance

Authority of Maine, the Dirigo Health Agency and the Judicial Department. She described the purpose of each program and recent funding history including two years of actual expenditures and two years of allocations for the state fiscal years 2012 and 2013 budget, including initial budget proposals and enacted outcomes. The presentation is included as Appendix D.

Judith Reidt-Parker of the Maine Children's Alliance provided information to the Commission about how Head Start and Early Head Start are funded in other states. Ms. Reidt-Parker stated that 30 states supplement dollars received from the federal government for Head Start and Early Head Start. States use state dollars for different purposes including funding additional slots, extending the day or professional development. Maine has appropriated General Fund dollars since 1983 and allocated Fund for a Healthy Maine dollars since 2000. And yet Maine serves only 10% of the children from birth up to age 3 years old who are eligible for Early Head Start and only 30% of the children from 3 years old through age 5 years old who are eligible for regular Head Start services.

Representatives of DHHS presented information of all programs within the department receiving Fund for a Healthy Maine money. The Department outlined a program description including the number of people and programs receiving funds, what is purchased, how service is delivered and how many staff are employed, four years of spending including the state fiscal years 2012 and 2013 budget, whether Fund for a Healthy Maine funds were used to meet a federal maintenance of effort requirements and federal match requirements, and goals and outcomes for each program. The presentation is included as Appendix E.

Keith Wilson, Contract and Compliance Manager for Child and Family Services in DHHS, presented information on the Home Visiting Program, Head Start and Early Head Start and Child Care. The Commission had extensive discussions on Head Start and Early Head Start asking for further information related to full federal subsidies, the long term benefits of the programs, and whether Maine would lose federal funds if Fund for a Healthy Maine funds were cut from Head Start.

Jennifer Palow, Pharmacy Benefits Manager in the Office of MaineCare Services in DHHS, presented information on the Elderly Low-Cost Drug program. The Commission discussed the benefits to enrollees in the Elderly Low-Cost Drug program and the funding of that program in some detail. Information presented to the Commission separated the funds from the General Fund, those from the tobacco master settlement agreement funds directed to the program through the Fund for a Healthy Maine and those from the slot machine gambling (racino revenues) that are directed to the program through the Fund for a Healthy Maine under Title 8, section 1036, subsection 2, paragraph E.

Geoffrey Miller, Associate Director for the Office of Substance Abuse in DHHS, discussed the accounts in the Substance Abuse program and the Medicaid Match. The Commission asked for more information about programs related to the use of alcohol in colleges and universities.

Kristen McAuley, Senior Health Program Manager in DHHS, Maine CDC, presented information on programs for Oral Health, Donated Dental, Tobacco Prevention, Control and

Treatment, Community/School Grants, Public Health Infrastructure, Family Planning and the Maine Immunization Program. Dr. Peter Smith, Director of Infectious Diseases in DHHS, Maine CDC also provided information on the universal childhood immunization program that provides free vaccinations to all children in Maine. The Commission requested information on the history of the Healthy Maine Partnerships program spending of 50:40:10 (tobacco, obesity, chronic disease) within the Public Health Infrastructure. Members of the Commission were interested in whether the formula had kept up with the rapidly increasing rate of obesity. The Commission was also interested in the U.S. CDC recommended funding levels for state tobacco prevention programs and the basis for those recommendations. This information is attached in Appendix F.

Following the presentation on the Family Planning program by Ms. McAuley and Valerie Ricker, Division Director of the Family Planning Program in DHHS, Maine CDC, the Commission had an extensive discussion of the family planning expansion plan utilized by a number of states under the Affordable Health Care Act but not utilized in Maine. The Medicaid expansion plan would expand access to family planning services to females up to 200% of the federal poverty level. Currently these females are only eligible for MaineCare if they are pregnant; the plan would expand services to these females in order to prevent unintended pregnancies. Kate Brogan of the Family Planning Association of Maine stated that if Maine amended its State Medicaid Plan and provided the state seed money, Maine would receive a 9:1 match. That is $9 in federal money for each $1 of state seed match.

During the second meeting, the Commission considered the possibility of the Fund for a Healthy Maine being established as a separate fund similar to the Dirigo Health Enterprise Fund. This would allow the Legislature to view several components for one program together. For example, the MaineCare Medical Assistance to Providers (MAP) account has separate entries for General Fund, Federal Funds, Other Special Revenue funds, American Recovery and Reinvestment Act funds and federal block grant funds but the Fund for a Healthy Maine funding is entered in the budget in a different program. Shirrin Blaisdell, of the Department of Administrative and Financial Services, and Christopher Nolan, of the Office of Fiscal and Program Review, agreed that a separate account would require a reprogramming of the budget but otherwise does not prompt a concern.

At the second meeting, the Commission began its discussions of how it would go about meeting the requirements of the resolve and particularly whether there should be a realignment of program spending of Fund for a Healthy Maine funds. Senator Katz, who was unavailable for the final meeting, stated his view that although many of the Fund for a Healthy Maine programs do a lot of good work, his preference was to use all of the Fund for a Healthy Maine funds for tobacco prevention and cessation and obesity reduction as well as enforcement of the tobacco master settlement agreement by the Office of the Attorney General. Senator Katz stated that all other programs currently funded by Fund for a Healthy Maine should be funded by General Fund dollars rather than Fund for a Healthy Maine dollars. Other members of the Commission argued that public health is broader than smoking cessation and obesity reduction and that the lack of money in the General Fund would result in programs with value falling through the cracks. Senator Katz submitted his recommendations in a memorandum to the Commission for the last meeting, stating that requests for allocations from the Fund for a Healthy Maine for programs

should be evaluated by asking how the programs directly impact tobacco use and how the programs directly impact on the prevalence of obesity within our population. See Appendix G.

The Commission also took public comment at the end of the second meeting. The Commission received testimony from representatives of the Maine Head Start Directors Association, Maine Network of Healthy Communities, the Family Planning Association, Planned Parenthood of Northern Maine, the Maine Equal Justice Project, the Maine Dental Access Coalition and the American Cancer Society.

Meeting Three

The third and last meeting of the Commission took place on November 29, 2011. The chairs of the Commission opened the meeting with an hour of public testimony and received public testimony from representatives of the Maine Children's Trust, the American Lung Association of New England, the Maine Head Start Directors Association, Eastern Maine Healthcare and the Family Planning Association of Maine.

Jan Clarkin of the Maine Children's Trust provided information on home visiting services, clarifying that home visitors are highly trained professionals and but are not required to be registered nurses. The home visiting handout presented at the meeting listed the following highlights for home visiting:

- 93% of children in home visiting families are up to date on their immunizations, which is 20% higher than the statewide immunization rate;
- 94% of expectant mothers in home visiting families receive adequate prenatal care, compared to the statewide rate of 85%;
- 1% of children in home visiting families were victims of substantiated abuse or neglect, compared to the statewide rate of 2.4%;
- Of children in home visiting families who were being exposed to secondhand smoke, 39% were no longer exposed and 29% were less exposed than previously; and
- In home visiting families the Home Safety Assessment improved across all measures, with a 38% improvement in outdoor safety, a 27% improvement in car safety and a 23% improvement in fire prevention.

Edward Miller from the American Lung Association of New England had presented information at an earlier meeting about the smoking cessation initiative undertaken in Massachusetts for Medicaid program members. At the final meeting, he distributed copies of a longitudinal study of that state's tobacco dependence treatments and a presentation by John Auerbach, Commissioner off the Massachusetts Department of Public Health.[5] The Massachusetts tobacco cessation and prevention program designed a low-barrier, comprehensive benefit for Medicaid recipients with an aggressive public education campaign. The results were dramatic. Smoking among Medicaid members decreased from 38% to 28%, with 33,000 people quitting smoking. Within one year the probability of hospitalization from heart attack decreased 46%, and from

[5] *Smoking Cessation Works: MassHealth Benefits*, by John Auerbach, Massachusetts Department of Public Health, November 16, 2011.

acute coronary heart disease it decreased 49%. The program was shown to produce a return on investment in one year of $2.21 for every $1 spent.

Douglas Orville, representing the Maine Head Start Directors Association, and Judith Reidt-Parker, of the Maine Children's Alliance, provided information that had been requested by the Commission on the benefits of Head Start and Early Head Start. They provided information stated that Head Start program participation results in increased kindergarten readiness and sustained cognitive, social-emotional and health outcomes and an increase in immunization rates from 78% to 91% by the end of a year of participation. Children who had participated in Head Start are 25% less likely to smoke as adults than non-participants, Head Start families use 25% less Medicaid services, and Head Start parents demonstrated increased supportive parenting practices.

Christopher Nolan, of the Office of Fiscal and Program Review, discussed the payment of slot machine revenues to the Fund for a Healthy Maine for use in the Elderly Low-Cost Drug program under Title 8, section 1036, subsection 2, paragraph E and clarified that no revenue will be due from the approval of table gaming in Bangor or the establishment of a new racino in Oxford. Building on information provided on an ongoing basis in the form of pie charts with nine segments for program areas by the Office of Fiscal and Program Review, Christopher Nolan provided information on which program accounts in the biennial budget fit into which of the segments. See Appendix H. He also provided information on the Medicare Buy-In program under the Elderly Low-Cost Drug program that had been provided to the Legislature during the consideration of L.D. 1045, which was finally enacted in the supplemental budget, Public Law 2011, chapter 380.

Several staff members of DHHS provided information requested by the Commission at its prior meetings. A complete copy of the information packet is attached as Appendix I. Therese Cahill-Low, Director of the Office of Child and Family Services in DHHS, spoke on home visiting, Head Start, Early Head Start, afterschool programs for 12 to 15 year olds, child care subsidies and maintenance of effort issues. Geoffrey Miller, Associate Director for the Office of Substance Abuse in DHHS, provided information on MaineCare and non-MaineCare substance abuse services, substance abuse funding at the campuses of Maine's colleges and universities, outcomes and performance measures and maintenance of effort issues. He also provided information on the cost of substance abuse in Maine in crime, death, medical care, injury, treatment and other costs, attached as Appendix J. Debra Wigand and Valerie Ricker, of the DHHS, Maine CDC, spoke with the Commission in response to questions regarding the Healthy Maine Partnerships' priority areas for activities, the 50:40:10 (tobacco, obesity, chronic disease) focus and maintenance of effort requirements in programs funded in whole or in part by the Fund for a Healthy Maine through the Maine CDC. See Appendix K. Megan Hannan, of the Planned Parenthood of Northern New England, and Kate Brogan, of the Family Planning Association, assisted Debra Wigand with the presentation of information of the funding of family planning services and on the possibility of a Medicaid State Plan amendment to expand Medicaid eligibility and provide family planning services to females below 200% of the federal poverty level using the 9 to 1 federal financial participation that is now available to the states.

Having completed the collection of information on the Fund for a Healthy Maine and programs funded by the fund in whole or in part, the Commission began discussion and deliberation on recommendations to forward to the Legislature in its report. Committee discussions on recommendations included whether to move funds from Head Start or the Donated Dental program into the Substance Abuse program given increasing issues surrounding substance abuse in Maine but this issue was not brought to a Commission vote. One Commission member was absent from the final meeting. Therefore the votes recorded are for the recommendations are of the 12 members present.

III. RECOMMENDATIONS

The following recommendations by the 12 members of the Commission who were present were made unanimously except for recommendation 4, which was supported by a vote of 9 to 3. Suggested legislation to accomplish the recommendations of the Commission is attached as Appendix L.

1. **Change the Fund for a Healthy Maine to a separate fund.** Amend the Fund for a Healthy Maine law to change the Fund for a Healthy Maine from a group of programs within Other Special Revenue Funds to a separate fund. Maintain current law on revenues paid into the fund.

2. **Include health promotion and prevention and overweight and obesity to the list of health purposes for the Fund for a Healthy Maine.** Amend the Fund for a Healthy Maine law to broaden "health-related purposes" to "prevention and health promotion purposes." Also amend the list of prevention and health promotion purposes to include overweight and obesity prevention, education and treatment activities.

3. **Require separate accounts and annual reporting about the use of Fund for a Healthy Maine funds.** Amend the Fund for a Healthy Maine law to require contractors, vendors and state agencies receiving funding from the Fund for a Healthy Maine to maintain money received from the Fund for a Healthy Maine in separate accounts and shall to provide a description of how Fund for a Healthy Maine funds for the prior state fiscal year were targeted to the prevention and health promotion purposes specified in the law. Require the Commissioner of Administrative and Financial Services to compile reports and forward information to the Legislature annually.

4. **Require Health and Human Services Committee review of Fund for a Healthy Maine legislation.** Amend the Fund for a Healthy Maine law to require review by the joint standing committee having jurisdiction over health and human services matters of all legislative proposals that affect the Fund for a Healthy Maine that have majority support in the committee to which the legislation was referred. This mirrors the provision currently in Joint Rule 317. This recommendation was adopted by a majority vote of 9 to 3. The minority supported continuing to impose review requirements under Joint Rule 317.

5. **Require study commission review of Fund for a Healthy Maine allocations every four years.** Amend the Fund for a Healthy Maine statute to require the Legislature to establish a study commission to review allocations of the Fund for a Healthy Maine beginning in 2015 and every 4 years thereafter. The composition and duties of the commission would mirror the current commission under Resolve 2011, chapter 112.

6. **Recommendations regarding separate program accounts.** Direct the Commissioner of Administrative and Financial Services to review program structure for the programs of the Fund for a Healthy Maine and to recommend a new program structure, including a program for overweight and obesity prevention, education and treatment, beginning in state fiscal year 2014-2015. Funding for the new overweight and obesity program is from funding currently provided for this purpose under existing programs. This recommendation was adopted unanimously.

7. **Issue a statement of support for funding continued enforcement by the Office of the Attorney General.** Include in the recommendations of the Commission a statement of support for continued funding for the Office of the Attorney General from the Fund for a Healthy Maine to enable the office to continue diligent enforcement of the tobacco master settlement agreement in accordance with the requirements of Title 22, chapter 263, subchapters 3 and 4. This recommendation was adopted unanimously.

8. **Issue a statement of support for investments in public health and prevention and for the original intent of the funding.** Include in the recommendations of the Commission a statement that the Commission recognizes the importance of investments in public health and prevention and believes that the original intent of the funding should be maintained and efforts should be made to eliminate health disparities. The statement will also include the following: "Access to adequate health coverage and support for building relationships with health care providers and the health care system are critical to the individual's ability to access important prevention, education and treatment resources related to smoking and tobacco, overweight and obesity, prenatal and young children's care, child care, health care, prescription drugs, dental and oral health care, substance abuse, school health and nutrition programs and counseling on ways to improve individual health behaviors." This recommendation was adopted unanimously.

Two proposals were discussed by the Commission and received support from a minority of members.

1. **Shift Fund for a Healthy Maine funding from family planning services to the child care subsidy program and consider a Medicaid State Plan amendment for family planning services with enhanced federal financial participation.** Deallocate $401,430 from FHM-Family Planning for state fiscal year 2012-2013, reallocate that funding to FHM-Purchased Social Services program for the child care subsidy program to enable the program to maximize matching federal block grant funds. In conjunction with the shift of funding, encourage the Appropriations and Financial Affairs Committee to consider a family planning Medicaid State Plan amendment. The family planning Medicaid

expansion would expand access to family planning services to females up to 200% of the federal poverty level while taking advantage of the enhanced 9 to 1 federal match rate, which will make up for the lost Fund for a Healthy Maine funding. This proposal was supported by 4 members of the Commission and opposed by 8 members.

2. **Raise tobacco and alcohol taxes and direct the revenues to prevention, education and treatment services.** Raise tobacco and alcohol taxes to help to meet the costs of addiction, directing revenues from the increased taxes to the General Fund to support substance abuse prevention, education and treatment services. This proposal was supported by 4 members of the Commission and opposed by 5 members. Two members abstained from voting.

APPENDIX A

Resolve 2011, chapter 112 – Resolve, To Study Allocations of the Fund for a Healthy Maine

APPROVED | CHAPTER
JUN 08 '11 | 112
BY GOVERNOR | RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND ELEVEN

H.P. 1144 - L.D. 1558

Resolve, To Study Allocations of the Fund for a Healthy Maine

Sec. 1. Commission established. Resolved: That the Commission To Study Allocations of the Fund for a Healthy Maine, referred to in this resolve as "the commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of no more than 13 members appointed as follows:

1. The President of the Senate shall:

A. Appoint 3 members of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature. At least one of the appointees must serve on the Joint Standing Committee on Appropriations and Financial Affairs and at least one of the appointees must serve on the Joint Standing Committee on Health and Human Services; and

B. Appoint one person representing municipal public health departments and one person representing a major voluntary nonprofit health organization; and

2. The Speaker of the House of Representatives shall:

A. Appoint 4 members of the House of Representatives, including members from each of the 2 parties holding the largest number of seats in the Legislature. At least one of the appointees must serve on the Joint Standing Committee on Appropriations and Financial Affairs and at least one of the appointees must serve on the Joint Standing Committee on Health and Human Services; and

B. One person representing a statewide organization of public health professionals, one person representing a public health organization or agency operating in a rural community, one person representing the organizations providing services supported by funds from the Fund for a Healthy Maine and one person who possesses expertise in the subject matter of the study under this resolve; and be it further

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission; and be it further

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 10 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. The chairs of the commission shall call and convene the first meeting of the commission within 15 days of the effective date of this resolve. If a majority of but not all appointments have been made within 10 days of the effective date of this resolve, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business; and be it further

Sec. 5. Meetings. Resolved: That the commission may meet only when the Legislature is not in regular or special session. The commission is authorized to meet up to 6 times to accomplish its duties; and be it further

Sec. 6. Duties. Resolved: That the commission shall review the alignment of allocations from the Fund for a Healthy Maine, established in the Maine Revised Statutes, Title 22, section 1511, with the State's current public health care and preventive health priorities and goals. The commission shall gather information and data from public and private entities as necessary to:

1. Identify or review the State's current public health care and preventive health priorities and goals;

2. Identify or review strategies for addressing priorities and goals and potential effectiveness of those strategies;

3. Assess the level of resources needed to properly pursue the strategies identified in subsection 2;

4. Make recommendations for how Fund for a Healthy Maine funds should be allocated to most effectively support the State's current public health and preventive health priorities, goals and strategies; and

5. Make recommendations for processes to be used to ensure that Fund for a Healthy Maine allocations stay aligned with the State's health priorities and goals; and be it further

Sec. 7. Cooperation. Resolved: That the Commissioner of Administrative and Financial Services, the Commissioner of Education, the Commissioner of Health and Human Services and the Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services shall provide information and data to the commission as necessary for its work; and be it further

Sec. 8. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission; and be it further

Sec. 9. Report. Resolved: That, no later than December 7, 2011, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services; and be it further

Sec. 10. Transfer of funds; Office of Program Evaluation and Government Accountability, General Fund. Resolved: That, on the effective date of this resolve, the State Controller shall transfer $6,960 from the Office of Program Evaluation and Government Accountability, General Fund account to the Miscellaneous Studies Legislative, General Fund account in the Legislature to fund the costs of the study.

APPENDIX B

Membership list, Commission to Study Allocations of the Fund for a Healthy Maine

Commission to Study Allocations of the Fund for a Healthy Maine

Resolve 2011, Chapter 112

Wednesday, December 7, 2011

Appointment(s) by the President

Sen. Earle L. McCormick - Chair 633 Hallowell Litchfield Road West Gardiner, ME 04345 207 724-3228	Senate Member
Sen. Margaret M. Craven 41 Russell St Lewiston, ME 04240 207 783-1897	Senate Members
Sen. Roger Katz 3 Westview Street Augusta, ME 04330 207 622-3711	Senate Members
Susan Tidd 140 Wyman Road Benton, ME 04901 207 877-4431	Representing a Major Voluntary Nonprofit Health Organization
Shawn Yardley City of Bangor Health and Community Services 103 Texas Ave. Bangor, ME 04401 207 299-7863	Representing Municipal Public Health Departments

Appointment(s) by the Speaker

Rep. Deborah J. Sanderson - Chair 64 Whittier Drive Chelsea, ME 04330 207 376-7515	House Members
Rep. Tyler Clark P.O. Box 243 Easton, ME 04740 207 227-6971	House Members
Rep. Mark Eves 78 Madison St No Berwick, ME 03906 207 850-0516	House Members
Rep. Meredith N. Strang Burgess 155 Tuttle Road Cumberland, ME 04021 207 775-5227	House Members
Dr. Joel A. Kase 36 Waters Edge Drive Lewiston, ME 04240 207 281-3665	Representing a Statewide Organization of Public Health Professionals
Dr. Sheila G. Pinette Maine CDC 11 State House Station Augusta, Maine 04333 207 287-3266	Individual with Expertise in Allocations of the Fund for a Healthy Maine
Lisa C. Kavanaugh 41 N. Shore Lane Winthrop, ME 04364	Representing a Public Health Organization or Agency in a Rural Community
Thomas M. Kivler 99 Loring Lane Pownal, ME 04069 207 373-6972	Representing Organizations Providing Services Funded from the Fund for a Healthy Maine

Staff:

Jane Orbeton 287-1670
OPLA

Anna Broome 287-1670
OPLA

APPENDIX C

Extract of November 4, 2011 Presentation of Department of Health and Human Services, Maine Center for Disease Control and Prevention, public health goals

Extract of November 4, 2011 Presentation of DHHS, Maine Center for Disease Control and Prevention

By Jane Orbeton, Office of Policy and Legal Analysis

1. **US DHHS, Four Overarching Goals of Healthy People 2020**
   - Attaining high-quality, longer lives
   - Achieving health equity
   - Creating environments that promote good health
   - Promoting quality of life and healthy development and behaviors across all life stages

2. **Maine DHHS Shared Goals Related to Healthy Maine 2010**
   a. Access to quality health care, disease prevention and health promotion
   b. Chronic disease
   c. Environmental health
   d. Reproductive health
   e. Infectious disease and immunization
   f. Injury prevention
   g. Mental health
   h. Occupational health
   i. Physical activity and nutrition
   j. Substance abuse prevention
   k. Identify disparities in outcomes among all populations
   l. Direct resources toward reducing or eliminating inequalities in health outcomes
   m. Levels of prevention activities

3. **Maine DHHS Strategies to Improve Health Outcomes**
   a. Build community capacity
   b. Build state and local public health capacity
   c. Workforce development
   d. Access to community prevention interventions
   e. Access to health and dental insurance
   f. Reducing barriers to high quality care
   g. Improving quality of health care systems

Information from Dr. Thomas Freiden, US DHHS, Center for Disease Control and Prevention	
"Winnable Health Battles"	"5-Tier Health Impact Pyramid"
Healthcare-associated infections	Counseling and education
HIV in the US	Clinical interventions
Motor vehicle injuries	Long lasting protective interventions
Nutrition, physical activity and obesity	Changes in environmental context
Teen pregnancy	Changes in socioeconomic factors
Tobacco use	

APPENDIX D

Non-Department of Health and Human Services programs funded by Fund for a Healthy Maine funds, November 17, 2011

Department of the Attorney General
FHM – Attorney General
Account 014-26A-0947-01

The FHM – Attorney General program funds one full-time Assistant Attorney General position to: (1) defend Maine's entitlement to full payments under the tobacco Master Settlement Agreement ("MSA") against challenges by participating tobacco manufacturers; (2) enforce the provisions of the MSA, including public health restrictions such as the ban on youth targeting; and (3) enforce Maine's statute requiring escrow payments from non-participating manufacturers, Maine's directory statute, Maine's retail licensing laws, and Maine's reduced ignition propensity statute. The position is critical to Maine's meeting the diligent enforcement requirement of the MSA, which the participating manufacturers have challenged and are expected to continue to challenge in their ongoing effort to substantially reduce the amount of their payments to the State.

Recent funding history is reflected below.

Line Category	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Personal Services	115,029	121,290	87,738	95,424
All Other	21,102	22,553	24,102	24,263
TOTAL	136,131	143,843	111,840	119,687

Up until the current fiscal year, Personal Services funding was provided to cover the salary and benefits of 1.5 attorney positions. The half-time position was eliminated in PL 2011, c. 380, Part RRR. All Other expenditures are incurred primarily in the areas of contractual services, travel, staff training, information technology and for the state's indirect cost allocation assessment.

Dirigo Health
FHM – Dirigo Health
Account 014-95D-Z070-01

The FHM – Dirigo Health program began receiving Fund for a Healthy Maine allocations in fiscal year 2008-09. Funds were to be used for the purposes of the Dirigo Health Program which was established to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis and to monitor and improve the quality of health care in this State. Funds currently allocated to the FHM – Dirigo Health program are used solely to support access to the DirigoChoice product for members with nominal assets and household incomes under 300% of the federal poverty limit. Current biennium allocations will support approximately 385 members.

Recent program history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	4,683,443	4,441,791	1,161,647	1,161,647
TOTAL	4,683,443	4,441,791	1,161,647	1,161,647

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – Dirigo Health program. The final biennial budget bill enacted by the Legislature, Public Law 2011, c. 380 included allocations for this program, although at a reduced level.

Department of Education
FHM – School Nurse Consultant
Account 014-05A-0949-10

The purpose of the FHM - School Nurse Consultant program is to provide ongoing consultation, policy development and technical assistance to the nearly 400 school nurses across the State. School nurses in Maine provide health services to students in order to assist them to be ready to learn. With changes in Federal regulations that require students to be educated in the least restrictive environment, many medically fragile students are now attending school. There are increasing numbers of students in school with diabetes, asthma and other chronic health conditions. School nurses are responsible for the health services provided to all students, are involved with environmental health and public health issues of the school, and work with school, parents and community health providers to improve the health of students.

Specifically the school nurse consultant: serves as a liaison and resource expert in school nursing and school health care program areas; monitors, interprets, synthesizes and disseminates relevant information; fosters and promotes staff development for school nurses; and gathers and analyzes data relevant to the school health care program and monitors standards to promote school nursing excellence and optimal health of school children.

The FHM allocation provided funding for the salary and benefits of one Education Specialist III position and related operating costs including staff travel, information technology charges and the state's indirect cost allocation assessment.

Recent funding history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Positions - Legislative Count	1.000	1.000	0.000	0.000
Personal Services	92,871	90,353	0	0
All Other	6,503	6,525	0	0
TOTAL	99,374	96,878	0	0

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – School Nurse Consultant program. This funding reduction was enacted in PL 2011, c. 380; however, the Department of Education was able to identify funding available from the American Recovery and Reinvestment Act of 2009 to create a limited-period position to provide these services for the 2012-2013 biennium. The department is currently exploring federal funding opportunities to continue the position beyond the 2012-2013 biennium.

Department of Education
FHM – School Breakfast Program
Account 014-05A-Z068-01

The FHM – School Breakfast Program provides funds to reimburse local school units that provide breakfasts to those students eligible for the reduced-price breakfast benefit for the cost of the breakfast. PL 2007, chapter 539, Part IIII enacted provisions that require public schools that serve breakfast to provide breakfast to students who are eligible for free and reduced-price meals at no cost to the student. The State is required to provide funding to the schools for the difference between the federal reimbursement for a free breakfast and the federal reimbursement for a reduced-price breakfast for each student eligible for a reduced-price breakfast and receiving breakfast. This same law provided Fund for a Healthy Maine allocations, beginning in fiscal year 2008-09, for this purpose.

Recent funding history is reflected below.

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	168,610	162,474	213,720	213,720
TOTAL	168,610	162,474	213,720	213,720

The Department of Education reimburses school administrative units on a monthly basis. Approximately 165 school units receive reimbursement annually. The department estimates that approximately 701,000 breakfasts are subsidized annually. Fund for a Healthy Maine resources provided in fiscal years 2009-10 and 2010-11 were not sufficient to cover all required costs. For FY 10, additional expenditures of $35,990 were paid from available Other Special Revenue Funds resources. For FY 2010-11, a General Fund appropriation of $50,000 was provided to cover the additional costs of which $39,016 was expended to cover the required program costs. Due to the historical cost trend, effective with fiscal year 2011-12, it was determined that additional allocations were required to meet funding requirements; these allocations were provided in Public Law 2011, chapter 380.

Finance Authority of Maine
FHM – Health Education Centers
Account 014-94F-0950-02

The goal of the FHM – Health Education Centers program is to attract and retain health care personnel in underserved areas of the state and to provide services to underserved cultural groups through educational system incentives. To meet this goal, the Finance Authority of Maine contracts with the University of New England to: provide continuing education courses to promote professional development for rural health professionals; provide clinical placements for health professions students in rural and underserved areas; and expose students in rural areas to health professions through career awareness programs and other educational experiences.

Recent funding history is reflected below.

	FY 2009-10 Actual Expenditures	**FY 2010-11 Actual Expenditures**	**FY 2011-12 Allocations**	**FY 2012-13 Allocations**
All Other	112,040	106,260	100,353	100,353
TOTAL	112,040	106,260	100,353	100,353

The Governor's proposed 2012-2013 budget proposed to eliminate funding for this program. However, the budget as enacted by the Legislature as Public Law 2011, c. 380 did continue funding for fiscal years 2011-12 and 2012-13 at levels slightly less than what was provided for fiscal year 2010-11.

Finance Authority of Maine
FHM – Dental Education
Account 014-94F-0951-01

The FHM – Dental Education program, the goal of which is to increase the number of dentists practicing in Maine in underserved areas or for underserved populations, is administered by the Finance Authority of Maine. There are two components of the program: The Maine Dental Education Loan Program provides forgivable loans to Maine residents pursuing postgraduate dental education, the goal of which is to increase the number of dentists practicing in Maine in underserved areas or for underserved populations; the Maine Dental Education Loan Repayment Program provides loan repayment assistance for dentists practicing general dentistry in eligible dental care facilities in underserved areas of the state of Maine.

Any Maine resident who is pursuing a career as a dentist and intends to practice primary dental care in an eligible dental care facility in an underserved area in Maine is eligible to apply for a loan under the Maine Dental Education Loan Program. In addition, an applicant must be Maine resident, for purposes other than education, for a minimum of two years prior to matriculation into dental school and must be admitted to a program of dentistry at an accredited institution of dental education, leading to a D.M.D. or D.D.S degree. Loans of up to $20,000 per year may be awarded, with a maximum aggregate amount of $80,000. Disbursement of loan funds is made directly to the dental school.

Certain loan program recipients may be granted loan forgiveness. Upon compliance with all necessary procedures, loan recipients practicing in underserved areas will be forgiven 25 percent of their original indebtedness on an annual basis. Loans, plus any accrued interest, must be repaid if a loan recipient is not eligible for forgiveness. If the loan recipient returns to Maine but does not enter an eligible underserved practice, the loan will have to be repaid at an annual rate of interest applicable to Stafford loans at the time of the recipient's original note. The recipient may receive a reduction of ½ percent or 1 percent, dependent on the type of practice they maintain. If the loan recipient does not return to Maine to practice, the loan will have to be repaid with interest at 1.5 percent above the Stafford Loan rate over a ten-year period.

Any dentist licensed to practice in Maine who is employed in or intends to establish a qualified practice, has qualifying outstanding dental education loans, and is not under agreement for loan repayment from a program funded by the National Health Service Corps, is eligible to apply for the Maine Dental Education Loan Repayment Program. The dentist does not have to establish prior Maine residency. Up to $20,000 per year of loan repayment may be awarded with a maximum aggregate amount of $80,000. Funds are disbursed directly to the dentist for payment toward outstanding dental education loans. Evidence of payment of outstanding education loans must be provided to receive subsequent disbursements.

Recent funding history is reflected below:

	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
All Other	265,428	251,735	237,740	237,740
TOTAL	265,428	251,735	237,740	237,740

	FY10 Actual	FY11 Actual	FY12 Projected	FY13 Projected
Loans Awarded	7	10	8	8
Loan Repayments Awarded	5	2	3	3

Since program's inception, 38 awards, 24 loans and 14 loan repayments have been funded.

Beginning in fiscal year 2000-01 and ending in fiscal year 2007-08, FAME was required annually to award up to three loans or loan repayment agreements annually up to an aggregate of twelve. Beginning in FY 2008-09, FAME is required to award up to three loans or loan repayment agreements annually, and may award additional loans or loan repayment agreements annually as funds permit.

Finance Authority of Maine
FHM – Quality Child Care
Account 014-94F-0952-03

The goal of the FHM – Quality Child Care program was to increase the skills of people working in childcare by providing educational grants for related education. Scholarships were awarded to eligible Maine residents enrolled in postsecondary courses related to early childhood education or child development. Funds for these scholarships were provided by FAME to participating Maine institutions to award to eligible students on an annual basis. FAME was authorized set aside up to 10 percent of available funding as a reserve to help non-degree students and for students attending out-of-state schools. Scholarships amounts were up to $500 per course within an eligible program of study, for a maximum of two courses per semester and up to a maximum of $2,000 per student per year. To be eligible for the program, a student needed to be a Maine resident, a United States Citizen or eligible non-citizen, a graduate of an approved secondary school or have successfully completed a general education development examination or its equivalent, must have been accepted for enrollment in an eligible program of study, and must have demonstrated the required financial need.

Recent funding history is reflected below:

	FY 2009-10 Actual Expenditures	**FY 2010-11 Actual Expenditures**	**FY 2011-12 Allocations**	**FY 2012-13 Allocations**
All Other	160,358	152,084	0	0
TOTAL	160,358	152,084	0	0

	FY10 Actual	FY11 Actual	FY12 Projected	FY13 Projected
Grants Awarded	276	176	-0-	-0-

The 2012-2013 biennial budget proposed by the Governor and enacted by the Legislature as Public Law 2011, chapter 380, eliminated Fund for a Healthy Maine allocations for this program effective with fiscal year 2011-12.

Judicial Department
FHM – Judicial Department
Account 014-40A-0963-01

The Judicial Branch has the authority to establish alcohol and drug treatment programs in the Superior and District Courts in accordance with the Maine Revised Statutes, Title 4, section 421. Allocations to the FHM – Judicial Department program were used to fund the salary of a Coordinator of Diversion and Rehabilitation Programs to assist the Judicial Branch to establish, staff, coordinate, operate and evaluate diversion and rehabilitation programs throughout the courts. Specifically the Coordinator works with all adult drug courts, serves as the liaison with parties involved in drug court cases; problem solve with the courts; and writes grants to obtain additional resources and administers the grants received.

Recent funding history is reflected below.

Line Category	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Positions - Legislative Count	1.000	1.000	0.000	0.000
Personal Services	113,913	107,294	0	0
All Other	722	829	0	0
TOTAL	114,635	108,123	0	0

Personal Services allocations provided for the salary and fringe benefits of the Coordinator position. All Other allocations represent the state's indirect cost allocation assessment.

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – Judicial Department program. This funding reduction was enacted in PL 2011, c. 380; however, the Judicial Department was able to identify alternative sources of funding to continue the Coordinator position.

Department of Public Safety
FHM – Fire Marshal
Account 014-16A-0964-01

Allocations for the FHM – Fire Marshal program were provided to support staff for the purpose of conducting fire safety inspections of child care facilities seeking new or renewed licenses. Personal Services allocations supported the salary and fringe benefits 3 Public Safety Inspector II positions and a portion of the cost of an Office Assistant II position. There were approximately 3,736 fire safety inspections conducted for the Department of Health and Human Services during SFY2011.

Recent funding history is reflected below:

Line Category	FY 2009-10 Actual Expenditures	FY 2010-11 Actual Expenditures	FY 2011-12 Allocations	FY 2012-13 Allocations
Positions - Legislative Count	3.000	3.000	0.000	0.000
Personal Services	237,637	242,439	0	0
All Other	13,227	8,645	0	0
Supplemental AO Allocation	1,140,780			
TOTAL	1,391,644	251,084	0	0

Allocations for All Other generally support staff travel and information technology expenses and the state's indirect cost allocation assessment. In FY 2009-10, a one-time FHM allocation of $1,140,780 was also provided to the program to pay an accrued balance due to the Fire Marshal's Office related to mandatory inspections of Department of Health and Human Services facilities that provide services to children.

The Governor's proposed 2012-2013 biennial budget included an initiative to end Fund for a Healthy Maine allocations for the FHM – Fire Marshal program. The final 2012-2013 biennial budget instead provided General Fund appropriations to the State Fire Marshal to fund this program.

APPENDIX E

Department of Health and Human Services programs funded by Fund for a Healthy Maine funds, November 17, 2011

Fund for a Healthy Maine Fact Sheet

Office: Child and Family Services **Date:** 11-17-11

Program Title: Maine Families Home Visiting

Account: 014-095306, FHM-Home Visitation

I. Program Description:

1) Overview of the program:

Home Visiting was formally established in state statute (Title 22, §262) as an effective primary prevention public health strategy to meet the goals of the Department by improving the health and well-being of Maine's young children and their families through a connected network of home visiting providers.

In accordance with the federal definition of home visiting as outlined in the Social Security Act, Title V, Section 511(b)(U.S.C. 701), as amended by the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent, short-term or supplemental home visiting), and is offered on a voluntary basis to mothers, fathers, families, pregnant women, infants, and children.

Maine Families Home Visiting delivers cost-effective focused services to a vulnerable population at the most critical time of children's physical and emotional development.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

The Maine Families Home Visiting Program serves vulnerable families of infants and toddlers. Typically, over 2500 families receive home visits each year. The families who received home visits were largely young (46% under age 23 at their child's birth), single or partnering (60%) and more likely to be facing economic challenges (over 1/3 of the families had incomes under $10,000 for the year). The program is making special efforts to reach the highest risk babies such as those that are drug affected or exposed to family violence.

3) What is purchased with these funds:

Maine Families Home Visiting is an evidence-based program providing focused services in response to an individualized needs assessment and is offered in families' homes. Well-trained professionals work in partnership with parents to insure safe home environments, promote healthy growth and development for babies and young children, and provide key connections to state and local services as needs are identified.

Expectant parents receive support to have a healthy pregnancy and access prenatal care. Parents of newborns are supported in their adjustment to parenthood and information is provided related to critical areas such as prevention of shaken baby syndrome, SIDS, suffocation and unintended injuries. Beyond the newborn period, ongoing educational and support services are provided to the most vulnerable families at a level reflecting the families' needs.

4) **What is the service delivery (i.e. state personnel, contracted services, etc):**
Contracted home visiting program sites are located in various health, educational and community agency settings and are available in every county in Maine. Sites work closely with other community service providers to collaborate and avoid duplication of services.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. **Relevant Legislative History:**

- State funded community- based home visiting was piloted originally in 1994 and expanded across the state in 2000 with the availability of funding from the Tobacco Settlement Funds.
- 2007, Title 22, §262: Home visiting
- 2011, Ch. 77, LD 1504, *Resolve, to Ensure a Strong Start for Maine's Infants and Toddlers by Extending the Reach of High Quality Home Visitation*
- Social Security Act, Title V, Section 511 (42 U.S.C. §701) as amended by Section 2951 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

III. **Financial Information:**

1) **4 Years of Spending and SFY12 & 13 Budget:**

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$ 5,378,750	$ 5,022,914	$ 5,064,553	$ 5,091,128	$ 2,653,383	$ 2,653,383
General Fund or Other Special Revenue					$ 2,000,000	$ 2,000,000
Federal Funds					$ 4,000,000	$ 5,200,000
Total	$ 5,378,750	$ 5,022,914	$ 5,064,553	$ 5,091,128	$ 8,653,383	$ 9,853,383

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:**
Fund for a Healthy Maine (FHM) funding represents 30.7% and 26.9% of the total funding for the Home Visitation program for FY 2012 and FY 2013 respectively.

IV. **Program Eligibility Criteria:**
Families may take part in the program beginning in pregnancy and may receive visits until their child turns three years of age. Beyond the prenatal/newborn period, eligibility for ongoing services is determined by an individualized needs assessment and is prioritized and focused on the most vulnerable families such as adolescents and those experiencing substance abuse, domestic violence, mental health issues, developmental/ health concerns or family stress.

V. **Are the Fund for a Healthy Maine funds used to meet MOE Requirements?** ☒ **Yes** ☐ **No**

If yes, please explain:

The Affordable Care Act – Maternal, Infant and Early Childhood Home Visiting Program grants (formula based grants and competitive expansion grant) were awarded to "effectively implement home visiting models (or a single home visiting model) in the state's at-risk community(ies) to promote improvements in the benchmark and participant outcome areas as specified in the legislation." States must use the federal funds to supplement, not supplant, funds from other sources for these early childhood home visiting services.

VI. **Goals & Outcomes of the program:**

1) **Please describe the goals of the program:**
   - Healthy and strong parent-child attachment.
   - Family health, emotional and physical well-being.
   - Reduced incidence of child abuse and neglect.
   - Positive and creative learning environment for the child.
   - Family self-sufficiency.
   - Positive and effective parenting.
   - Parental competencies and self-confidence.
   - Community linkages/reduced family isolation.
   - Educational success.

2) **Please describe how the outcomes are measured:**

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering several domains of health and well-being. The state home visiting plan submitted in June 2011 included detailed descriptions of how each benchmark is measured. One example is included below:

Benchmark I. Improved Maternal and Newborn Health	
Construct	**(ii) Parental use of alcohol, tobacco, or illicit drugs**
Indicator	Percentage of pregnant women enrolled in the program using tobacco at intake who have ceased tobacco use by 3 months post enrollment
Indicator Type	Outcome Measure
Measurable Objective *Operational definition of improvement*	Increase or maintain the percentage of enrolled pregnant women using tobacco who cease tobacco use within three months post-enrollment from year 1 baseline to the 3-year benchmark reporting period.
Measurement Tool	Behavioral Health Risk Screening Tool for Pregnant Women and Women of Childbearing Age (BHRST)
Validity of proposed measurement tool	The Virginia Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Health (VDH) and the Home Visiting Consortium developed the *Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age* based on the Integrated Screening Tool developed by the Institute for Health and Recovery (IHR). (IHR's tool may be located online at www.mhqp.org/guidelines/perinatalPDF/IHRIntegratedScreeningTool.pdf. Virginia follows Bright Futures Guidelines (www.brightfutures.org/mentalhealth) as a framework for prevention and use of standardized screening tools. This tool incorporates the 4P's Plus, EPDS-3 and a Domestic Violence screening question. The 4P's Plus tool reliably and effectively screens pregnant women screened for substance abuse, including those women typically missed by other perinatal screening methods. The overall reliability for the 5-item measure was 0.62. Seventy-four (32.5%) of the women had a positive screen. Sensitivity and specificity was very good at 87% and 76% respectively. Positive predictive validity was low (36%) but negative predictive validity was high (97%). According to the author, "In an evaluation of clinical experience with the 4P's Plus, effective identification of pregnant women at highest risk for substance use can be accomplished within the context of routine prenatal care." (Chasnoff, et al., 2005)

Benchmark I. Improved Maternal and Newborn Health	
Construct	**(ii) Parental use of alcohol, tobacco, or illicit drugs**
Population to be assessed	Caregiver (pregnant women)
Sampling Plan, if applicable	N/A All families included
Special Considerations	None
Data Collection Plan (Including schedule/how often)	All pregnant caregivers will be screened for alcohol, tobacco, and drug use using the BHRST. Baseline data results of the screen will be entered into the database, ongoing parent report on current use of tobacco will be collected at each visit and change will be captured in the online database.
Data Analysis Plan *(include plan for the identification of scale scores, ratios, or other metrics most appropriate to the measurement proposed)*	Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: • Enrollment from the start of the project period • Families identified as pregnant at enrollment • Tobacco use as noted from enrollment data • Tobacco use at date 3 months from enrollment The calculation will be determined by dividing the total number of pregnant women who cease tobacco use within three months post-enrollment by the number of women enrolled prenatally who are using tobacco (at any intensity) at enrollment.

3) **Please describe the measurable outcomes of the program:**

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering the following domains: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. See Social Security Act, Title V, Section 511 (d) (1) (42 U.S.C. §701).

Highlights of the recent outcome data for Maine Families Home Visiting:
HEALTH AND DEVELOPMENT OUTCOMES (FY11)

- 99.8% of children have a primary care provider and 97.3% have health insurance.
- 93% are up to date with their well-child check-ups and their immunizations (20% higher than the Maine immunization rate).
- All age-eligible children are screened regularly for possible developmental delays (with parent permission). Seven percent of children on average are identified with possible delays and provided supports to help address those delays early before more costly remediation is needed in school.
- Of children exposed to second hand smoke, 39% are no longer exposed and 29% have reduced exposure, reducing their risk of developing respiratory and other related health issues.
- 94% of expectant mothers received adequate prenatal care (Maine rate 85%) resulting in fewer premature and low birth weight babies and saving significant related health care costs.

SAFETY OUTCOMES (FY10)

- 1% of children in the program were victims of substantiated abuse or neglect. (Maine rate 2.4%)
- Home Safety Assessment improved across all measures, with the largest impacts in fire prevention (23%), outdoor safety (38%) and car safety (27%).

PARENTS' REPORT OF POSITIVE CHANGE AS A RESULT OF PARTICIPATION:

- Child Development 99%
- Home Safety 98%
- Child Nutrition 98%
- Child Discipline 98%
- Car Seat Safety 96%
- Breastfeeding 91%
- Second-hand Smoke 92%

Fund for a Healthy Maine Fact Sheet

Office: MaineCare Services **Date:** 11/17/11

Program Title: Drugs for the Elderly

Account: 014-10A-Z01501

I. Program Description:

1) Overview of the program:
22 §254-D. ELDERLY LOW-COST DRUG PROGRAM was first adopted in 2005. Policy 10-144 Chapter 10 Section 2. DEL is funded by all state dollars and rebates from drug manufacturers. Part D became effective in 2006 and changed the program.

DEL provides prescriptions and nonprescription drugs, medication and medical supplies to disadvantaged, elderly and disabled individuals. The program is limited to drugs where the manufacturer has a DEL rebate agreement in place.

The program covers individuals who are disabled between the ages of 19-61. The members who are not yet eligible for Medicare (they must be disabled for 24 months) receive assistance with prescription medications, the State will pay 80% less $2 the member pays the rest. Members over 62 receive the same benefit until they receive Medicare.

The DEL program has a wrap benefit that assist members who have other insurance. This benefit follows the formulary of the plan or Medicare. The wrap will cover:

- 50% of a brand name drug up to $10 (DUAL, MSP and DEL)
- 100% Up to $2.60 on generic medications. (DUAL, MSP and DEL)
- 100% Part D premiums – average cost is $31 per month per member
- 50% of the part D Deductable*
- In the donut hole (or Gap) the member converts to original DEL benefits where the state will pay 80% less $2 of the drug cost.
- State pays 100% for excluded drugs*

*Part D plans are contracted by the state. The pharmacy unit will go through the RFP process and select qualified benchmark plans. We do an intelligent assignment where we look at a members drug profile and assign to a plan that best fits their needs. The average cost is $31 PMPM.

*Excluded drugs are drugs that do not have to be covered by the plan according to CMS, for example – benzodiazepine drugs are not required to be covered by a part D plan so this class of drug is considered excluded. The ACA has changed this so now there are no excluded drugs.

In 2006 when Part D started, DEL members were enrolled into Part D insurance

plans. Before part D the DEL wrap cost was nearly $13mil. This included all the items mentioned above. Part D premiums were roughly $6mil.

In April of 2007 the Department expanded the Medicare Savings program, this moved most DEL members to MSP. As an MSP member, individuals received additional benefits such as having the PART B premium paid, assistance with coinsurance and deductable, smaller copay's, no longer have a donut hole.

WRAP cost today are approximately $3.3mil and the part D premiums are roughly $500k annually.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

DEL Population per fiscal year

	2008	2009	2010	2011
DEL COMBO (DRUGS FOR THE ELDERLY COMBINATION)	5037	3796	3645	4022
DEL COMBO / QI, AGED	1553	2135	2847	2999
DEL ONLY (DRUGS FOR THE ELDERLY ONLY)			1	
DEL COMBO / QI, DISABLED / QI, BLIND	436	614	781	858
DEL COMBO / QMB - AGED	16795	18297	21114	21714
DEL COMBO / QMB - DISABLED / QMB - BLIND	5234	6444	7641	8537
DEL COMBO / SLMB - AGED	3726	4243	5217	5586
DEL COMBO / SLMB DISABLED / SLMB BLIND	1022	1215	1491	1664
DEL COMBO / SSI AND-OR STATE SUPPLEMENT (NO MEDICAID)	2			
	33805	36744	42737	45380

3) What is purchased with these funds:
The Wrap program:
- 50% of a brand name drug up to $10 (DUAL, MSP and DEL)
- 100% Up to $2.60 on generic medications. (DUAL, MSP and DEL)
- 100% Part D premiums – average cost is $31 per month per member
- 50% of the part D Deductable*
- In the donut hole (or Gap) the member converts to original DEL benefits where the state will pay 80% less $2 of the drug cost.
- State pays 100% for excluded drugs*

4) What is the service delivery (i.e. state personnel, contracted services, etc):
- Part D plans are contracted so that the Department can pay the members premium.
- Legal Services for the Elderly are contracted to provide appeal services for the population
- Goold Health Services is contracted to enroll members into Part D plans as well as participate in the billing process. DEL claims are transmitted through the MEPOPS program, TROOP is calculated, costs are avoided as with any other third party plan.
- Part B Premiums
- This account funds legislative membership in the National Legislative Association on Prescription Drug Prices (NLARx). Membership runs from July 1 through June 30. Executive Director of NLARx is Sharon Treat.

5) Department Program Staff:
Number of employees: _____ Cost of employees: $ _____

- Limited period positions ended in June 2011, no other personnel are paid from this budget.

II. Relevant Legislative History:

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund 014-Z01501	12,069,185	11,488,182	12,839,107	12,352,334	11,934,230	11,934,230
General Fund or Other Special Revenue 010-020201 014-020201 010-092701 014-092701	2,788,244 534,559 18,000 209,310	3,982,679 677,555 18,000 257,193	1,176,556 0 151,979 4,843	6,530,197 0 48,275 118	4,462,786 0 0 135,736	4,462,786 0 0 135,736
Federal Funds						
Total	15,619,298	16,423,609	14,172,485	18,930,924	16,532,752	16,532,752

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:

Part B premiums: 73.67%
$13,129,639
64.85% 014-18F-092101 - Tobacco Settlement
35.15% 014-18F-092102 - Slots (Racino)

All Other DEL: 26.33%
FHM - $4,691,958

IV. Program Eligibility Criteria:

Members with disability who are not eligible for Medicaid, QI, QMB and SLMB members receive the WRAP benefit.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☐ No
If yes, please explain:

Note: I would say yes to this because we can't roll back the MSP this is a violation of the MOE. We can eliminate the DEL only portion of the program.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:
Provide assistance to the Elderly and Disabled to receive drugs.

2) Please describe how the outcomes are measured:

Note: we have never measured the program

3) Please describe the measurable outcomes of the program:

Fund for a Healthy Maine Fact Sheet

Office: Office of Substance Abuse **Date:** 11-17-11

Program Title: FHM - Substance Abuse

Account: 01414G094801

I. Program Description:

1) Overview of the program: The Maine Office of Substance Abuse is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office provides leadership in substance abuse prevention, intervention, treatment, and recovery. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.

The Prevention, Intervention, and Treatment Services all receive funds from the Fund for a Healthy Maine.

Prevention Services are evidence based curriculum driven services that are provided to youth in school and community settings though 9 prevention contracts. On average the FHM funds 30% of the total amount of these contracts.

Data collection and performance monitoring of Prevention contracts is provided through the KIT Solutions contract who provide OSA Web-based Monitoring and Reporting System. FHM fund 16.5% of the KIT Solutions contact. This also provides prevention data required by OSAs SAMHSA Substance Abuse Prevention and Treatment Block Grant.

OSA contracts with the Maine Association of Substance Abuse Programs to fund Maine's Higher Education Alcohol Prevention Partnership (HEAPP). HEAPP is a prevention initiative collaboratively developed between the Maine Office of Substance Abuse and many of Maine's colleges and universities which aims to reduce college students' high-risk alcohol use and its impact upon individuals, campuses, and communities statewide. Forty percent (40%) of the budget is funded by the Fund for Healthy Maine which is supported with tobacco settlement dollars. Approximately 50% of HEAPP's operating budget supports mini-grants to colleges/universities for the implementation of evidence-based substance abuse prevention, early intervention, and enforcement strategies.

Intervention services provided with partial funding of is the Prescription Monitoring Program contract with PMP Web Portal Company Health Information Design at approximately 39% of this contact. Treatment Services provided primarily during SFY 12 for the provision of Substance Abuse Residential Treatment statewide.

Treatment services that are provided through 9 contracts funded in part with FHM include primarily Substance Abuse Residential Services, but may also include Outpatient, and Intensive Outpatient Services. The percent of FHM funds in these ranges from

2) Who is served with these funds (i.e. # of people, # of programs, etc):

Prevention Programs: 1925 participants in 18 recurring evidence based curriculum prevention programs provided by 13 Prevention Provider Agencies. These same agencies

with this funding provided outreach to 4296 people through single events, meetings, media campaigns, etc. and disseminated 1430 prevention materials.

HEAPP works to bring about long-term, systemic change in how high-risk drinking and other substance abuse issues among Maine college/university students are addressed at both the state and local level. All the Strategies and activities of the statewide initiative aim to engage all colleges and universities in Maine that are interested in addressing underage and/or high-risk student drinking so that the non-campus specific environmental factors and capacity for evidence-based prevention may be improved.

Intervention Program: The Prescription Monitoring Program is to assist all Mainers; however access is limited and falls under the PMP rules. Pharmacists, prescribers and their medical assistants can access the system for information regarding their own patients, and prescribers can download a list of all prescriptions attributed to them. Medical Assistants Licensing boards may use the information for investigations they are conducting. Law enforcement officials can access the data only through the Attorney General's Office by grand jury subpoena for a case they are currently investigating. MaineCare's Program Integrity Unit has access for fraud investigations. The Office of the Chief Medical Examiner is allowed access for cause of death determination in their investigations. Individuals may come to Augusta to receive information about themselves up request.

Treatment Programs: Individuals who have a substance abuse or dependence diagnosis or those individuals who are affected by another's use (affected other). These funds during SFY 12 were primarily used for the provision of Substance Abuse Residential Treatment Services. In 2011, 538 clients received treatment services in part with this funding combined with other funds through the continuum of services.

3) What is purchased with these funds:

Prevention: Evidence based curriculum driven services to youth in school and community settings. These are programs that are aimed at youth 12 – 18 that are at risk of substance abuse. KIT Solutions performance based monitoring system for Block Grant reporting and OSA contract monitor and reporting. HEAPP: Maine University and College campuses self-selecting to implement the local component of the HEAPP program receive mini-grants to develop/enhance campus-community coalitions to assess and plan evidence based substance use prevention efforts.

Intervention: Funds part of the PMP contract with Health Information Designs the developer of the electronic prescription monitoring system that Maine uses.

Treatment Services: Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management

4) What is the service delivery (i.e. state personnel, contracted services, etc): Contracted Community Providers statewide.

5) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History: Allocations of the Fund for Healthy Maine for Substance abuse prevention and treatment are stated in Maine Statute Title 22 §1511. Fund for a Healthy Maine established, 6. Health purposes. Allocations are limited to the following health-related purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State; [1999, c. 401, Pt. V, §1 (NEW).]
B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age; [1999, c. 401, Pt. V, §1 (NEW).]
C. Child care for children up to 15 years of age, including after-school care; [1999, c. 401, Pt. V, §1 (NEW).]
D. Health care for children and adults, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
F. Dental and oral health care to low-income persons who lack adequate dental coverage; [1999, c. 401, Pt. V, §1 (NEW).]
G. Substance abuse prevention and treatment; and [1999, c. 401, Pt. V, §1 (NEW).]
H. Comprehensive school health and nutrition programs, including school-based health centers. [2007, c. 539, Pt. IIII, §3 (AMD).]

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund	$6,374,744	$6,349,924	$6,351,468	$4,919,385	$3,286,345 **($2,028,679 – 094801;** $1,257,666 – 094802)	TBD
General Fund or Other Special Revenue	$11,445,840 $697,455	$10,933,307 $744,874	$11,493,871 $643,297	$11,678,870 $667,782	$14,966,404	TBD
Federal Funds **SAPT-BG**	$5,428, 433 + $6,820,035	$5,942,379 + $6,512,077	$6,060,038 + $5,300,042	$1,412,778 + $6,415,223	$7,117,834 + $7,306383	TBD
Total	$30,766,507	$30,482,561	$29,904,455	$25,094,038	$32,647,255	TBD

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program for 2012: For 094801 = 6.21%; For 094802 = 3.85% Combined = 10.06%

IV. Program Eligibility Criteria:

Prevention Services: Provided by Substance Abuse Prevention Providers that are awarded through an RFP process. The programs that are funded are evidence based. Providers through the RFP process need to state the need for the program and the populations that they will be serving based on the identified need. Some services may be prevention support services as the

KIT Prevention system are needed for data collection for Block Grant requirements, but also help in monitoring and reporting the work being provided.

Intervention Services: The Prescription Monitoring program contract with Health Information Design was awarded through an RFP process and use of the PMP Electronic system is limited to prescribers and dispensers that are registered through the PMP.

Treatment Services: Individuals must be diagnosed with a substance abuse or dependence disorder or be an individual affected by another's use of substances.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? X Yes ☐ No
If yes, please explain:

These funds are part of state funds that are used in the Maintenance of Effort Requirement for the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) that Maine's receives annual. This funding helps to ensure that Maine receives its maximum amount of SAPT BG allotment available for Substance Abuse Prevention and Treatment programs.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

Prevention: To prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine.

Intervention: The primary goals of the Prescription Monitoring Program are to reduce the quantity of controlled substances obtained by fraud from doctors and pharmacies and reduce the adverse effects of controlled substance abuse. A secondary goal of the program is to assist investigators for the Maine Boards of Pharmacy and Licensure in Medicine, and other health care licensing boards, in the identification of prescription drug diverters.

Treatment: Works with the statewide provider network to assure access to a full continuum of quality treatment services and provides technical assistance to providers around program development, implementation, and best practices in alcohol and drug treatment programs.

2) Please describe how the outcomes are measured:

Prevention: Prevention services are tracked in the Web-based KIT Prevention System and the outcomes that are developed are specific to each Contracted Provider and the evidence-based program that they are implementing and the outcomes that the program is designed to address. Quarterly narrative and fiscal reports are used to monitor progress on deliverables and outcomes.

Intervention: Through the HID contract the outcomes are met through the deliverables of HID. Here are some of the outcomes and deliverables of an extensive list: Collection of Schedule II, III, and IV drug data from dispensers; Creating editing processes for the importing of the pharmacy data to aid in the cleaning of the data to ensure it is as accurate

and complete as possible; development of a secure database to manage the data collected from the pharmacies; loading of the pharmacy data into the database must take place at least once a week; programming, development, and mailing of at least three sets of notification reports that will show unacceptable thresholds of prescription use on a variety of levels.

Treatment: A combination of compliance and outcome measures via the treatment data system database. In addition, OSA staff (assigned responsibility for contract oversight, management, and technical assistance) conduct site visits, work with the Division of Licensing and Regulatory Services and the Office of Maine Care services to ensure quality programming is occurring.

3). Please describe the measurable outcomes of the program:

Prevention: The outcomes are based on addressing risk and protective factors that and in turn changes in attitudes, behaviors, and prevalence rates of use of substances. The outcomes are measured through program level surveys, local level surveys, or surveillance surveys depending on the reach and impact of the program and availability of data. An example of a long term outcome is: By the end of the academic year, 75% of SIRP participants will report a decrease in their frequency and/or quantity of their use of alcohol, tobacco, and other drugs. This will be measured by the pre-survey and the 90-day survey.

Intervention: The PMP has the following board outcomes that the HID contract assists in meeting: Accurate background information on a new patient can be obtained. Current patients can be monitored. Threshold reports provide warnings on patients who may be misusing or diverting prescription drugs and can assist prescribers in coordination of care. Reports are automatically sent to prescribers when threshold numbers of prescribers and pharmacies have been reached or exceeded by a patient during a given quarter. Contract specific outcomes and deliverables are monitored by the PMP Coordinator to ensure that deliverables are being met by HID.

Treatment: (Collect data that is ultimately reflected in the National Outcome Measures and per SAPTBG Statutory requirements regardless of payer source)

Outpatient

- Time from first call to first face to face: 5 days
  Time to first treatment appointment: 14 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Intensive Outpatient

- Time from first call to first face to face: 4 days
- Time to first treatment appointment: 7 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Tracking measures:

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem

- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment

Referral to Mental Health Services

Substance Abuse Residential Programming:

There are varying levels of residential care (LOC) based on medical necessity. There are also population specific measures. The most common indicators are below with minimum standards set for each based on LOC and population

PERFORMANCE INDICATORS

Abstinence/drug free 30 days prior to discharge
Reduction of use of primary substance abuse problem
Employability
Participation in self-help during treatment
Referral in the Continuum of Care
Completed Treatment

TRACKING ONLY

Average Time in Treatment for Completed Clients (Weeks)
Global Assessment of Functioning Improvement
Conduct follow up contact (phone, text, email) with client 1x a week for first 30 days, then 60 days, 90 days, and 1 year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine program effectiveness, as this may be requested by OSA.

Fund for a Healthy Maine Fact Sheet

Office: Office of Substance Abuse **Date:** 11-17-11

Program Title: FHM - OSA Medicaid Match

Account: 01414G094802

I. Program Description:

1) Overview of the program: The FHM- OSA Medicaid Match is a portion of the budget that OSA has obligated under the Office of Maine Care Services for the provision of the continuum of substance abuse services statewide. These services include Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management.

2) Who is served with these funds (i.e. # of people, # of programs, etc): The number represented here is the number of people served through Medicaid Funding (combined General Fund and FHM. We cannot delineate which individuals were served by just one funding source or another). In SFY 11 individuals served in the treatment continuum were 6,923. Please note that this was collected via Treatment Data System (TDS) database. The accuracy is contingent upon providers putting in the required data.

3) What is purchased with these funds: Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management.

4) What is the service delivery (i.e. state personnel, contracted services, etc): As with Maine Care State Plan Services, it is community based "any willing provider", who is licensed and qualified to provide the service. As of 11/15/11 there were 50 known agencies able to bill Maine Care. There are no direct service state personnel.

5) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History: Allocations of the Fund for Healthy Maine for Substance abuse prevention and treatment are stated in Maine Statute Title 22 §1511. Fund for a Healthy Maine established, 6. Health purposes. Allocations are limited to the following health-related purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State; [1999, c. 401, Pt. V, §1 (NEW).]
B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age; [1999, c. 401, Pt. V, §1 (NEW).]
C. Child care for children up to 15 years of age, including after-school care; [1999, c. 401, Pt. V, §1 (NEW).]
D. Health care for children and adults, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
F. Dental and oral health care to low-income persons who lack adequate dental coverage; [1999, c. 401, Pt. V, §1 (NEW).]
G. Substance abuse prevention and treatment; and [1999, c. 401, Pt. V, §1 (NEW).]

H. Comprehensive school health and nutrition programs, including school-based health centers. [2007, c. 539, Pt. IIII, §3 (AMD).]

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund	$6,374,744	$6,349,924	$6,351,468	$4,919,385	$3,286,345 ($2,028,679 – 094801; **$1,257,666 – 094802**)	TBD
General Fund or Other Special Revenue	$11,445,840 $697,455	$10,933,307 $744,874	$11,493,871 $643,297	$11,678,870 $667,782	$14,966,404	TBD
Federal Funds **SAPT -BG**	$5,428, 433 + $6,820,035	$5,942,379 + $6,512,077	$6,060,038 + $5,300,042	$1,412,778 + $6,415,223	$7,117,834 + $7,306383	TBD
Total	$30,766,507	$30,482,561	$29,904,455	$25,094,038	$32,647,255	TBD

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program for 2012: For 094801 = 6.21%; For 094802 = 3.85% Combined = 10.06%

IV. Program Eligibility Criteria: Individuals must be diagnosed with a substance abuse or dependence disorder or be an individual affected by another's use of substances.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: These funds are part of state funds that are used in the Maintenance of Effort Requirement for the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) that Maine's receives annual. This funding helps to ensure that Maine receives its maximum amount of SAPT BG allotment available for Substance Abuse Prevention and Treatment programs.

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

Treatment: Works with the statewide provider network to assure access to a full continuum of quality treatment services and provides technical assistance to providers around program development, implementation, and best practices in alcohol and drug treatment programs.

2) Please describe how the outcomes are measured: A combination of compliance and outcome measures via the treatment data system database. In addition, OSA staff (assigned responsibility for contract oversight, management, and technical assistance) conduct site visits, work with the Division of Licensing and Regulatory Services and the Office of Maine Care services to ensure quality programming is occurring.

3) Please describe the measurable outcomes of the program: (Collect data that is ultimately reflected in the National Outcome Measures and per SAPTBG Statutory requirements regardless of payer source)

Outpatient

- Time from first call to first face to face: 5 days
  Time to first treatment appointment: 14 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Intensive Outpatient

- Time from first call to first face to face: 4 days
- Time to first treatment appointment: 7 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Tracking measures:

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment
  Referral to Mental Health Services

Substance Abuse Residential Programming:

There are varying levels of residential care (LOC) based on medical necessity. There are also population specific measures. The most common indicators are below with minimum standards set for each based on LOC and population

INDICATOR

Abstinence/drug free 30 days prior to discharge
Reduction of use of primary substance abuse problem
Employability
Participation in self-help during treatment
Referral in the Continuum of Care
Completed Treatment

TRACKING ONLY

Average Time in Treatment for Completed Clients (Weeks)
Global Assessment of Functioning Improvement

Conduct follow up contact (phone, text, email) with client 1x a week for first 30 days, then 60 days, 90 days, and 1 year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine program effectiveness, as this may be requested by OSA.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** 11/17/11

Program Title: FHM - Oral Health

Account: 01410A095301

I. Program Description:

1) Overview of the program:
   a. Dental Services Subsidy Program ($350,000): subsidizes dental care provided at nonprofit clinics to low income patients who have no insurance.
   b. School Oral Health Program ($250,000): provides funds to schools based on community risk guidelines for classroom education, fluoride mouthrinse, and dental sealant application.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
   a. In SFY 12, 6 contracted organizations provided dental services at 12 sites. In FY 10, 13 organizations participated, with over 33,700 dental services provided at 18 locations to an estimated 18,407 individuals. In FY 11, at 19 locations, they provided just under 37,000 dental services to 19,259 people.
   b. In SFY 11 (the 2010-11 school year), 77 school districts funded to reach 23,248 children in grades K-4 participating in over 230 schools; of these children 75% participated in the mouthrinse program. In SFY 10, there were 30,514 children in grades K-6 participating in over 230 schools; of these children, 74% participated in the mouthrinse program. In all years, about half of participating schools are funded to offer dental sealants to second graders; over the past several years, the average number of children served has been about 1000 with each child receiving an average of 3.3 sealants.

3) What is purchased with these funds:
   a. Dental Services Subsidy Program: provides a subsidy or offset to eligible community organizations providing care to eligible individuals (who have no insurance for dental care and are low-income (below 200% of the Federal Poverty Level).
   b. School Oral Health Program: provides funds to schools and school districts based on community risk guidelines to assist them to implement classroom-based oral health education programming in grades K-6, a weekly fluoride mouthrinse program in grades K-4 (cut back from K-6), and a dental sealant program for second-graders. Washington and Aroostook counties have been a priority for funding.

4) What is the service delivery (i.e. state personnel, contracted services, etc): Contracted (state personnel oversee contracts.)
   a. Dental Services Subsidy Program: contractors provide detailed invoices that document care provided to eligible individuals and are paid accordingly within the limits of funds allocated to this program.
   b. School Oral Health Program: schools and community agencies are contracted to provide program components.

5) Department Program Staff:
   Number of employees: none Cost of employees: $ N/A

II. Relevant Legislative History:
   a. Dental Services Subsidy Program: was established by legislation in 1999/2000 (22 MRSA § 2127) and rules (10-144, ch 295) with initial funding in 2001. $350,000 annually is the present funding amount; no other sources of funds pay for this service.

b. School Oral Health Program: funding first authorized by the Dental Education Act in 1975.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget (reflects all funds used by OHP):

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	1,043,143	991,953	927,453	925,047	600,000	600,000
General Fund or Other Special Revenue	358,608	365,622	396,905	92,000	94,980	94,980
Federal Funds	515,761	884,574	994,189	1,274,141	753,630	473,630
Total	1,917,512	2,242,189	2,318,547	2,291,188	1, 448,610	1,168,610

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 41.4% in current year (FY 12). All sources remaining equal, this will be 51% in SFY13.

IV. Program Eligibility Criteria:

a. Dental Services Subsidy Program: Community-based dental clinics are eligible to participate, within the limits of existing funds. They may choose not to; they must be able to meet program reporting requirements, see MaineCare eligible patients, and offer dental services on a sliding fee scale. Patients for whom a subsidy is claimed must have no insurance for dental care and be low-income (below 200% of the Federal Poverty Level).

b. School Oral Health Program: eligibility is determined at the school or community level. School eligibility is determined based on the proportion of students eligible for the Free & Reduced Lunch Program and the extent of fluoridated public water as primary factors; it is thus directed to schools where children are more likely to have problems getting dental care, since socio-economic status is directly related to the ability to obtain that care. Grants are made according to a per capita funding formula, within the limits of funding.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes X No
If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:

a. Dental Services Subsidy Program: to offset the costs of providing essential dental care to low-income uninsured individuals (mostly adults) receiving care at community-based dental clinics. The legislative intent for this program was to facilitate access to dental care for such individuals by helping to keep sliding fee scales affordable.

b. School Oral Health Program: to provide oral health education and primary dental disease prevention services in elementary schools assessed to represent children at highest risks of having untreated dental disease and less ability to access the dental care system.

2) Please describe how the outcomes are measured:

a. Dental Services Subsidy Program: contractors report the numbers of individuals seen, the numbers of patient visits and the numbers of services provided.
b. School Oral Health Program: the Maine Integrated Youth Health Survey includes dental screenings and by a random sample includes some participating schools; schools provide screening data to the Oral Health Program along with data describing participation in the fluoride mouthrinse and dental sealant components of the school-based programs.

3) Please describe the measurable outcomes of the program:
   a. Dental Services Subsidy Program: contractors document the numbers of patients seen whose care is facilitated by this funding.
   b. School Oral Health Program:
      1) The Maine Integrated Youth Health Survey indicated the following:
      - In 2009, 18.2% of kindergarten students and 29.5% of 3rd graders had tooth decay, compared to 31.4% of grade K and 44.7% of the 3rd graders in 1999.
      - The proportion of Maine 3rd grade students with dental sealants has increased from 47% in 1999 to 61% in 2009.
      2) Reports from participating schools have documented improvements in the oral health of children in their communities.

4) Total funds for Oral Health:

FHM: funds major portions of the program carried out by staff and contracts.

- School Oral Health Program ($250,000): provides funds to schools based on community risk guidelines for classroom education, fluoride mouthrinse, and dental sealant application
- Dental Services Subsidy Program ($350,000): subsidizes dental care provided at nonprofit clinics to low income patients who have no insurance
- Donated Dental Services ($38,463): funds a contract to support a program that connects patients to dental offices that donate their services free for disabled or elderly with no other means

State General Fund:

- Supports program administration ($21,684) including rent, etc. for 2 FTEs.
- Match for Maternal Child Health Block Grant: $48,296 supports program administration and some of the School Oral Health Program component.

State Special Revenue - $25,000 (ME School Oral Health Fund) – supports screening and coordination component in several School Oral Health Program contracts.

Federal Funds:

- Federal CDC - $374,354 for the project year July 31, 2011- July 30, 2012. No match required. Supports 2.0 FTE and associated costs, to administer the program and 0.5 FTE in Drinking Water Program to work on quality assurance in water fluoridation. This grant also pays for epidemiology services, program evaluation assistance, and program coordination.
- Federal HRSA, MCH Block Grant - $99.276 supports 1.84 FTE (Division's FHM pays for .16 FTE)
- Federal HRSA, Bureau of Health Professions: $280,000 in SFY12 (grant ends 8/31/12) support dental workforce development initiatives: dental education loan repayment and dental equipment revolving loan programs at FAME.

Fund for a Healthy Maine Fact Sheet

Office: Maine Center for Disease Control **Date:** 11/17/2011

Program Title: Tobacco Prevention, Control & Treatment

Account: 01410A095302

I. Program Description:

1) Overview of the program:

The program was established in statute in 1997 to prevent youth from ever using tobacco and assist youth and adults who currently smoke and use other tobacco products to discontinue use as well as to protect people from secondhand exposure. The purpose is to eliminate the health and economic burden of tobacco use using a mix of educational, clinical, regulatory, and social strategies.

2) Who is served with these funds (i.e. # of people, # of programs, etc):

All of Maine's citizens are affected by program initiatives. This is a comprehensive program that educates and motivates youth and adults not to smoke using a full range of media, as well as educating citizens on dangers of secondhand smoke.

- Provides tobacco cessation counseling and medication for those who use tobacco.
- Provides cessation training to multiple classes of providers, offering academic detailing and continuing education credits.
- Assists retailers to support access to tobacco laws affecting youth.
- Increases awareness of dangers of secondhand smoke, supports policies to create smoke free areas and support for compliance with smoke free laws.

3. What is purchased with these funds: **See answer for Q4**

4. What is the service delivery (i.e. state personnel, contracted services, etc):

Most of program services are contracted:

a. Public Education, Communication, and Media: $1,800,000

These funds support multiple educational interventions using a wide variety of media:

- Research-driven and tested messages to counter Tobacco Industry advertising
- Educational and motivational materials for distribution to schools, healthcare providers, and members of the public
- Materials that assist population groups who are disproportionately affected by tobacco use
- Messages and materials to raise awareness about the availability and effectiveness of the tobacco treatment and the Maine Tobacco HelpLine
- Youth-directed counter-marketing messages to prevent beginning to use tobacco
- Materials and training to support local community and school efforts

b. Tobacco Treatment and Medications $2,600,000

The Maine Tobacco HelpLine provides outreach and support for those who want to quit tobacco use. Trained counselors work with callers by phone. The contract also provides training for healthcare providers and tobacco treatment specialists on how to assist those who want to quit. Medications are provided to eligible participants who do not have insurance coverage –nearly doubles quit rate to use medications.

c. Evaluation – $500,000

Contractors monitor program activities, assess efforts and provide performance data to make programs and initiatives more effective. The program helps support two major

surveys (contracted) used by state, community and private organizations to monitor and evaluate health-related programs.

d. Enforcement and Compliance $150,000

Enforces workplace, public place and tobacco retail laws. Supports training for retailers and their personnel to better meet compliance..

5. Department Program Staff:

Number of employees: 7 staff Cost of employees: $580,050 for SFY2012

2 Partnership For A Tobacco-Free Maine – public health educators

3 Physical Activity, Nutrition, Healthy Weight Program, program manager and 2 health planners

1 Cardiovascular Health Program – public health educator

1 Division of Population Health – office manager

II. Relevant Legislative History: Tobacco Prevention and Control Program was established in statute by Title 22, Subtitle 2, Part 1, Chapter 102 (PL 1997, c. 560, PT, D, Section 2) 272. Laws related to public place and workplace smoking and smoke exposure and in Title 22 for DHHS to enforce.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund						
Personal Services	262,951	262,459	443,322	538,391	580,050	599,379
All Other	5,992,203	6,466,853	6,569,657	4,412,244	5,822,030	5,822,114
Total	6,255,154	6,729,312	7,012,979	4,950,635	6,402,080	6,421,493

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 85%. Federal CDC provides 15% of funding annually. This grant requires a 1-4 match. One-time awards under ARRA and ACA provided extra funds, mainly for the Helpline.

IV. Program Eligibility Criteria:

The state's HelpLine/Quitline is available to any Maine resident who wishes to use its services. People who are ready to quit within 30 days are eligible for the multi-call program. Multi-call program participants who are over 18 years old can receive up to three months of Nicotine Replacement Therapy (NRT) at no cost provided they pass a medical screen and do not have insurance that covers NRT

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes x No

If yes, please explain:

IV. Goals & Outcomes of the program:

1. Please describe the goals of the program:
   a. Prevent initiation among young and young adults
   b. Promote quitting among adults and youth

c. Eliminate exposure to secondhand smoke
d. Identify and eliminate tobacco related disparities among population groups

2. Please describe how the outcomes are measured:
Long-term outcomes are measured by indicators tracked by the state adult and youth surveys, which the program contributes funds to support.

3. Please describe the measurable outcomes of the program:

Outcomes: Data points tracked over time –top level, other data is tracked.
Youth smoking High School 18% in 2009, YRBSS; high of 39% in 1997
Smoked a Cigarette before age 13 (HS) 12% 2009, YRBSS; high of 30% in 1997

Adult smoking 18% in 2010, BRFSS; high of 25% in 1995
Young adult (age 18-24) Smoking 23% in 2010, BRFSS; high of 35% in 1996

Other relevant data:
Former smokers in population – 30% in 2010, BRFSS
Attempted to quit in past 12 months among smokers:
Adults – 59% 2010, BRFSS
High School youth – 44% 2010,BRFSS

Rules for no smoking in home (adults age 18+) – 83% in 2010
Hours exposed to any smoke at work in a week (adults age 18+) – 18 hours average exposed in 2010, BRFSS
Seen people smoking on school grounds (adults age 18+) – 14% saw smoking in 2010, BRFSS

MaineCare population smoking rate (adults age 18+) – 42% 2009, BRFSS
Maine tribes smoking rate 44% (average 2005,2006 BRFSS)

Women Smoking (adults age 18) rate 17% 2010, BRFSS
Pregnant Women who smoke (adults age 18) 21 %, 2009, PRAMS
MaineCare Pregnant women who smoke(adults age 18) 36% 2009, PRAMS

Smoking rates by Education:
Less than High School – 35% 2010, BRFSS
High School (HS) or GED – 26% 2010, BRFSS
Some post HS – 20% 2010, BRFSS
College Grad – 7% 2010, BRFSS

4. Total Funds for Tobacco Program:

FHM funds major portions of the tobacco prevention and control program that are carried out by staff and through contracts. Initiatives include youth prevention, tobacco cessation and treatment, and preventing exposure to secondhand smoke (which includes enforcement of state laws related to workplace, public place and retail sales laws).

Staff – FHM covers 2 FTE tobacco prevention and control program Health Educator positions who implement evidence-based interventions to decrease tobacco use initiation, increase cessation, and protect people from second hand smoke.

PTM does not receive any General Funds; the only state funds received are FHM.

Federal Funds:

- Federal CDC grant - about $979,248 annually. Requires a 1-4 match; the grant pays for 6 program staff and 2.15 Division cross program positions.
- Federal CDC ARRA grant - $548,000 one-time funds; 2 year period ending February 2012; enhanced Helpline outreach.
- Federal CDC ARRA grant - $49,753 one-time funds; ending February 2012.
- Federal CDC ACA grant - $53,098 one-time funds; 2 year period ending September 2012 to learn more about MaineCare member motivation to quit smoking.
- Federal FDA grant - $701,299 annually (Oct. 1-Sept. 30) to support FDA tobacco retail regulations in the state. No state related work can be done under this money from FDA.

Fund for a Healthy Maine Fact Sheet

Office: Maine Center for Disease Control and Prevention **Date:** November 17, 2011

Program Title: Community/School Grants & State-wide Coordination

Account: 01410A095307

There are several content areas covered in this allocation. Each content area is broken out into a letter. For instance, a in each section refers to Division of Local Public Health, b refers to Healthy Maine Partnerships, etc.

I. Program Description:

1) Overview of the program:
   a) Positions for Division of Local Public Health to support Maine's Public Health Districts and associated seat costs
   b) Healthy Maine Partnerships, 26 local Comprehensive Community Health Coalitions that focus on tobacco, obesity, and chronic disease
   c) Tribal Public Health District (District Liaisons and Healthy Maine Partnership)
   d) School Based Health Centers
      The Department has funded SBHCs since 1987. SBHCs educate youth about: healthy/unhealthy behaviors and how that will affect their future health; appropriate use of the health care system (i.e. not using the ER for non emergency care, etc.); preventive care such as routine exams, immunizations and anticipatory guidance; and they provide screening, including a health risk assessment, and early intervention for adolescents for both physical and behavioral health issues.
   e) Prevention initiative to address obesity in youth
2) Who is served with these funds (i.e. # of people, # of programs, etc):
   a) Entire population of Maine
   b) Entire population of Maine
   c) All Tribal members of Maine's Tribal nations
   d) Eight organizations are funded and operate 16 SBHCs across Maine. Annually, approximately 7,000 students (3/4 high school and ¼ middle school/junior high) are enrolled in school-based health centers.
   e) Entire population of Maine
3) What is purchased with these funds:
   a) Approx .3 FTE of salaries for 5 District Liaisons and 1 Office Director in the Office of Local Public Health (2.34 FTE)
   b) (26) HMPs across Maine work to assist local communities, schools, organizations and businesses in changing policies and creating community environments that support healthy behaviors and healthy lifestyles
   c) (2) Tribal Liaisons and (1) Tribal HMP Director
   d) School-based, physical and mental health services and program evaluation and quality improvement service
   e) Education and training for obesity prevention and control in children

4) What is the service delivery (i.e. state personnel, contracted services, etc):
   a) State personnel for Division of Local Public Health
   b) Contracted services for 26 Healthy Maine Partnerships
   c) Contracted personnel for 1 Tribal District
   d) Contracted services in 16 School Based Health Centers
   e) Contracted services for one Prevention Research Center, located at the University of New England, Center for Community and Public Health

5) Department Program Staff:
Number of employees: 2.34 FTE Cost of employees: $ 315,000

II. Relevant Legislative History:
Maine State Law: Title 22; § 411 – 412 defines and establishes multiple public health structures to enhance the delivery of public health services across Maine. Included in in the statute are the State Coordinating Council, District Coordinating Councils, Tribal District, the Healthy Maine Partnerships, and District Public Health Units. This applies to sections a), b), and c). No legislation applies to sections d), and e).

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$9,345,000	$9,182,000	$8,489,745	$7,876,458	$7,777,979	$7,788,922
General Fund or Other Special Revenue	a) 0 d) 223,915	a) 233,863 d) 223,915	a) 379,923 d) 219,945	a) 368,056 d) 232,013	a) 442,153 d) 232,013	a) 442,153 d) 223,013
Federal Funds	a) 0 b) USDA - $.3 CDC Asthma - $.031 OSA SPF/SIG – $2.1 c) CDC CVH - $.05 d) 0 e) 0	a) .156 b) USDA - $.3 CDC Asthma $.031 OSA SPF/SIG – $2.1 c) CDC CVH - $.05 d) 0 e) 0	a) .248 b)USDA - $.3 CDC Asthma - $.031 OSA SPF/SIG – $2.1 c)CDC CVH - $.05 d) 0 e) 0 f) 0	a) .296 b) USDA - $.3 CDC Asthma - $.031 OSA SPF/SIG – $2.1 c) CDC CVH - $.05 d) 0 e) 0	a) .330 b) USDA - $.3 CDC Asthma - $.016 OSA BG - $.08 c) CDC CVH - $.05 d) 0 e) 0	a) .300 b) USDA - $.3 Asthma - $16,00 OSA BG - $.08 c) CDC CVH – $.05 d) 0 e) 0
Total						

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:
a) 29%
b) 88%
c) 86%
d) 66%
e) 100%

IV. Program Eligibility Criteria:
a) Positions for Division of Local Public Health - None
b) Healthy Maine Partnerships - Must be a designated Healthy Maine Partnership to receive these grant funds; awarded through a competitive process that identifies necessary characteristics to receive funding.

c) Tribal Public Health District – Tribal member
d) School Based Health Centers - High school or middle school/junior high students whose parents enrolled them in the SBHC
e) Initiatives to address obesity - NA

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☒ No

If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:
   a) Oversee and Coordinate the local Public Health infrastructure
   b) 1. Ensure that Maine has the lowest smoking rates in the nation;
      2. Prevent the development and progression of obesity, substance abuse, and chronic disease related to or affected by tobacco use;
      3. Optimize the capacity of Maine's cities, towns and schools to provide health promotion, prevention, health education and self-management of health;
      4. Develop and strengthen local capacity to deliver essential public health services across the state of Maine.
   c) Provide and coordinate public health services to Maine's Tribal members
   d) The overarching goal is to improve access to healthcare for adolescents, a population that historically does not receive preventive health care through the traditional health care system. This provides a health safety net. Identify tools and practices that are effective in addressing the fight against obesity
   e) The goal is to increase physical activity, improve nutrition and reduce overweight and obesity in Maine. The contractor provides evidence-based strategies, training and technical assistance, and evaluation support to the Healthy Maine Partnerships as well as to other communities, partners and organizations.

2) Please describe how the outcomes are measured:
   a) Quarterly reports on work plan deliverables are received and reviewed by staff; site visits are held annually.
   b) Quarterly reports on work plan deliverables are received and reviewed by staff; site visits are held annually.
   c) Quarterly reports on work plan deliverables are received and reviewed by staff; attendance at tribal meetings.
   d) SBHCs provide us with data twice a year, which is compiled, analyzed and monitored for the results. Baselines are established at the start of the competitively bid contract and we look for continuous improvement in subsequent years
   e) Quarterly reports on workplan deliverables are received and reviewed by staff; staff also participate in quarterly meetings

3) Please describe the measurable outcomes of the program:
   a. Completion of local Public Health Improvement Plans and District Public Health Improvement Plans in each Public Health District
   b. Highlights of a recent evaluation report of the 26 Healthy Maine Partnerships include:
      - Worked with 884 employers to promote the services offered through the Maine Tobacco HelpLine.
      - Collaborated with 84 hospitals, primary care offices & organizations to establish links with health care providers that connect patients to needed community resources for better management of their chronic diseases.
      - Provided resources and assistance to 148 community organizations to help increase opportunities for family-based physical activity.

- Developed policies/procedures that added an average of 20 minutes per day of physical activity for all students in the school.

c. Improved ability to serve Maine's tribes with community-based prevention activities.
d. Outcomes include (1) increasing the health knowledge, positive attitudes and skills for adolescents, (2) decrease risky health behaviors, including smoking, and risky sexual behavior, (3) increase healthy habits, including appropriate use of health care, good nutrition, physical activity, use of seat belt and helmets, and (4) help-seeking for behavioral health issues, particularly depression and suicidal ideation.
e. Highlights of recent accomplishments include:
    i. Completed case studies of schools in Maine that are exceptional in providing students with opportunities to by physically active throughout the school day.
    ii. Completed an evaluation report on the final year of the Maine Youth Overweight Collaborative involving more than 20 physician practices statewide on strategies to prevent and treat overweight and obese youth.

Fund for a Healthy Maine Fact Sheet

Office: Maine Center for Disease Control and Prevention **Date:** November 17, 2011

Program Title: Public Health Infrastructure

Account: 01410A095308

I. Program Description:

1) Overview of the program: This program is part of the Healthy Maine Partnerships initiative and works to develop and strengthen local capacity to deliver key essential public health services across the state of Maine. In addition to this work, the account has been used in the past to fund (1) position dedicated to staffing the Maine Children's Cabinet.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
The entire population of Maine is reached through each of the public health districts.

3) What is purchased with these funds:
Local HMP coalition participation and contribution to the local public health infrastructure including the development of local and District Public Health Improvement Plans

4) What is the service delivery (i.e. state personnel, contracted services, etc):
Contracted services

5) Department Program Staff:
Number of employees: (1) FY 2010 and 2011 only
Cost of employees: Vacant position; no cost at this time

II. Relevant Legislative History: Maine State Law: Title 22; § 411 – 412 defined and establishes multiple public health structures to enhance the delivery of public health services across Maine. Included in in the statute are the State Coordinating Council, District Coordinating Councils, a Tribal District, the Healthy Maine Partnerships, and District public health units.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$1,267,008	$1,462,393	$1,365,572	$1,420,437	$1,366,802	$1,369,315
General Fund or Other Special Revenue						
Federal Funds						
Total	$1,267,008	$1,462,393	$1,365,572	$1,420,437	$1,366,802	$1,369,315

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 90%

IV. Program Eligibility Criteria: Must be a designated Healthy Maine Partnership to receive these grant funds; disbursed through an RFP process.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☒ No

If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program: Develop and strengthen local capacity to deliver essential public health services across the state of Maine.

2) Please describe how the outcomes are measured: Evaluation and monitoring through quarterly reports

3) Please describe the measurable outcomes of the program: Development of 26 Local Public Health Improvement Plans. Development of 8 District Public Health Improvement Plans

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** November 17, 2011

Program Title: Family Planning

Account: 01410A095601

I. Program Description:

1) Overview of the program: The FHM funds supplement the clinical family planning services that are purchased through Maine CDC and OCFS blended funding. The supplemental work that FHM supports focuses upon adolescent pregnancy prevention by providing training and professional development opportunities to teachers, school nurses, guidance counselors, school health coordinators and community-based organizations regarding puberty, adolescent development, and the delivery of age appropriate health and sexuality education to Maine youth. To supplement clinical services, teen pregnancy/STI prevention activities are targeted toward high teen pregnancy rate areas of the State that have hard-to-reach and vulnerable populations. Training on how to engage their communities in addressing the multiple factors that can play a role in teen pregnancy and sexually transmitted infections (STIs) is provided along with how to identify and implement evidence-based programs that have been proven effective. Print and web-based materials are made available to family and community members.

2) Who is served with these funds (i.e. # of people, # of programs, etc): Last year 8 schools/community-based organizations (CBOs) were served, reaching over 500 youth. 144 school and CBO staff participated in training and professional development opportunities. This does not include youth and staff served with federal PREP funding. Over 800 FACTS (Families And Children Talking About Sexuality) magazines were distributed to parents

3) What is purchased with these funds: What is the service delivery (i.e. state personnel, contracted services, etc): contracted services.

4) Department Program Staff: 0
Number of employees: _____ Cost of employees: $ _____

Relevant Legislative History: **(See funding table below) In FY09, the allocation for family planning within the Social Services Block Grant was reduced by $415,000. In response, the legislature approved a one-time increase within family planning's Fund for a Healthy Maine appropriation. In the FY10-11 biennium, the State Social Services line received a one-time increase of $300,000 per year, intended to offset the end of that one-time FHM increase. That increase does not affect the baseline funding and will not be carried into the FY 12-13 biennium.*

The State Purchased Social Services account also received a decrease in FY 08 due to a 4th quarter curtailment and a $90,000 one-time reduction in the FY10 Curtailment Order.

II. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	468,942	884,240*	448,183	425,061	401,430	401,430
General Fund:**						
SPSS	205,055	273,406	573,406	505,155	281,599	281,599
MCHBG match	285,843	285,843	306,843	329,965	306,843	306,843
Community FP	225,322	225,322	225,322	225,322	225,322	225,322
Federal Funds: ***						
SSBG	525,552	110,274	110,274	110,274	410,274	410,274
PREP					241,317	241,317
Total	1,710,714	1,779,085	1,664,028	1,595,777	1,866,785	1,866,785

* See above "legislative history"

** SPSS - State Purchased Social Services
MCHBG - Maternal and Child Health Block Grant
Community Family Planning

*** SSBG - Social Services Block Grant
PREP – Personal Responsibility Education Program

Note: SPSS and SSBG funds are administered by the Office of Child and Family Services, Maine DHHS, and blended with Maine CDC funding

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: average of 22% to 26%

III. Program Eligibility Criteria: Schools and CBOs statewide are eligible to participate. Parent information is available to anyone that requests it.

IV. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes **X** No
If yes, please explain:

V. Goals & Outcomes of the program:

1) Please describe the goals of the program: Increase knowledge, skills and attitudes around teen pregnancy and STI/HIV prevention. Increase understanding of evidence-based programs and how to select them based on community needs and how to implement them with fidelity. Support parents by enhancing their knowledge of sexual development and encouraging communication with their children around their health issues and healthy relationships. Provide on-line information for professionals, parents, adults and teenagers.

2) Please describe how the outcomes are measured: Baselines were established at the start of the contract period and we review reports to establish whether or not goals have been met. Pre and post surveys assess changes in knowledge, attitudes, skills and/or intended behaviors. Attendance at educational offerings. Tracking of materials distributed. Web hits and feedback received. A Grants Management Team meets regularly to monitor and evaluate efficiency and effectiveness of programs through reports, site visits and analysis of data.

3) Please describe the measurable outcomes of the program: Outcomes include 1) increasing the number of schools and CBOs selecting and implementing evidence-based approaches to preventing teen pregnancies and STIs, 2) increasing the knowledge, skills and comfort level of teachers and youth serving CBO staff in delivering comprehensive health and sexuality education to Maine youth, and 3) improving the knowledge, skills and attitudes of Maine parents, family members and community members around the issues of sexuality and reproductive health.

   For activities under this funding three objectives have been established and eleven activities will be implemented to meet those objectives. Reports will be reviewed twice yearly for compliance with contract commitments.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** 11/17/11

Program Title: FHM – Donated Dental

Account: 01410A095801

I. Program Description:

1) Overview of the program:
These dollars fund a contract with Dental Lifeline Network (National Foundation of Dentistry for the Handicapped) to administer a donated services program for those who are disabled or elderly and have no other means of paying for dental care.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
The DDS program coordinates care for elderly, disabled, and certain other medically needy/compromised individuals who have no insurance to cover dental care and meet the program's financial criteria. In SFY11, 102 patients were treated; of the 154 volunteer dentists enrolled in the program, 90 were involved with completed cases. There were 44 volunteer dental labs enrolled in the program (labs provide prosthetics such as dentures) and 24 of them were involved with completed cases. These numbers are typical of recent years as the DDS program has become more established.

3) What is purchased with these funds: The contract is used to support a part-time coordinator who matches clients with volunteer dental providers who donate their services and coordinates their care; it also helps offset some operational expenses. In SFY 11, the value of care to patients treated was $281,714 and the value of donated lab services was $22,857. The ratio of donated treatment per dollar of operating costs in SFY 11 was $7.11. Since its inception in 1999, the DDS Program has provided care to 873 patients with the total value of care to patients treated estimated to be $2.07 million.

4) What is the service delivery (i.e. state personnel, contracted services, etc): Contracted

5) Department Program Staff:
Number of employees: none Cost of employees: $ N/A

II. Relevant Legislative History: Legislation was first submitted in 1999 to support a Donated Dental Services Program in Maine, in collaboration with the ME Dental Association (which solicits dentists to volunteer) and the National Foundation of Dentistry for the Handicapped. The initial contract may have been supported with a State General Fund allocation and was changed to the FHM (by legislative direction) when those funds became available. It was, and has remained, a separate budget item from other oral health allocations.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$42,562	$42,562	$40,654	$36,823	$36,463	$36,463
General Fund or Other Special Revenue	0	0	0	0	0	0
Federal Funds	0	0	0	0	0	0
Total	$42,562	$42,562	$40,654	$36,243	$36,463	$36,463

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program: 100%

IV. Program Eligibility Criteria: This program is open to disabled, aged, or medically at-risk individuals who have no insurance to cover needed dental care and have no other means.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes X No
If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program: Each year, the DDS program sets goals for the numbers of people to be seen and for whom treatment will be completed, as well as for the dollar value of contributed lab services. The DDS program is not a source of ongoing care; it provides a resolution for a defined problem and can only be utilized once by an individual.

2) Please describe how the outcomes are measured: The contractor provides quarterly reports that itemize patients according to the numbers of active cases, referrals, and patients treated; the numbers of applicants and pending applications; the numbers of volunteer dentists and dental labs and the numbers involved with completed cases; the value of care to patients treated; the average value of treatment per case; the value of paid and donated lab services; operating costs; and the ratio of donated treatment per dollar of operating costs.

3) Please describe the measurable outcomes of the program: See #2 immediately above. These figures are provided quarterly and annually and can be aggregated over the life of this program in Maine.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC Date: 11/17/11

Program Title: Maine Immunization Program

Account: 014-10A-Z04801

I. Program Description:

1) Overview of the program:
Several hundred people die every year in Maine from vaccine-preventable influenza and bacterial pneumonia. Influenza vaccine can prevent 60% of hospitalizations and 80% of deaths from influenza-related complications among the elderly. 23% of Mainers 65 and older in 2007 have not had a flu shot, and this is greatly improved from 36% in 1995. 29% of Mainers 65 and older in 2007 have not had a pneumonia shot, and this is greatly improved from the 65% in 1995.

2) Who is served with these funds (i.e. # of people, # of programs, etc):
This funding for influenza and pneumococcal vaccines has supported purchasing these vaccines for employees and patients in long-term care facilities, patients served by health centers, Bangor and Portland public health clinics, hospitals, and uninsured individuals in private practices.

3) What is purchased with these funds:
About 90,000 doses of vaccines distributed to providers in multiple settings, including FQHCs & RHCs, Hospitals, Long-term care facilities, City/local public clinics, Adult and pediatric medical practices.

4) What is the service delivery (i.e. state personnel, contracted services, etc):
No personnel or contracted services are purchased with these funds.

5) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History:
No legislative history directly relevant to the FHM funding or influenza vaccine.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	1,035,301	1,090,710	1,085,499	1,078,884	1,078,884	1,078,884
General Fund or Other Special	342,562	1,018,791	739,765	0	$7,000,000	12,000,000

Revenue						
Federal Funds	2,955,488	3,382,414	3,033,557	2,914,480	2,914,480	4,171,376
Total	4,333,351	5,494,915	4,858,821	3,993,364	10,993,364	17,250,260

2) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:
The Fund for a Healthy Maine makes up less than 10% of total funding to the Maine Immunization Program for combined vaccine purchase and operations (personnel, contractual and IT costs). However, the vast majority of funding to the program is directed specifically to pediatric vaccine, and no other funds specifically provide for the purchase of influenza and pneumococcal vaccines for adults. A single dose of influenza vaccine costs about $10, but when provided to a vulnerable person or in a susceptible setting, can prevent an institutional outbreak of influenza or prevent complications leading to hospitalization and possibly death. By comparison, the cost of a treatment course of oseltamivir (Tamiflu) costs over five times that amount, which does not include the cost of medical treatments or hospitalizations.

IV. Program Eligibility Criteria:

Vaccine purchased with FHM funds is made available to:

- Employees of schools that provide onsite vaccine clinics on school days
- Pregnant women and their partners (through health care providers who routinely care for pregnant women)
- Nursing home employees and residents
- Any Underinsured or Uninsured adult in any setting (if the patient's insurance does not cover vaccines or if the patient does not have insurance)
- All individuals served by Tribal health centers and Municipal Health Departments

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☐X No
If yes, please explain:

VI. Goals & Outcomes of the program:

1) Please describe the goals of the program:
The Maine Immunization Program strives to ensure full protection of all Maine children and adults from vaccine-preventable disease. Through cooperative partnerships with public and private health practitioners and community members, the MIP provides vaccine, comprehensive education and technical assistance, vaccine-preventable disease tracking and outbreak control, accessible population-based management tools, and compassionate support services that link individuals into comprehensive health care systems.

The goal of the Fund for a Healthy Maine immunization funds is to reduce the impact of respiratory infectons on the health of Maine people. We do this by providing access to influenza and pneumococcal vaccine to individuals or group settings where it can

provide the greatest benefit.

2) Please describe how the outcomes are measured:
The most appropriate measure of program effectiveness is state specific estimates of immunization rates. Immunization rates are estimated annually through public health surveys conducted across the United States.

3) Please describe the measurable outcomes of the program:
The number of people over age 65 who have not had a flu or pneumococcal vaccine in Maine has improved considerably since 1995.

	1995	2007	2009	2010
>65 w/o flu	36%	23%	27%	28%
>65 w/o pneumo	65%	29%	29%	28%

Fund for a Healthy Maine Fact Sheet

Office: Office of Child & Family Services **Date:** 11/17/11

Program Title: Head Start

Account: 014-095901; FHM- Head Start

I. **Program Description:** Eligible Maine children receive high quality, comprehensive early care and education services that foster children's growth and development by supporting and nurturing their social, emotional, cognitive and physical development. The primary mission has been to prepare children for success in school and local programs have worked hard to meet the rigorous standards in serving children and families.

1) **Overview of the program:** Provide a safe, high learning experience that fosters school readiness by providing education, health, vision, hearing, dental, mental health, nutrition, social and parenting education. Significant emphasis is placed on the involvement of families, as the program engages parents in their children's learning and helps make progress toward their own educational, literacy and employment goals. Eleven Head Start grantees in Maine are funded primarily through the federal Office of Head Start. Three additional Head Start programs are funded by the Tribal Office of Head Start and are managed by the Passamaquoddy, Micmac and Maliseet tribes within their communities. Head Start provides early care and education, as well as health, nutrition, mental health, social and family support to low income families.

2) **Who is served with these funds (i.e. # of people, # of programs, etc):** Head Start and Early Head Start Programs begin serving children 6 weeks up to 5 years of age/ school age unless the approved federal grant provides otherwise. 65% of the families must have income at or below the federal poverty level. The State of Maine contracted with 11 Head Start Programs and served 4,638 children & 76 pregnant women for a total of 4,714 according to the 2010-2011 Program Information Report (PIR).

3) **What is purchased with these funds:** Head Start Programs are Evidence-Based programs that utilize Federal Performance Standards that measure Goals, Objectives and Outcomes. Head Start funds assist with providing a safe, high learning experience that fosters school readiness by providing education, health, vision, hearing, dental, mental health, nutrition, social and parenting education.

4) **What is the service delivery (i.e. state personnel, contracted services, etc):** Contracted Head Start Program sites are located in educational and community agency settings and services are available in every Maine County. Head Start Programs work closely with DHHS, DOE, Resource Development Centers and other community providers to ensure that needs are being met with minimal duplication of services.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. **Relevant Legislative History:** State General Funds were first implemented in 1983 as part of a broad education reform effort, which included pre-k (4year olds only) in the Essential Programs and Services formula for school funding. The Legislature specifically designated funds for Head Start comprehensive services to expand those services where current federal Head Start programming existed and must be directed to Head Start grantees in the State of Maine. The

services supported by these funds must align with Federal Head Start Performance Standards. These Head Start funds must be awarded to the agencies competitively selected and awarded the Federal Head Start Program by the Administration for Children and Families, U.S. Department of Health and Human Services. An agreement supporting a single Head Start program for the State of Maine was signed by the Maine DHHS and the US DHHS on 5/10/2000. This agreement states that Maine has the authority to allocate State funds to existing Federal grantees only. On December 12,2007 President Bush signed Public Law 110-134 "Improving Head Start for School Readiness Act of 2007" reauthorizing the Head Start Program. This law contained significant revisions to the previous Head Start Act and authorizes Head Start through September 30, 2012.

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$ 1,520,939	$ 1,575,264	$ 1,507,256	$ 1,440,941	$ 1,354,580	$ 1,354,580
General Fund or Other Special Revenue	$ 2,390,129	$ 2,443,514	$ 2,441,940	$ 2,354,169	$ 2,448,875	$ 2,448,875
Federal Funds	$ 65,831	$ 42,724	$ 119,261	$ 38,300	$ 109,152	$ 109,152
Total	$ 3,976,899	$ 4,061,502	$ 4,068,457	$ 3,833,410	$ 3,912,607	$ 3,912,607

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:** Fund for a Healthy Maine allocations make up 34.6% of the overall funding for the FY2012 and FY 2013 Head Start Program allocations.

IV. **Program Eligibility Criteria:** Under the current contract structure; children 6 weeks to compulsory school age are eligible for services under this agreement unless the approved federal grant provides otherwise. 65% of families must have income at or below the federal poverty level.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: Block Grant Requirement is to spend no less than 70% of Mandatory and Matching grant on child care services.

VI. Goals & Outcomes of the program:

- **Please describe the goals of the program:** Provide Maine families with high quality, comprehensive services that foster each child's growth by supporting and nurturing the child's social, educational, emotional, cognitive and physical development.

- **Please describe how the outcomes are measured:** Head Start Programs outcomes are measured by the Federal Head Start Performance Standards. The current Performance Standards require that each program, at least once a year, conduct a self-assessment to examine how the program is meeting its own goals and objectives and its success in implementing the Program Performance Standards and other federal regulations. The process must involve program parents, staff and the community, and self-assessment results are intended to influence future program planning and continuous program improvement.

- **Please describe the measurable outcomes of the program:** As a recipient of Federal Head Start funds, Maine is required to demonstrate progress on the 24 Federal Performance Measures. The five overall objectives reflect Head Start's philosophy and successful track record of promoting school readiness through a comprehensive, integrated set of strategies and services.

- **Objective 1-** Enhance children's healthy growth and development

- **Objective 2-** Strengthen families as the primary nurturers of their children

- **Objective 3-** Provide children with educational, health, and nutritional services

- **Objective 4-** Link children and families to needed community services

- **Objective 5-** Ensure well-managed programs that involve parents in decision-making

Fund for a Healthy Maine Fact Sheet

Office: Office of Child & Family Services **Date:** 11/17/11

Program Title: Child Care

Account: 014-096101; FHM- Purchased Social Services

I. **Program Description:** **Child Care Subsidy Program (CCSP)** Provide assistance to Maine Families who Gross income does not exceed 85% of State Median Income (SMI) level; and the Child's Parents are employed and /or attending Job Training or Educational Program. The parent fee or Co-pay cannot exceed 10% of the families' gross income.
12-15 year old Afterschool Program- Improve and/or enhance educational, social, cultural, emotional, and physical development through developmentally appropriate activities.

1) **Overview of the program:** **CCSP-** The purpose of the Maine Child Care Subsidy Program is to increase the availability, affordability, and quality of Child Care Services. In order to maximize parental choice for purchasing child care, Maine provides financial support for eligible low-income families and other designated client groups through the use of vouchers.
12-15 yr. old Afterschool Program- Provide Maine youth with a safe, healthy, quality environment that will enhance their social, cultural, emotional and physical development.

2) **Who is served with these funds (i.e. # of people, # of programs, etc):** **CCSP-** Provides direct service to eligible Maine families. Redetermination of benefits occurs every 6 months. The Fund for a Healthy Maine will assist/ support up to 925 children.
12-15 Afterschool Program- 18 agencies receive a total of $677,368 which helps assist/ support over 2,200 youth in the State of Maine.

3) **What is purchased with these funds:** **CCSP –** High quality child care from a Licensed Child Care Provider.
12-15 year old Afterschool Program- Quality Afterschool Programming that is geared toward providing a safe environment that will enhance their social, cultural, emotional and physical development.

4) **What is the service delivery (i.e. state personnel, contracted services, etc):** **CCSP-** Provide direct service to eligible families through contracts, subsidy and or awards.
12-15 year old Afterschool Program is a contracted service; with sites located in educational and community agency settings and services are available in every Maine County. The 12-15 Afterschool Programs works closely with DHHS and Maine Afterschool Network to ensure that quality Afterschool Programming occurs as well as to stay abreast of current best practices & Anti-delinquency efforts.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. **Relevant Legislative History:** Maine Revised Statute Title 22, Chapter 1052-A: Child Care Services 22 Title 22, §3731-3740

III. Financial Information:

1) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$4,203,946	$4,489,375	$3,780,006	$4,015,056	$3,942,236	$3,942,236
General Fund or Other Special Revenue	$1,259,364	$1,270,583	$1,277,425	$1,249,639	$1,300,000	$1,300,000
Federal Funds	$20,526,757	$14,290,765	$13,850,859	$16,808,882	$17,159,186	$16,159,186
Total	$25,990,067	$20,050,723	$18,908,290	$22,073,577	$22,401,422	$21,966,501

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:** Fund for a Healthy Maine allocation makes up 17.6% for FY12 and 17.9% for FY13 overall funding.

IV. **Program Eligibility Criteria:** **CCSP** – Maine Families whose gross income does not exceed the 85% State Median Income (SMI); and the Child's Parents are employed and /or attending Job Training or Educational Program. All families must meet Financial and Program Eligibility Requirements.
12-15 year old Afterschool Program- Participant must be between the ages of 12-16 (less than 16) and/ or 16-19 but less than 19 who are physically and/or mentally incapable of self-care.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: Block Grant Requirement is to spend no less than 70% of Mandatory and Matching grant on child care services. If we do not make MOE this would impact services to 1740 children.

VI. Goals & Outcomes of the program:

- **Please describe the goals of the program:** **CCSP:** Increase the availability, affordability, and quality of Child Care Services.
  12-15 year old Afterschool Program – Provide Maine youth with a safe, healthy, quality environment that will enhance their educational, social, cultural, emotional and physical development.
- **Please describe how the outcomes are measured:** **CCSP:** In order to maximize parental choice for purchasing child care, Maine provides a system of financial support for eligible low income families and other designated client groups through the use of vouchers.
  12-15 year old Afterschool Program- Performance outcomes are measured by having Performance based contracts. Contracts are monitored by Program Staff which include

but are not limited to Agency Monitoring Meetings, Site Visits, Fiscal Reports, Quarterly Reports, Attendance Counts, Participant/Parent Surveys, and Narratives.

- **Please describe the measurable outcomes of the program: CCSP:** As a recipient of Child Care Development Funds, Maine is required to conduct ongoing comprehensive audits and site visits to ensure that CCDF funds are being administered according to Federal Guidelines. (Time of initial application to subsidy granted, financial and program requirements are reviewed as well as Improper Authorization Payments (IAP) are reviewed ongoing/Federal audit every 3 years for CCDF funds.

12-15 year old Afterschool Program:

- **Objective 1**- Developing emotionally supportive relationships with adults and other youth;
- **Objective 2-** Developing skills and interest;
- **Objective 3-** Improve academic achievement
- **Objective 4-** Strengthening physical ability
- **Objective 5-** Community Service- increase tolerance for diversity, self-knowledge, increase leadership skills and increase feeling of being connected to community.

APPENDIX F

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention recommended funding levels for state tobacco prevention programs

FY2011 Rankings of Funding for State Tobacco Prevention Programs

State	FY2011 Current Annual Funding ($millions)	CDC Annual Recommendation (millions)	FY2011 Percent of CDC's Recommendation	Current Rank
Alaska*	$9.8	$10.7	92.0%	1
North Dakota*	$8.2	$9.3	88.1%	2
Hawaii	$9.3	$15.2	61.1%	3
Montana	$8.4	$13.9	60.4%	4
Wyoming	$5.4	$9.0	60.0%	5
Delaware	$8.3	$13.9	59.5%	6
Maine	$9.9	$18.5	53.5%	7
Oklahoma	$21.7	$45.0	48.2%	8
Vermont	$4.5	$10.4	43.4%	9
Minnesota	$19.6	$58.4	33.6%	10
Arkansas	$11.8	$36.4	32.4%	11
South Dakota	$3.5	$11.3	31.0%	12
Utah	$7.1	$23.6	30.2%	13
New Mexico	$7.0	$23.4	29.8%	14
Florida	$61.6	$210.9	29.2%	15
Arizona	$19.8	$68.1	29.1%	16
Mississippi	$9.9	$39.2	25.3%	17
New York	$58.4	$254.3	23.0%	18
West Virginia	$5.7	$27.8	20.4%	19
Iowa	$7.3	$36.7	20.0%	20
Washington	$13.4	$67.3	19.8%	21
North Carolina	$18.3	$106.8	17.1%	22
California	$75.0	$441.9	17.0%	23
Louisiana	$9.0	$53.5	16.9%	24
Oregon	$7.1	$43.0	16.6%	25
Nebraska	$2.9	$21.5	13.3%	26
Colorado	$7.0	$54.4	12.9%	27
Indiana	$9.2	$78.8	11.7%	28

State	FY2011 Current Annual Funding ($millions)	CDC Annual Recommendation (millions)	FY2011 Percent of CDC's Recommendation	Current Rank
Wisconsin	$6.9	$64.3	10.7%	29
Pennsylvania	$14.7	$155.5	9.5%	30
Virginia	$9.4	$103.2	9.1%	31
Idaho	$1.5	$16.9	8.9%	32
South Carolina	$5.0	$62.2	8.0%	33
Maryland	$4.3	$63.3	6.9%	34
Illinois	$9.5	$157.0	6.1%	35
District of Columbia	$569,000	$10.5	5.4%	36
Massachusetts	$4.5	$90.0	5.0%	37
Rhode Island	$735,095	$15.2	4.8%	38
Kentucky	$2.6	$57.2	4.5%	39
Texas	$11.4	$266.3	4.3%	40
Kansas	$1.0	$32.1	3.1%	41
Michigan	$2.6	$121.2	2.1%	42
Georgia	$2.0	$116.5	1.8%	43
Alabama	$860,000	$56.7	1.5%	44
Connecticut	$400,000	$43.9	0.9%	45
New Jersey	$600,000	$119.8	0.5%	46
Tennessee	$222,268	$71.7	0.3%	47
Missouri	$60,000	$73.2	0.1%	48
Nevada	$0	$32.5	0.0%	51
New Hampshire	$0	$19.2	0.0%	51
Ohio	$0	$145.0	0.0%	51

* Alaska and North Dakota currently fund tobacco prevention programs at the CDC-recommended levels if both state and federal funding is counted.

Appendix A

History of Spending for State Tobacco Prevention Programs FY2006 - FY2011

	FY2011		FY2010		FY2009		FY2008		FY2007		FY2006	
	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.
States Total	**$517.9**	**14.0%**	**$569.3**	**15.4%**	**$670.9**	**18.1%**	**$717.2**	**44.8%**	**$597.5**	**37.2%**	**$551.0**	**34.4%**
Alabama	$0.9	1.5%	$0.8	1.3%	$1.2	2.1%	$0.8	2.9%	$0.7	2.6%	$0.3	1.2%
Alaska	$9.8	92.0%	$9.2	86.0%	$8.2	76.6%	$7.5	92.5%	$6.2	76.6%	$5.7	70.5%
Arizona	$19.8	29.1%	$22.1	32.5%	$21.0	30.8%	$23.5	84.6%	$25.5	91.8%	$23.1	83.1%
Arkansas	$11.8	32.4%	$18.7	51.4%	$16.0	44.0%	$15.6	87.1%	$15.1	84.3%	$17.5	97.7%
California	$75.0	17.0%	$77.1	17.4%	$77.7	17.6%	$77.4	46.9%	$84.0	50.9%	$79.7	48.3%
Colorado	$7.0	12.9%	$11.1	20.4%	$26.4	48.5%	$26.0	105.9%	$25.0	101.8%	$27.0	110.0%
Connecticut	$0.4	0.9%	$6.1	13.9%	$7.4	16.9%	$0.0	0.0%	$2.0	9.4%	$0.0	0.2%
Delaware	$8.3	59.5%	$10.1	72.7%	$10.7	77.0%	$10.7	123.8%	$10.3	119.4%	$9.2	106.6%
DC	$0.6	5.4%	$0.9	8.1%	$3.6	34.3%	$3.6	48.1%	$0.5	6.7%	$0.0	0.0%
Florida	$61.6	29.2%	$65.8	31.2%	$59.5	28.2%	$58.0	74.0%	$5.6	7.1%	$1.0	1.3%
Georgia	$2.0	1.8%	$2.1	1.8%	$2.3	2.0%	$2.2	5.3%	$2.3	5.4%	$3.1	7.3%
Hawaii	$9.3	61.1%	$7.9	52.0%	$10.5	69.1%	$10.4	96.3%	$9.1	84.0%	$5.8	53.8%
Idaho	$1.5	8.9%	$1.2	7.1%	$1.7	10.1%	$1.4	12.6%	$0.9	8.2%	$0.5	4.9%
Illinois	$9.5	6.1%	$8.5	5.4%	$8.5	5.4%	$8.5	13.1%	$8.5	13.1%	$11.0	16.9%
Indiana	$9.2	11.7%	$10.8	13.7%	$15.1	19.2%	$16.2	46.6%	$10.9	31.3%	$10.8	31.1%
Iowa	$7.3	20.0%	$10.1	27.5%	$10.4	28.3%	$12.3	63.5%	$6.5	33.6%	$5.6	28.9%
Kansas	$1.0	3.1%	$1.0	3.1%	$1.0	3.1%	$1.4	7.8%	$1.0	5.5%	$1.0	5.5%
Kentucky	$2.6	4.5%	$2.8	4.9%	$2.8	4.9%	$2.4	9.4%	$2.2	8.8%	$2.7	10.8%
Louisiana	$9.0	16.9%	$7.8	14.6%	$7.6	14.2%	$7.7	28.3%	$8.0	29.5%	$8.0	29.5%
Maine	$9.9	53.5%	$10.8	58.4%	$10.9	58.9%	$16.9	151.2%	$14.7	131.3%	$14.2	126.9%
Maryland	$4.3	6.9%	$5.5	8.7%	$19.6	31.0%	$18.4	60.7%	$18.7	61.7%	$9.2	30.4%
Massachusetts	$4.5	5.0%	$4.5	5.0%	$12.2	13.6%	$12.8	36.2%	$8.3	23.4%	$4.3	12.1%
Michigan	$2.6	2.1%	$2.6	2.1%	$3.7	3.1%	$3.6	6.6%	$0.0	0.0%	$0.0	0.0%
Minnesota	$19.6	33.6%	$20.3	34.8%	$20.5	35.1%	$22.1	77.2%	$21.7	75.8%	$22.1	77.2%
Mississippi	$9.9	25.3%	$10.6	27.0%	$10.3	26.3%	$8.0	42.6%	$0.0	0.0%	$20.0	106.4%
Missouri	$0.1	0.1%	$1.2	1.6%	$1.7	2.3%	$0.2	0.6%	$0.0	0.0%	$0.0	0.0%

	FY2011		FY2010		FY2009		FY2008		FY2007		FY2006	
	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Rec. *	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.	Spending ($millions)	Percent of CDC Min.
Montana	$8.4	60.4%	$8.4	60.4%	$8.5	61.2%	$8.5	90.6%	$6.9	73.7%	$6.8	72.6%
Nebraska	$2.9	13.3%	$3.0	14.0%	$3.0	14.0%	$2.5	18.8%	$3.0	22.5%	$3.0	22.5%
Nevada	$0.0	0.0%	$2.9	8.9%	$3.4	10.5%	$2.0	14.8%	$3.8	28.2%	$4.2	31.2%
New Hampshire	$0.0	0.0%	$0.0	0.0%	$0.2	1.0%	$1.3	12.3%	$0.0	0.0%	$0.0	0.0%
New Jersey	$0.6	0.5%	$7.6	6.3%	$9.1	7.6%	$11.0	24.4%	$11.0	24.4%	$11.5	25.5%
New Mexico	$7.0	29.8%	$9.5	40.6%	$9.6	41.0%	$9.6	70.1%	$7.7	56.2%	$6.0	43.8%
New York	$58.4	23.0%	$55.2	21.7%	$80.4	31.6%	$85.5	89.2%	$85.5	89.2%	$43.4	45.3%
North Carolina	$18.3	17.1%	$18.3	17.1%	$17.1	16.0%	$17.1	40.2%	$17.1	40.2%	$15.0	35.2%
North Dakota	$8.2	88.1%	$8.2	88.2%	$3.1	33.3%	$3.1	38.4%	$3.1	38.0%	$3.1	38.0%
Ohio	$0.0	0.0%	$6.0	4.1%	$6.0	4.1%	$44.7	72.4%	$45.0	72.9%	$47.2	76.4%
Oklahoma	$21.7	48.2%	$19.8	44.0%	$18.0	40.0%	$14.2	65.1%	$10.0	45.8%	$8.9	40.8%
Oregon	$7.1	16.6%	$6.6	15.3%	$8.2	19.1%	$8.2	38.8%	$3.5	16.3%	$3.5	16.3%
Pennsylvania	$14.7	9.5%	$17.7	11.4%	$32.1	20.6%	$31.7	48.3%	$30.3	46.2%	$32.9	50.2%
Rhode Island	$0.7	4.8%	$0.7	4.6%	$0.9	6.1%	$0.9	9.5%	$1.0	9.6%	$2.1	21.2%
South Carolina	$5.0	8.0%	$2.0	3.2%	$0.0	0.0%	$2.0	8.4%	$2.0	8.4%	$0.0	0.0%
South Dakota	$3.5	31.0%	$5.0	44.2%	$5.0	44.2%	$5.0	57.5%	$0.7	8.1%	$0.7	8.1%
Tennessee	$0.2	0.3%	$0.2	0.3%	$5.0	7.0%	$10.0	31.0%	$0.0	0.0%	$0.0	0.0%
Texas	$11.4	4.3%	$11.4	4.3%	$11.8	4.4%	$11.8	11.4%	$5.2	5.0%	$7.0	6.8%
Utah	$7.1	30.2%	$7.1	30.1%	$7.2	30.5%	$7.3	47.7%	$7.2	47.3%	$7.2	47.3%
Vermont	$4.5	43.4%	$4.8	46.2%	$5.2	50.0%	$5.2	66.0%	$5.1	64.5%	$4.9	61.9%
Virginia	$9.4	9.1%	$12.3	11.9%	$12.7	12.3%	$14.5	37.3%	$13.5	34.7%	$12.8	32.9%
Washington	$13.4	19.8%	$15.8	23.5%	$27.2	40.4%	$27.1	81.1%	$27.1	81.3%	$27.2	81.6%
West Virginia	$5.7	20.4%	$5.7	20.5%	$5.7	20.5%	$5.7	40.0%	$5.4	38.1%	$5.9	41.7%
Wisconsin	$6.9	10.7%	$6.9	10.7%	$15.3	23.8%	$15.0	48.1%	$10.0	32.1%	$10.0	32.1%
Wyoming	$5.4	60.0%	$4.8	53.3%	$6.0	66.7%	$5.9	80.1%	$5.9	79.9%	$5.9	79.9%
Total	**$517.9**	**14.0%**	**$569.3**	**15.4%**	**$670.9**	**18.1%**	**$717.2**	**44.8%**	**$597.5**	**37.2%**	**$551.0**	**34.4%**

* In 2007, the CDC updated its recommendation for the amount each state should spend on tobacco prevention programs, taking into account new science, population increases, inflation and other changes since it last issued its recommendations in 1999. In most cases, the updated recommendations are higher than previous ones. Starting in FY2009, this report assessed the states based on these new recommendations.

CDC Best Practices for Comprehensive Tobacco Control Programs Oct 2007

Appendix B Funding Recommendation Formulations

In *Best Practices for Comprehensive Tobacco Control Programs—August 1999*, funding formulas were provided for the nine specific elements of a comprehensive program. These formulas were based on evidence from scientific literature and the experience of large-scale and sustained efforts of state programs in California and Massachusetts.[1]

In December 2006, technical consultation was sought from a panel of experts regarding the best available evidence to determine updated cost parameters and metrics for major components of a comprehensive tobacco control program. The panel reviewed data relevant to potential changes in the 1999 funding recommendations, including state experience and findings on program effectiveness that have emerged since the release of *Best Practices—1999*. The panel generally agreed that the published funding formulas remained sound but that technical updates were necessary.[2] A listing of participants in the expert panel is provided in Appendix A.

Funding recommendations in this publication are based on the funding formulas presented in 1999, with adjustments to specific variables to account for changes in the total population (2006), population of persons aged 18 years and older (2006), public (2006) and private (2003) school enrollment, and smoking prevalence (2006), as well as an increase to keep pace with the national cost of living (June 2007).[3-7]

The original basis for budget recommendations is as follows:[1]

- Community Programs: $850,000-$1,200,000 (statewide training and infrastructure) + $0.70-$2.00 per capita
- Tobacco-Related Disease Programs: Average of $2.8 million - $4.1 million per year
- School Programs: $500,000-$750,000 (statewide training and infrastructure) + $4-$6 per student (K-12)
- Enforcement: $150,000-$300,000 estimated range for youth access and smoke-free air enforcement + $0.43-$0.80 per capita
- Statewide Programs: $0.40-$1.00 per capita
- Counter-Marketing: $1.00-$3.00 per capita
- Cessation
  - Minimum: $1 per adult (screening) + $2 per smoker (brief counseling)
  - Maximum: $1 per adult (screening) + $2 per smoker (brief counseling) + $13.75 per smoker (50% of quitline cost for 10% of smokers) + $27.50 per smoker for NRT (assumes approximately 25% of smokers treated are covered by state-financed programs)
- Surveillance and Evaluation: 10% of program total
- Administration and Management: 5% of program total

As with the funding guidance first published in 1999, recommended annual costs can vary within the lower and upper estimates provided for each state. Therefore, to better assist states, specific guidance is now provided regarding each state's recommended level of investment within its range. These recommended levels of annual investment factor in state-specific variables, such as the overall population; smoking prevalence; the proportion of the population uninsured or receiving publicly financed insurance or living at or near the poverty level; infrastructure costs; the number of local health units; geographic size; the targeted reach for quitline services; and the cost and complexity of conducting mass media campaigns to reach targeted audiences, such as youth, racial/ethnic minorities, or people of low socioeconomic status.[3,6,8-14]

Per capita formula adjustments for 2007 include:

- Community Programs: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account smoking prevalence, proportion of the population living at or below 200% of the poverty level, average wage rates for implementing public health programs, the number of local health units, and geographic size.
- Tobacco-Related Disease Programs: Total budget numbers were adjusted for inflation and distributed to each state on a per capita basis.
- School Programs: Budget numbers were adjusted for inflation and applied to state school enrollment.
- Enforcement: Budget numbers were adjusted for inflation.
- Statewide Programs: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account smoking prevalence, proportion of the population living at or below 200% of the poverty level, average wage rates for implementing public health programs, the number of local health units, and geographic size.
- Counter-Marketing: Upper and lower limits were adjusted for inflation. Specific state estimates within these limits took into account relative media costs and the complexity of the media market.
- Cessation:
  - Health care systems (screening and brief counseling) budget numbers were adjusted for inflation.
  - Quitline support: (number of callers enrolled in quitline) x (per person cost for counseling) + (per person cost for NRT). Formula assumes 6% of adult smokers in the state receive treatment each year.
- Surveillance and Evaluation: 10% of program total.
- Administration and Management: 5% of program total.

Appendix B Funding Recommendation Formulations

Multiplying state per capita funding recommendations by state population will provide the total funding recommendations presented in the total funding summary table and the state-specific pages. Because total funding recommendations are rounded to the nearest hundred thousand, the reverse calculation might produce slightly different per capita estimates. The recommended levels of investment (per capita and total) are presented in 2007 dollars using 2006 population rates. These should be updated annually according to the U.S. Department of Labor Consumer Price Index and U.S. Census Bureau.[3,7]

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APPENDIX G

Memorandum from Senator Roger Katz to Members of the Commission to Study Allocations of the Fund for a Healthy Maine, November 28, 2011

125th Legislature
Senate of Maine
Senate District 24

Senator Roger J. Katz
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Home (207) 622-9921

TO: Members of the Commission to Study Allocations of the Fund for a Healthy Maine

FR: Senator Roger Katz

RE: Commission Meeting Tuesday, November 29, 2011

DT: November 28, 2011

Dear Colleagues:

I am really sorry that I am unable to attend Tuesday's Commission meeting, but I have a trial in Penobscot County that I could not change.

As we went through our meetings and reviewed the large amount of materials available to us, I was struck by several things:

- The Commission Members with whom I serve are a diverse and talented group of people who bring a wide range of expertise to the discussion;
- A full exploration of the issues before us would take several more meetings; but
- We must do the best we can with our mandate and the short period of time we have been given.

I wanted to take one more opportunity to summarize my personal thoughts on what we ought to do. From my perspective, we are in a unique position to re-deploy our limited Fund for Healthy Maine dollars in order to maximize their impact. To me, the key principle is "prevention". But what should we be trying to prevent? My own thought is that we should focus like a laser on the major drivers of our ever-increasing health care costs: tobacco use and obesity. As we have learned, these largely-preventable conditions contribute as much as 30%-40% to our burgeoning MaineCare expenses. With about $50

million of tobacco settlement money available to us each year, I think we should direct these funds to those two goals.

I must tell you I come to the discussion from the perspective of someone who serves on the Appropriations Committee. I sit there in our budget discussions constantly having to vote "no" to public investments which I know would move our state ahead. More money for higher education. More money for teacher development. More research and development funding to improve our economy. The list goes on. But the sad reality is that our skyrocketing public healthcare costs are slowly but inexorably sucking all the oxygen out of the room in terms of the ability to fund them. It is from that perspective that I come to my conclusions.

Accordingly, I would personally ask with respect to every program we are asked to fund through FHM:

A. How does it directly impact on tobacco use in the State of Maine; and

B. How does it directly impact on the prevalence of obesity within our population?

If a program cannot answer at least one of these questions in a direct and quantifiable way, I respectfully suggest it should not continue as part of the Fund for Healthy Maine allocation process. There may be several programs we now fund which are of significant benefit to critical populations within our state. If so, and if they do not meet the above criteria, they should compete for dollars with other programs through the General Fund budget process. I would be the first to advocate for several of them based upon their own unquestioned merit. However, for at least this Commission member, the Fund for Healthy Maine should concentrate on programs which have the best chance of reducing our healthcare costs in the most dramatic of ways.

I thank you in advance for considering my thoughts and again express my apologies for my absence.

Best regards,

Roger J. Katz
State Senator, District 24
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RJK/cam

APPENDIX H

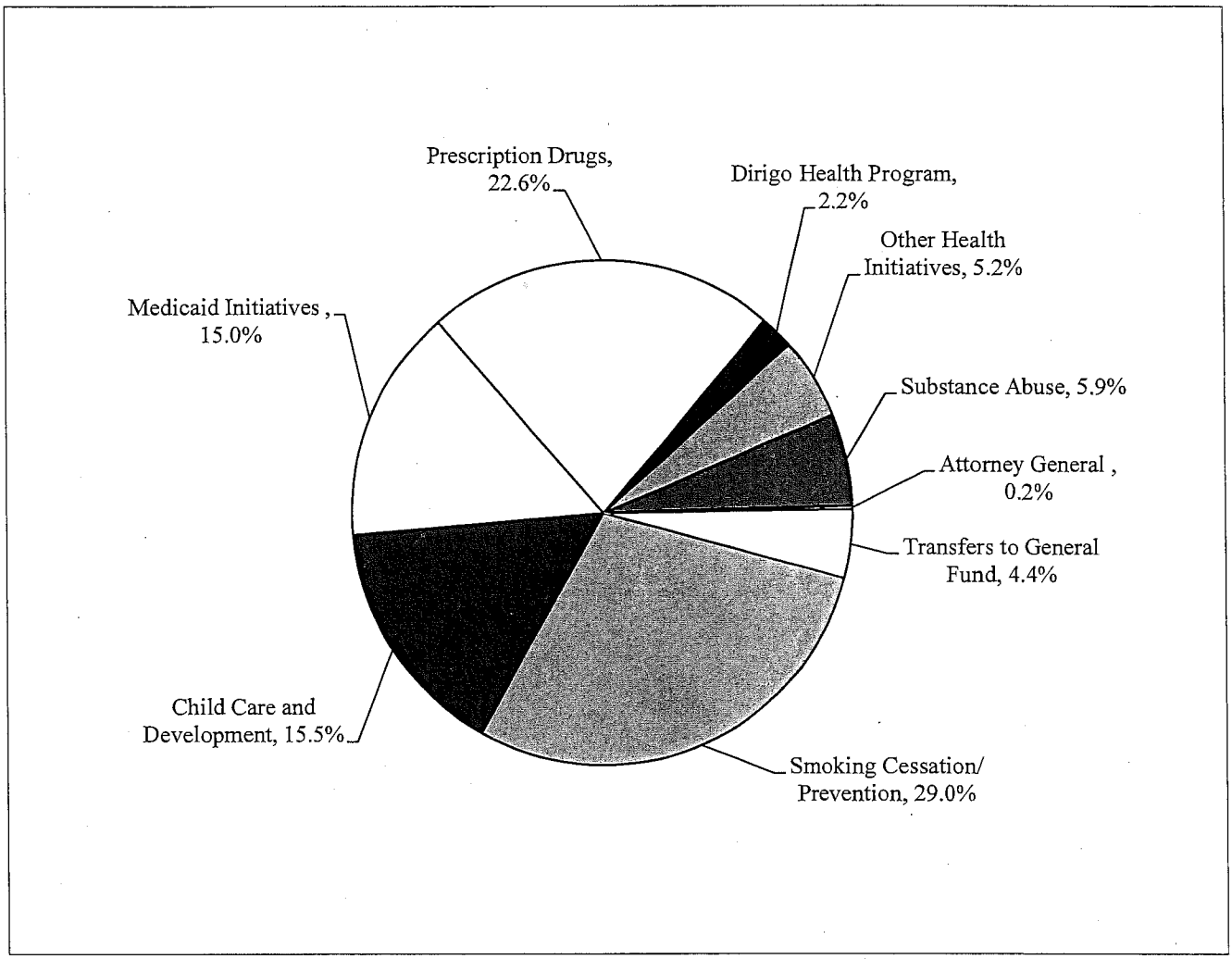
Office of Fiscal and Program Review pie chart of Fund for a Healthy Maine program spending

Updated 11/28/2011

Fund for a Healthy Maine (FHM)

Budgeted Allocations and Uses *

2012-2013 Biennium



	2011-12	2012-13	Biennium
Smoking Cessation/ Prevention	$15,258,943	$15,289,299	$30,548,242
Child Care and Development	$8,163,919	$8,163,919	$16,327,838
Medicaid Initiatives	$7,876,677	$7,906,432	$15,783,109
Prescription Drugs	$11,934,230	$11,934,230	$23,868,460
Dirigo Health Program	$1,161,647	$1,161,647	$2,323,294
Other Health Initiatives	$2,742,788	$2,745,301	$5,488,089
Substance Abuse	$3,105,972	$3,105,972	$6,211,944
Attorney General	$111,840	$119,687	$231,527
Transfers to General Fund	$1,375,000	$3,240,000	$4,615,000
Totals	$51,731,016	$53,666,487	$105,397,503

** Reflects Budgeted Allocations and Uses through the 125th Legislature, 1st Regular Session*

Prepared by the Office of Fiscal and Program Review

Updated 11/28/2011

Fund for a Healthy Maine (FHM)

Budgeted Allocations and Uses Detail*

2012-2013 Biennium

	2011-12	2012-13	Biennium
Smoking Cessation/ Prevention	**$15,258,943**	**$15,289,299**	**$30,548,242**
0953-02 FHM - BoH Tobacco Prevention and Control	*$6,402,080*	*$6,421,493*	*$12,823,573*
0953-07 FHM - BoH Community/School Grants	*$7,777,979*	*$7,788,922*	*$15,566,901*
Z015 FHM - Immunization	*$1,078,884*	*$1,078,884*	*$2,157,768*
Child Care and Development	**$8,163,919**	**$8,163,919**	**$16,327,838**
Z068 FHM - School Breakfast Program	*$213,720*	*$213,720*	*$427,440*
0953-06 FHM - BoH Home Visits	*$2,653,383*	*$2,653,383*	*$5,306,766*
0959 FHM - Head Start	*$1,354,580*	*$1,354,580*	*$2,709,160*
0961 FHM - Purchased Social Services	*$3,942,236*	*$3,942,236*	*$7,884,472*
Medicaid Initiatives	**$7,876,677**	**$7,906,432**	**$15,783,109**
0960 FHM - Medical Care	*$7,876,677*	*$7,906,432*	*$15,783,109*
Prescription Drugs	**$11,934,230**	**$11,934,230**	**$23,868,460**
Z015 FHM - Drugs for the Elderly & Disabled	*$11,934,230*	*$11,934,230*	*$23,868,460*
Dirigo Health Program	**$1,161,647**	**$1,161,647**	**$2,323,294**
Z070 FHM - Dirigo Health	*$1,161,647*	*$1,161,647*	*$2,323,294*
Other Health Initiatives	**$2,742,788**	**$2,745,301**	**$5,488,089**
0953-01 - BoH Oral Health Program	*$600,000*	*$600,000*	*$1,200,000*
0953-08 - BoH Public Health Infrastructure	*$1,366,802*	*$1,369,315*	*$2,736,117*
0956 FHM - Family Planning	*$401,430*	*$401,430*	*$802,860*
0958 FHM - Donated Dental	*$36,463*	*$36,463*	*$72,926*
0950 FHM - Health Education Centers	*$100,353*	*$100,353*	*$200,706*
0951 FHM - Dental Education	*$237,740*	*$237,740*	*$475,480*
Substance Abuse	**$3,105,972**	**$3,105,972**	**$6,211,944**
0948-01 FHM - Substance Abuse	*$1,848,306*	*$1,848,306*	*$3,696,612*
0948-02 FHM - Substance Abuse	*$1,257,666*	*$1,257,666*	*$2,515,332*
Attorney General	**$111,840**	**$119,687**	**$231,527**
0947 FHM - Attorney General	*$111,840*	*$119,687*	*$231,527*
Transfers to General Fund	**$1,375,000**	**$3,240,000**	**$4,615,000**
Totals	**$51,731,016**	**$53,666,487**	**$105,397,503**

** Reflects Budgeted Allocations and Uses through the 125th Legislature, 1st Regular Session*

Prepared by the Office of Fiscal and Program Review

APPENDIX I

Information requests from Department of Health and Human Services, November 29, 2011

Commission to Study Allocations of the Fund for a Healthy Maine
Requests for Information from November 17 meeting

1. Please provide information on the number of children each year who are served free and reduced price breakfasts through FHM funding? *Shirrin Blaisdell, DAFS, and Dept of Education*

2. Please provide information on how the revenues from the Oxford casino are to be used by the State? *Chris Nolan, OFPR*

3. Please provide information on which other states are using tobacco settlement funds for Head Start and Early Head Start. *Judith Reidt-Parker, Maine Children's Alliance*

4. Can MaineCare require participation in tobacco cessation program as a condition of eligibility for MaineCare? *Ana Hicks, Maine Equal Justice Project, stated later in the meeting that the federal Centers for Medicare and Medicaid Services determines what eligibility criteria the states may impose and does not allow participation in tobacco cessation program as a requirement.*

5. Please provide information on the federal match requirements for state funding of home visiting. Can Maine decrease its financial commitment without losing federal funds? What is the point at which a financial penalty is applied? What is the nature of the penalty? Is it full or partial loss of federal funds? Conversely could Maine increase its financial commitment and gain extra federal funds? *Keith Wilson, OCFS, DHHS* ***P.7***

6. Please provide a complete listing of all home visiting funding and Head Start and Early Head Start funding, from all sources. *Keith Wilson, OCFS, DHHS* ***Pp. 11 & 12***

7. Please provide data on the benefits of Head Start and Early Head Start, showing short-term and long-term effects of participation in the programs. *Judith Reidt-Parker, Maine Children's Alliance*

8. With regard to federal funding for Head Start and Early Head Start please provide information on the federal match requirements for state funding. Can Maine decrease its financial commitment without losing federal funds? What is the point at which a financial penalty is applied? What is the nature of the penalty? Is it full or partial loss of federal funds? Conversely could Maine increase its financial commitment and gain extra federal funds? *Keith Wilson, OCFS, DHHS* ***P. 13***

9. Please provide information on the levels of eligibility for state payment for Medicare benefits under Medicare Savings Programs in Maine (under the Elderly Low-Cost Drug program) and other states. Does Maine pay for persons with incomes above the levels in other states? If so, what are the benefits to Maine and to the Maine Medicare beneficiary? *Jennifer Palow, OMS, DHHS, and Chris Nolan, OFPR* ***P. 19***

10. Please provide information on how many people receive treatment services paid for with FHM funds under Office of Substance Abuse Services. Please separate MaineCare and non-MaineCare services. *Geoffrey Miller, OSA, DHHS* ***P. 26***

11. Please provide information on which higher education campuses receive substance abuse prevention funding under the HEAPP program. If there are additional higher education campuses that previously received HEAPP funding and continued prevention programs without the funding, please provide information on those campuses. *Geoffrey Miller, OSA, DHHS* **P. 27**

12. With regard to federal funding for substance abuse services please provide information on the federal match requirements for state funding. Can Maine decrease its financial commitment without losing federal funds? What is the point at which a financial penalty is applied? What is the nature of the penalty? Is it full or partial loss of federal funds? Conversely could Maine increase its financial commitment and gain extra federal funds? *Geoffrey Miller, OSA, DHHS* **P. 29**

13. Please provide data on outcomes/performance measures for substance abuse treatment programs funded through OSA. *Geoffrey Miller, OSA, DHHS* **P. 30**

14. Please provide information on the focus of Healthy Maine Partnership funding historically, starting from the focus this biennium 50-40-10 (50% tobacco prevention, 40% obesity prevention and 10% chronic disease prevention) and working backwards in time. *Kristen McAuley, CDC, DHHS* **P. 34**

15. Please provide information on how the 50-40-10 focus was established and by what entity. *Kristen McAuley, CDC, DHHS* **P. 35**

16. Please provide information on expenditures from the FHM-Family Planning account. Please provide information on other accounts that pay for family planning services and what services are provided through the use of those funds. *Valerie Ricker, CDC, DHHS* **P. 36**

17. Please provide information on the rates of adolescent pregnancy in different parts of Maine. If information is available on rates over a time period please provide that information. *Valerie Ricker, CDC, DHHS* **P. 40**

18. Please provide information on the allocation of FHM funding among the 8 public health purposes outlined in Title 22, section 1511, subsection 6. *Chris Nolan, OFPR, and Bonnie Smith, DHHS*

19. Please provide information on whether FHM spending could be reallocated to produce increased federal funding. *Bonnie Smith, DHHS*

20. Please provide information on the federal Center for Disease Control and Prevention recommended levels of spending on tobacco prevention, including a cite to the source, and information on Maine's level of spending in the last 6 years. Spending levels in other states would also be helpful. *Hilary Schneider, American Cancer Society, and Anna Broome, OPLA*

NOTE: Page 46 through 48 provide the response to Jane Orbeton's additional data request dated 11/28/2011. **P. 46**

Fund for a Healthy Maine Fact Sheet

Office: Child and Family Services **Date:** 11-17-11

Program Title: Maine Families Home Visiting

Account: 014-095306, FHM-Home Visitation

I. **Program Description:**

1) **Overview of the program:**
Home Visiting was formally established in state statute (Title 22, §262) as an effective primary prevention public health strategy to meet the goals of the Department by improving the health and well-being of Maine's young children and their families through a connected network of home visiting providers.

In accordance with the federal definition of home visiting as outlined in the Social Security Act, Title V, Section 511(b)(U.S.C. 701), as amended by the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent, short-term or supplemental home visiting), and is offered on a voluntary basis to mothers, fathers, families, pregnant women, infants, and children.

Maine Families Home Visiting delivers cost-effective focused services to a vulnerable population at the most critical time of children's physical and emotional development.

2) **Who is served with these funds (i.e. # of people, # of programs, etc.):**
The Maine Families Home Visiting Program serves vulnerable families of infants and toddlers. Typically, over 2500 families receive home visits each year. The families who received home visits were largely young (46% under age 23 at their child's birth), single or partnering (60%) and more likely to be facing economic challenges (over 1/3 of the families had incomes under $10,000 for the year). The program is making special efforts to reach the highest risk babies such as those that are drug affected or exposed to family violence.

3) **What is purchased with these funds:**
Maine Families Home Visiting is an evidence-based program providing focused services in response to an individualized needs assessment and is offered in families' homes. Well-trained professionals work in partnership with parents to insure safe home environments, promote healthy growth and development for babies and young children, and provide key connections to state and local services as needs are identified.

Expectant parents receive support to have a healthy pregnancy and access prenatal care. Parents of newborns are supported in their adjustment to parenthood and information is provided related to critical areas such as prevention of shaken baby syndrome, SIDS, suffocation and unintended injuries. Beyond the newborn period, ongoing educational and support services are provided to the most vulnerable families at a level reflecting the families' needs.

4) **What is the service delivery (i.e. state personnel, contracted services, etc.):**
Contracted home visiting program sites are located in various health, educational and community agency settings and are available in every county in Maine. Sites work closely with other community service providers to collaborate and avoid duplication of services.

5) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History:

- State funded community- based home visiting was piloted originally in 1994 and expanded across the state in 2000 with the availability of funding from the Tobacco Settlement Funds.
- 2007, Title 22, §262: Home visiting
- 2011, Ch. 77, LD 1504, *Resolve, to Ensure a Strong Start for Maine's Infants and Toddlers by Extending the Reach of High Quality Home Visitation*
- Social Security Act, Title V, Section 511 (42 U.S.C. §701) as amended by Section 2951 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

III. Financial Information:

1) **4 Years of Spending and SFY12 & 13 Budget:**

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$ 5,378,750	$ 5,022,914	$ 5,064,553	$ 5,091,128	$ 2,653,383	$ 2,653,383
General Fund or Other Special Revenue					$ 2,000,000	$ 2,000,000
Federal Funds					$ 4,000,000	$ 5,200,000
Total	$ 5,378,750	$ 5,022,914	$ 5,064,553	$ 5,091,128	$ 8,653,383	$ 9,853,383

2) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:**
Fund for a Healthy Maine (FHM) funding represents 30.7% and 26.9% of the total funding for the Home Visitation program for FY 2012 and FY 2013 respectively.

IV. Program Eligibility Criteria:
Families may take part in the program beginning in pregnancy and may receive visits until their child turns three years of age. Beyond the prenatal/newborn period, eligibility for ongoing services is determined by an individualized needs assessment and is prioritized and focused on the most vulnerable families such as adolescents and those experiencing substance abuse, domestic violence, mental health issues, developmental/ health concerns or family stress.

V. **Are the Fund for a Healthy Maine funds used to meet MOE Requirements?** ☒ **Yes** ☐ **No**

If yes, please explain:

The Affordable Care Act – Maternal, Infant and Early Childhood Home Visiting Program grants (formula based grants and competitive expansion grant) were awarded to "effectively implement home visiting models (or a single home visiting model) in the state's at-risk community(ies) to promote improvements in the benchmark and participant outcome areas as specified in the legislation." States must use the federal funds to supplement, not supplant, funds from other sources for these early childhood home visiting services.

VI. **Goals & Outcomes of the program:**

1) **Please describe the goals of the program:**

- Healthy and strong parent-child attachment.
- Family health, emotional and physical well-being.
- Reduced incidence of child abuse and neglect.
- Positive and creative learning environment for the child.
- Family self-sufficiency.
- Positive and effective parenting.
- Parental competencies and self-confidence.
- Community linkages/reduced family isolation.
- Educational success.

2) **Please describe how the outcomes are measured:**

As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering several domains of health and well-being. The state home visiting plan submitted in June 2011 included detailed descriptions of how each benchmark is measured. One example is included below:

Benchmark I. Improved Maternal and Newborn Health	
Construct	**(ii) Parental use of alcohol, tobacco, or illicit drugs**
Indicator	Percentage of pregnant women enrolled in the program using tobacco at intake who have ceased tobacco use by 3 months post enrollment
Indicator Type	Outcome Measure
Measurable Objective *Operational definition of improvement*	Increase or maintain the percentage of enrolled pregnant women using tobacco who cease tobacco use within three months post-enrollment from year 1 baseline to the 3-year benchmark reporting period.
Measurement Tool	Behavioral Health Risk Screening Tool for Pregnant Women and Women of Childbearing Age (BHRST)
Validity of proposed measurement tool	The Virginia Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Health (VDH) and the Home Visiting Consortium developed the *Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age* based on the Integrated Screening Tool developed by the Institute for Health and Recovery (IHR). (IHR's tool may be located online at www.mhqp.org/guidelines/perinatalPDF/IHRIntegratedScreeningTool.pdf. Virginia follows Bright Futures Guidelines (www.brightfutures.org/mentalhealth) as a framework for prevention and use of standardized screening tools. This tool incorporates the 4P's Plus, EPDS-3 and a Domestic Violence screening question. The 4P's Plus tool reliably and effectively screens pregnant women screened for substance abuse, including those women typically missed by other perinatal screening methods. The overall reliability for the 5-item measure was 0.62. Seventy-four (32.5%) of the women had a positive screen. Sensitivity and specificity was very good at 87% and 76% respectively. Positive predictive validity was low (36%) but negative predictive validity was high (97%). According to the author, "In an evaluation of clinical experience with the 4P's Plus, effective identification of pregnant women at highest risk for substance use can be accomplished within the context of routine prenatal care." (Chasnoff, et al., 2005)

Benchmark I. Improved Maternal and Newborn Health	
Construct	**(ii) Parental use of alcohol, tobacco, or illicit drugs**
Population to be assessed	Caregiver (pregnant women)
Sampling Plan, if applicable	N/A All families included
Special Considerations	None
Data Collection Plan (Including schedule/how often)	All pregnant caregivers will be screened for alcohol, tobacco, and drug use using the BHRST. Baseline data results of the screen will be entered into the database, ongoing parent report on current use of tobacco will be collected at each visit and change will be captured in the online database.
Data Analysis Plan *(include plan for the identification of scale scores, ratios, or other metrics most appropriate to the measurement proposed)*	Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: • Enrollment from the start of the project period • Families identified as pregnant at enrollment • Tobacco use as noted from enrollment data • Tobacco use at date 3 months from enrollment The calculation will be determined by dividing the total number of pregnant women who cease tobacco use within three months post-enrollment by the number of women enrolled prenatally who are using tobacco (at any intensity) at enrollment.

3) **Please describe the measurable outcomes of the program:**
As a recipient of federal ACA funds, Maine is required to demonstrate improvements in 34 benchmarks covering the following domains: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. See Social Security Act, Title V, Section 511 (d) (1) (42 U.S.C. §701).

Highlights of the recent outcome data for Maine Families Home Visiting:
HEALTH AND DEVELOPMENT OUTCOMES (FY11)

- 99.8% of children have a primary care provider and 97.3% have health insurance.
- 93% are up to date with their well-child check-ups and their immunizations (20% higher than the Maine immunization rate).
- All age-eligible children are screened regularly for possible developmental delays (with parent permission). Seven percent of children on average are identified with possible delays and provided supports to help address those delays early before more costly remediation is needed in school.
- Of children exposed to second hand smoke, 39% are no longer exposed and 29% have reduced exposure, reducing their risk of developing respiratory and other related health issues.
- 94% of expectant mothers received adequate prenatal care (Maine rate 85%) resulting in fewer premature and low birth weight babies and saving significant related health care costs.

SAFETY OUTCOMES (FY10)

- 1% of children in the program were victims of substantiated abuse or neglect. (Maine rate 2.4%)
- Home Safety Assessment improved across all measures, with the largest impacts in fire prevention (23%), outdoor safety (38%) and car safety (27%).

PARENTS' REPORT OF POSITIVE CHANGE AS A RESULT OF PARTICIPATION:

- Child Development 99%
- Home Safety 98%
- Child Nutrition 98%
- Child Discipline 98%
- Car Seat Safety 96%
- Breastfeeding 91%
- Second-hand Smoke 92%

Question 5:
Please provide information on the federal match requirements for state funding of home visiting. Can Maine decrease its financial commitment without losing federal funds? What is the point at which a financial penalty is applied? What is the nature of the penalty? Is it full or partial loss of federal funds? Conversely, could Maine increase its financial commitment and gain extra federal funds?

Answer:
Yes, it appears that Maine can decrease its financial commitment without losing federal funds because match and MOE don't apply to Maine by statute (which references state general funds investment on 3/25/2010, of which we had had none). However, it is unclear whether upon decreasing state funds and submitting a budget revision of the federal dollars, we are actually in violation of supplantation. There are no financial penalties other than having to return funds or not fund direct service if it supplants existing resources because the federal grant was for expansion of an existing successful and efficient program. Maine cannot increase its financial commitment and gain extra federal funding.

Fund for a Healthy Maine Fact Sheet

Office: Office of Child & Family Services **Date:** 11/17/11

Program Title: Head Start

Account: 014-095901; FHM- Head Start

VII. **Program Description:** Eligible Maine children receive high quality, comprehensive early care and education services that foster children's growth and development by supporting and nurturing their social, emotional, cognitive and physical development. The primary mission has been to prepare children for success in school and local programs have worked hard to meet the rigorous standards in serving children and families.

6) **Overview of the program:** Provide a safe, high learning experience that fosters school readiness by providing education, health, vision, hearing, dental, mental health, nutrition, social and parenting education. Significant emphasis is placed on the involvement of families, as the program engages parents in their children's learning and helps make progress toward their own educational, literacy and employment goals. Eleven Head Start grantees in Maine are funded primarily through the federal Office of Head Start. Three additional Head Start programs are funded by the Tribal Office of Head Start and are managed by the Passamaquoddy, Micmac and Maliseet tribes within their communities. Head Start provides early care and education, as well as health, nutrition, mental health, social and family support to low income families.

7) **Who is served with these funds (i.e. # of people, # of programs, etc.):** Head Start and Early Head Start Programs begin serving children 6 weeks up to 5 years of age/ school age unless the approved federal grant provides otherwise. 65% of the families must have income at or below the federal poverty level. The State of Maine contracted with 11 Head Start Programs and served 4,638 children & 76 pregnant women for a total of 4,714 according to the 2010-2011 Program Information Report (PIR).

8) **What is purchased with these funds:** Head Start Programs are Evidence-Based programs that utilize Federal Performance Standards that measure Goals, Objectives and Outcomes. Head Start funds assist with providing a safe, high learning experience that fosters school readiness by providing education, health, vision, hearing, dental, mental health, nutrition, social and parenting education.

9) **What is the service delivery (i.e. state personnel, contracted services, etc.):** Contracted Head Start Program sites are located in educational and community agency settings and services are available in every Maine County. Head Start Programs work closely with DHHS, DOE, Resource Development Centers and other community providers to ensure that needs are being met with minimal duplication of services.

10) **Department Program Staff:**
Number of employees: 0 Cost of employees: $ 0

VIII. **Relevant Legislative History:** State General Funds were first implemented in 1983 as part of a broad education reform effort, which included pre-k (4year olds only) in the Essential Programs and Services formula for school funding. The Legislature specifically designated funds for Head Start comprehensive

services to expand those services where current federal Head Start programming existed and must be directed to Head Start grantees in the State of Maine. The services supported by these funds must align with Federal Head Start Performance Standards. These Head Start funds must be awarded to the agencies competitively selected and awarded the Federal Head Start Program by the Administration for Children and Families, U.S. Department of Health and Human Services. An agreement supporting a single Head Start program for the State of Maine was signed by the Maine DHHS and the US DHHS on 5/10/2000. This agreement states that Maine has the authority to allocate State funds to existing Federal grantees only. On December 12,2007 President Bush signed Public Law 110-134 "Improving Head Start for School Readiness Act of 2007" reauthorizing the Head Start Program. This law contained significant revisions to the previous Head Start Act and authorizes Head Start through September 30, 2012.

IX. Financial Information:

3) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$ 1,520,939	$ 1,575,264	$ 1,507,256	$ 1,440,941	$ 1,354,580	$ 1,354,580
General Fund or Other Special Revenue	$ 2,390,129	$ 2,443,514	$ 2,441,940	$ 2,354,169	$ 2,448,875	$ 2,448,875
Federal Funds	$ 65,831	$ 42,724	$ 119,261	$ 38,300	$ 109,152	$ 109,152
Total	$ 3,976,899	$ 4,061,502	$ 4,068,457	$ 3,833,410	$ 3,912,607	$ 3,912,607

4) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:** Fund for a Healthy Maine allocations make up 34.6% of the overall funding for the FY2012 and FY 2013 Head Start Program allocations.

X. **Program Eligibility Criteria:** Under the current contract structure; children 6 weeks to compulsory school age are eligible for services under this agreement unless the approved federal grant provides otherwise. 65% of families must have income at or below the federal poverty level.

XI. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☒ Yes ☐ No

If yes, please explain: Block Grant Requirement is to spend no less than 70% of Mandatory and Matching grant on child care services.

XII. **Goals & Outcomes of the program:**

4) **Please describe the goals of the program:** Provide Maine families with high quality, comprehensive services that foster each child's growth by supporting and nurturing the child's social, educational, emotional, cognitive and physical development.

5) **Please describe how the outcomes are measured:** Head Start Programs outcomes are measured by the Federal Head Start Performance Standards. The current Performance Standards require that each program, at least once a year, conduct a self-assessment to examine how the program is meeting its own goals and objectives and its success in implementing the Program Performance Standards and other federal regulations. The process must involve program parents, staff and the community, and self-assessment results are intended to influence future program planning and continuous program improvement.

6) **Please describe the measurable outcomes of the program:** As a recipient of Federal Head Start funds, Maine is required to demonstrate progress on the 24 Federal Performance Measures. The five overall objectives reflect Head Start's philosophy and successful track record of promoting school readiness through a comprehensive, integrated set of strategies and services.

7) **Objective 1-** Enhance children's healthy growth and development

8) **Objective 2-** Strengthen families as the primary nurturers of their children

9) **Objective 3-** Provide children with educational, health, and nutritional services

10) **Objective 4-** Link children and families to needed community services

11) **Objective 5-** Ensure well-managed programs that involve parents in decision-making

Question 5: (question 5 is repeated here because it answers Question 6 in part)
Please provide information on the federal match requirements for state funding of home visiting. Can Maine decrease its financial commitment without losing federal funds? What is the point at which a financial penalty is applied? What is the nature of the penalty? Is it full or partial loss of federal funds? Conversely could Maine increase its financial commitment and gain extra federal funds?

Answer:
Yes, it appears that Maine can decrease its financial commitment without losing federal funds because match and MOE don't apply to Maine by statute (which references state general funds investment on 3/25/2010, of which we had had none). However, it is unclear whether upon decreasing state funds and submitting a budget revision of the federal dollars, we are actually in violation of supplantation. There are no financial penalties other than having to return funds or not fund direct service if it supplants existing resources because the federal grant was for expansion of an existing successful and efficient program. Maine cannot increase its financial commitment and gain extra federal funding.

Question # 6:

Please provide a complete listing of all home visiting funding and Head Start and Early Head Start funding, from all sources.

Head Start is a federally funded program; Maine's 11 grantees received a combined total of $31,146,173 in Federal funds for Fiscal 2012.There are no Federal requirements that the State contribute to Head Start Programs. Maine is 1 of 16 States that contribute General Funds to Head Start Programs.

Agency	Federal Award FY12 Head Start & Early Head Start	General Fund 010-10A-8255	Fund for a Healthy Maine 014-10A-9255	HS Collaboration Grant 013-10A-8256
Androscoggin Head Start and Child Care	$2,382,508	$155,637	$102,895	
Aroostook County Action Program	$2,967,764	$169,235	$102,098	
Child & Family Opportunity	$2,205,639	$291,629	$102,098	
Community Concepts	$2,896,741	$146,993	$193,277	
KVCAP	$2,892,394	$291,629	$102,098	
Midcoast Maine CAP	$2,545,670	$264,429	$102,098	
Penquis CAP	$5,130,191	$315,425	$193,277	
PROP	$3,431,454	$437,819	$102,098	$5,000
SKCDC	$2,595,953	$126,004	$102,098	
Waldo CAP	$1,679,185	$118,238	$102,098	
York County CAP	$2,418,674	$131,837	$102,098	
Total	**$31,146,173**	**$2,550,973**	**$1,354,580**	**$125,000** ($30,000 In Contracts)

Head Start/Early Head Start Funding Breakdown FY12

Agency	Head Start	Early Head Start
Androscoggin Head Start and Child Care	$1,952,582	$429,926
Aroostook County Action Program	$2,967,764	
Child and Family Opportunity	$2,205,639	
Community Concepts Inc.	$2,896,741	
KVCAP	$2,194,397	$697,997
Midcoast Maine CAP	$2,545,670	
Penquis CAP	$4,116,417	$1,013,774
PROP	$2,466,437	$965,017
SKCDC	$2,595,953	
Waldo CAP	$1,679,185	
York County CAP	$2,418,674	
Total	**$28,039,459**	**$3,106,714**

Question # 8

With regard to federal funding for Head Start and Early Head Start please provide information on the federal match requirements for state funding. Can Maine decrease its financial commitment without losing federal funds? What is the point at which a financial penalty is applied? What is the nature of the penalty? Is it full or partial loss of federal funds? Conversely could Maine increase its financial commitment and gain extra federal funds?

Answer:

The Head Start Act stipulates that the Federal share of the total costs of the Head Start program will not exceed 80 percent of the total grantee budget unless a waiver has been granted (Head Start Act Section 640(b)). If the grantee agency fails to obtain and document the required 20 percent, or other approved match, a disallowance of Federal funds may be taken. Non-Federal share must meet the same criteria for allowability as other costs incurred and paid with Federal funds.

While state funds are one way to make the required match, other items that can be used are:

- In-kind contributions
- Volunteer time
- Donated supplies
- Donated equipment
- Donated land/buildings
- Cash contributions (from non-federal sources, such as private and corporate contributions)

Waivers are also granted to grantees that are not able to make their match. The criteria for receiving a waiver include:

1. Lack of community resources.
2. Impact of cost an agency may incur in the early days of the program
3. Impact of an unanticipated increase in cost
4. Community affected by disaster
5. Impact upon the community if the program is discontinued

To receive a waiver - or a reduction in the required non-Federal share, the grantee agency must provide the ACF Regional Office written documentation of need. This request may be submitted with the grant proposal document or during the budget period if a situation arises that will make it impossible to meet the requirement. Approval of the waiver request cannot be assumed by the grantee agency without written notice from the ACF Regional Office.

Failure to meet the non-Federal share requirement can have a severe impact on the grantee agency. If it is determined that the requirement has not been met, the grantee agency may be required to repay $4 for every $1 of shortfall. For example, a shortfall of $10,000 could result in a disallowance of $40,000 of Federal funds. This amount must be repaid by the grantee agency from agency funds. Federal funds may not be used to repay the disallowance. The shortfall may be the result of a failure to accumulate the match, lack of documentation or incorrect valuation that results in a subsequent disallowance. While not required, it is advisable to accumulate extra match that may be used in this situation as replacement to avoid possible repayment.

http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/operations/Fiscal/Financial%20Management/Budgets/Non-Federal%20Share.htm

4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	$5,378,750	$5,022,914	$5,064,553	$5,091,128	$2,653,383	$2,653,383
General Fund or Other Special Revenue					$2,000,000	$2,000,000
Federal Funds*					$1,000,000** $3,500,000*** $2,199,733****	$1,000,000** $4,712,500*** $2,263,872****
Total	$5,378,750	$5,022,914	$5,064,553	$5,091,128	$11,353,116	$12,629,755

*Federal funds for the Maternal, Infant, and Early Childhood Home Visiting program were accessible because the state was able to leverage both General Fund and Special Revenue (FHM) and build on its existing program.

** Formula based grant awarded to all states based on population and poverty level

***Four Year Competitive Expansion Grant award allowable for direct services (includes set-aside for tribal home visiting). *Funding is contingent on retaining current state funding levels.*

****Four Year Competitive Expansion Grant award allowable for non-direct services, including Fetal Alcohol Spectrum Disorder Coordinator at the Office of Substance Abuse, federally required evaluation, staffing, collaboration, and sustainability activities. *Funding is contingent on retaining current state funding levels.*

1) **Percent of the Fund for a Healthy Maine funding vs. total funding for the program:**

Fund for a Healthy Maine (FHM) funding represents 23.4% and 21% of the total funding for the Home Visitation program for FY 2012 and FY 2013 respectively.

Fund for a Healthy Maine Fact Sheet

Office: MaineCare Services **Date:** 11/17/11

Program Title: Drugs for the Elderly

Account: 014-10A-Z01501

XIII. Program Description:

11) Overview of the program:
22 §254-D. ELDERLY LOW-COST DRUG PROGRAM was first adopted in 2005. Policy 10-144 Chapter 10 Section 2. DEL is funded by all state dollars and rebates from drug manufacturers. Part D became effective in 2006 and changed the program.

DEL provides prescriptions and nonprescription drugs, medication and medical supplies to disadvantaged, elderly and disabled individuals. The program is limited to drugs where the manufacturer has a DEL rebate agreement in place.

The program covers individuals who are disabled between the ages of 19-61. The members who are not yet eligible for Medicare (they must be disabled for 24 months) receive assistance with prescription medications, the State will pay 80% less $2 the member pays the rest. Members over 62 receive the same benefit until they receive Medicare.

The DEL program has a wrap benefit that assist members who have other insurance. This benefit follows the formulary of the plan or Medicare. The wrap will cover:

- 50% of a brand name drug up to $10 (DUAL, MSP and DEL)
- 100% Up to $2.60 on generic medications. (DUAL, MSP and DEL)
- 100% Part D premiums – average cost is $31 per month per member
- 50% of the part D Deductible*
- In the donut hole (or Gap) the member converts to original DEL benefits where the state will pay 80% less $2 of the drug cost.
- State pays 100% for excluded drugs*

*Part D plans are contracted by the state. The pharmacy unit will go through the RFP process and select qualified benchmark plans. We do an intelligent assignment where we look at a member's drug profile and assign to a plan that best fits their needs. The average cost is $31 PMPM.

*Excluded drugs are drugs that do not have to be covered by the plan according to CMS, for example – benzodiazepine drugs are not required to be covered by a part D plan so this class of drug is considered excluded. The ACA has changed this so now there are no excluded drugs.

In 2006 when Part D started, DEL members were enrolled into Part D insurance plans. Before part D the DEL wrap cost was nearly $13mil. This included all the items mentioned above. Part D premiums were roughly $6mil.

In April of 2007 the Department expanded the Medicare Savings program, this moved most DEL members to MSP. As an MSP member, individuals received additional benefits such as having the PART B premium paid, assistance with coinsurance and deductible, smaller copay's, no longer have a donut hole.

WRAP cost today are approximately $3.3mil and the part D premiums are roughly $500k annually.

12) Who is served with these funds (i.e. # of people, # of programs, etc.):

DEL Population per fiscal year

	2008	2009	2010	2011
DEL COMBO (DRUGS FOR THE ELDERLY COMBINATION)	5037	3796	3645	4022
DEL COMBO / QI, AGED	1553	2135	2847	2999
DEL ONLY (DRUGS FOR THE ELDERLY ONLY)			1	
DEL COMBO / QI, DISABLED / QI, BLIND	436	614	781	858
DEL COMBO / QMB - AGED	16795	18297	21114	21714
DEL COMBO / QMB - DISABLED / QMB - BLIND	5234	6444	7641	8537
DEL COMBO / SLMB - AGED	3726	4243	5217	5586
DEL COMBO / SLMB DISABLED / SLMB BLIND	1022	1215	1491	1664
DEL COMBO / SSI AND-OR STATE SUPPLEMENT (NO MEDICAID)	2			
	33805	36744	42737	45380

13) What is purchased with these funds:

The Wrap program:

- 50% of a brand name drug up to $10 (DUAL, MSP and DEL)
- 100% Up to $2.60 on generic medications. (DUAL, MSP and DEL)
- 100% Part D premiums – average cost is $31 per month per member
- 50% of the part D Deductible*
- In the donut hole (or Gap) the member converts to original DEL benefits where the state will pay 80% less $2 of the drug cost.
- State pays 100% for excluded drugs*

14) What is the service delivery (i.e. state personnel, contracted services, etc.):

- Part D plans are contracted so that the Department can pay the members premium.
- Legal Services for the Elderly are contracted to provide appeal services for the population
- Goold Health Services is contracted to enroll members into Part D plans as well as participate in the billing process. DEL claims are transmitted through the MEPOPS program, TROOP is calculated, costs are avoided as with any other third party plan.
- Part B Premiums
- This account funds legislative membership in the National Legislative Association on Prescription Drug Prices (NLARx). Membership runs from July 1 through June 30. Executive Director of NLARx is Sharon Treat.

15) Department Program Staff:
Number of employees: _____ Cost of employees: $ _____

- Limited period positions ended in June 2011, no other personnel are paid from this budget.

XIV. Relevant Legislative History:

XV. Financial Information:

2) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund 014-Z01501	12,069,185	11,488,182	12,839,107	12,352,334	11,934,230	11,934,230
General Fund or Other Special Revenue 010-020201 014-020201 010-092701 014-092701	2,788,244 534,559 18,000 209,310	3,982,679 677,555 18,000 257,193	1,176,556 0 151,979 4,843	6,530,197 0 48,275 118	4,462,786 0 0 135,736	4,462,786 0 0 135,736
Federal Funds						
Total	15,619,298	16,423,609	14,172,485	18,930,924	16,532,752	16,532,752

3) Percent of the Fund for a Healthy Maine funding vs. total funding for the program:

Part B premiums: 73.67%
$13,129,639
64.85% 014-18F-092101 - Tobacco Settlement
35.15% 014-18F-092102 - Slots (Racino)

All Other DEL: 26.33%
FHM - $4,691,958

XVI. Program Eligibility Criteria:

Members with disability who are not eligible for Medicaid, QI, QMB and SLMB members receive the WRAP benefit.

XVII. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes ☐ No
If yes, please explain:

Note: I would say yes to this because we can't roll back the MSP this is a violation of the MOE. We can eliminate the DEL only portion of the program.

XVIII. Goals & Outcomes of the program:

12) Please describe the goals of the program:
Provide assistance to the Elderly and Disabled to receive drugs.

13) Please describe how the outcomes are measured:

Note: we have never measured the program

14) Please describe the measurable outcomes of the program:

Question # 9:

Please provide information on the levels of eligibility for state payment for Medicare benefits under Medicare Savings Programs in Maine (under the Elderly Low-Cost Drug program) and other states. Does Maine pay for persons with incomes above the levels in other states? If so, what are the benefits to Maine and to the Maine Medicare beneficiary?

The Office of MaineCare Services does not keep a state by state comparison for data.

The current FPL qualifications for Maine's MSP:

- QMB – equal to or less than 150%.
  - For a couple this is $1822 per month and for a single this is $1354 per month
- SLMB – Greater than 150% but less than 170%
  - For a couple this is $2065 per month and for a single this is $1535 per month
- QI – greater than 170% but less than 185%
  - For a couple this is $2809 per month and for a single this is $2088 per month.

Minimum FPL Federal Qualifications:

- QMB – equal to or less than 100% FPL
  - For a couple this is $1215 per month and for a single this is $903 per month
- SLMB – Greater than 100% but less than 120% FPL (eligible for Part B premium assistance)
  - For a couple this is $1457 per month and for a single this is $1083 per month
- QI – greater than 120% but less than 135% FPL (eligible for Part B premium assistance)
  - For a couple this is $1640 per month and for a single this is $1219 per month

Fund for a Healthy Maine Fact Sheet

Office: Office of Substance Abuse **Date:** 11-17-11

Program Title: FHM - Substance Abuse

Account: 01414G094801

I. Program Description:

16) Overview of the program: The Maine Office of Substance Abuse is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office provides leadership in substance abuse prevention, intervention, treatment, and recovery. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.

The Prevention, Intervention, and Treatment Services all receive funds from the Fund for a Healthy Maine.

Prevention Services are evidence based curriculum driven services that are provided to youth in school and community settings though 9 prevention contracts. On average the FHM funds 30% of the total amount of these contracts.

Data collection and performance monitoring of Prevention contracts is provided through the KIT Solutions contract who provide OSA Web-based Monitoring and Reporting System. FHM fund 16.5% of the KIT Solutions contact. This also provides prevention data required by OSAs SAMHSA Substance Abuse Prevention and Treatment Block Grant.

OSA contracts with the Maine Association of Substance Abuse Programs to fund Maine's Higher Education Alcohol Prevention Partnership (HEAPP). HEAPP is a prevention initiative collaboratively developed between the Maine Office of Substance Abuse and many of Maine's colleges and universities which aims to reduce college students' high-risk alcohol use and its impact upon individuals, campuses, and communities statewide. Forty percent (40%) of the budget is funded by the Fund for Healthy Maine which is supported with tobacco settlement dollars. Approximately 50% of HEAPP's operating budget supports mini-grants to colleges/universities for the implementation of evidence-based substance abuse prevention, early intervention, and enforcement strategies.

Intervention services provided with partial funding of is the Prescription Monitoring Program contract with PMP Web Portal Company Health Information Design at approximately 39% of this contact. Treatment Services provided primarily during SFY 12 for the provision of Substance Abuse Residential Treatment statewide.

Treatment services that are provided through 9 contracts funded in part with FHM include primarily Substance Abuse Residential Services, but may also include Outpatient, and Intensive Outpatient Services. The percent of FHM funds in these ranges from

17) Who is served with these funds (i.e. # of people, # of programs, etc.):

Prevention Programs: 1925 participants in 18 recurring evidence based curriculum prevention programs provided by 13 Prevention Provider Agencies. These same agencies with this funding provided outreach to 4296 people through single events, meetings, media campaigns, etc. and disseminated 1430 prevention materials.

HEAPP works to bring about long-term, systemic change in how high-risk drinking and other substance abuse issues among Maine college/university students are addressed at both the state and local level. All the Strategies and activities of the statewide initiative aim to engage all colleges and universities in Maine that are interested in addressing underage and/or high-risk student drinking so that the non-campus specific environmental factors and capacity for evidence-based prevention may be improved.

Intervention Program: The Prescription Monitoring Program is to assist all Mainers; however access is limited and falls under the PMP rules. Pharmacists, prescribers and their medical assistants can access the system for information regarding their own patients, and prescribers can download a list of all prescriptions attributed to them. Medical Assistants Licensing boards may use the information for investigations they are conducting. Law enforcement officials can access the data only through the Attorney General's Office by grand jury subpoena for a case they are currently investigating. MaineCare's Program Integrity Unit has access for fraud investigations. The Office of the Chief Medical Examiner is allowed access for cause of death determination in their investigations. Individuals may come to Augusta to receive information about themselves up request.

Treatment Programs: Individuals who have a substance abuse or dependence diagnosis or those individuals who are affected by another's use (affected other). These funds during SFY 12 were primarily used for the provision of Substance Abuse Residential Treatment Services. In 2011, 538 clients received treatment services in part with this funding combined with other funds through the continuum of services.

18) What is purchased with these funds:

Prevention: Evidence based curriculum driven services to youth in school and community settings. These are programs that are aimed at youth 12 – 18 that are at risk of substance abuse. KIT Solutions performance based monitoring system for Block Grant reporting and OSA contract monitor and reporting. HEAPP: Maine University and College campuses self-selecting to implement the local component of the HEAPP program receive mini-grants to develop/enhance campus-community coalitions to assess and plan evidence based substance use prevention efforts.

Intervention: Funds part of the PMP contract with Health Information Designs the developer of the electronic prescription monitoring system that Maine uses.

Treatment Services: Outpatient, Intensive Outpatient, Opiate Treatment, Substance Abuse Residential Services, and Targeted Case Management

19) What is the service delivery (i.e. state personnel, contracted services, etc.): Contracted Community Providers statewide.

20) Department Program Staff:
Number of employees: 0 Cost of employees: $ 0

II. Relevant Legislative History: Allocations of the Fund for Healthy Maine for Substance abuse prevention and treatment are stated in Maine Statute Title 22 §1511. Fund for a Healthy Maine established, 6. Health purposes. Allocations are limited to the following health-related purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State; [1999, c. 401, Pt. V, §1 (NEW).]
B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age; [1999, c. 401, Pt. V, §1 (NEW).]
C. Child care for children up to 15 years of age, including after-school care; [1999, c. 401, Pt. V, §1 (NEW).]
D. Health care for children and adults, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; [1999, c. 401, Pt. V, §1 (NEW).]
F. Dental and oral health care to low-income persons who lack adequate dental coverage; [1999, c. 401, Pt. V, §1 (NEW).]
G. Substance abuse prevention and treatment; and [1999, c. 401, Pt. V, §1 (NEW).]
H. Comprehensive school health and nutrition programs, including school-based health centers. [2007, c. 539, Pt. IIII, §3 (AMD).]

III. Financial Information:

4) 4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Budget	SFY13 Budget
FHM Fund	$6,374,744	$6,349,924	$6,351,468	$4,919,385	$3,286,345 **($2,028,679 – 094801;** $1,257,666 – 094802)	TBD
General Fund or Other Special Revenue	$11,445,840 $697,455	$10,933,307 $744,874	$11,493,871 $643,297	$11,678,870 $667,782	$14,966,404	TBD
Federal Funds **SAPT -BG**	$5,428, 433 + $6,820,035	$5,942,379 + $6,512,077	$6,060,038 + $5,300,042	$1,412,778 + $6,415,223	$7,117,834 + $7,306383	TBD
Total	$30,766,507	$30,482,561	$29,904,455	$25,094,038	$32,647,255	TBD

5) Percent of the Fund for a Healthy Maine funding vs. total funding for the program for 2012: For 094801 = 6.21%; For 094802 = 3.85% Combined = 10.06%

IV. Program Eligibility Criteria:

Prevention Services: Provided by Substance Abuse Prevention Providers that are awarded through an RFP process. The programs that are funded are evidence based. Providers through the RFP process need to state the need for the program and the populations that they will be serving based on the identified need. Some services may be prevention support services as the KIT Prevention system are needed for data collection for Block Grant requirements, but also help in monitoring and reporting the work being provided.

Intervention Services: The Prescription Monitoring program contract with Health Information Design was awarded through an RFP process and use of the PMP Electronic system is limited to prescribers and dispensers that are registered through the PMP.

Treatment Services: Individuals must be diagnosed with a substance abuse or dependence disorder or be an individual affected by another's use of substances.

V. Are the Fund for a Healthy Maine funds used to meet MOE Requirements? X Yes ☐ No
If yes, please explain:

These funds are part of state funds that are used in the Maintenance of Effort Requirement for the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) that Maine's receives annual. This funding helps to ensure that Maine receives its maximum amount of SAPT BG allotment available for Substance Abuse Prevention and Treatment programs.

VI. Goals & Outcomes of the program:

15) Please describe the goals of the program:

Prevention: To prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine.

Intervention: The primary goals of the Prescription Monitoring Program are to reduce the quantity of controlled substances obtained by fraud from doctors and pharmacies and reduce the adverse effects of controlled substance abuse. A secondary goal of the program is to assist investigators for the Maine Boards of Pharmacy and Licensure in Medicine, and other health care licensing boards, in the identification of prescription drug diverters.

Treatment: Works with the statewide provider network to assure access to a full continuum of quality treatment services and provides technical assistance to providers around program development, implementation, and best practices in alcohol and drug treatment programs.

16) Please describe how the outcomes are measured:

Prevention: Prevention services are tracked in the Web-based KIT Prevention System and the outcomes that are developed are specific to each Contracted Provider and the evidence-based

program that they are implementing and the outcomes that the program is designed to address. Quarterly narrative and fiscal reports are used to monitor progress on deliverables and outcomes.

Intervention: Through the HID contract the outcomes are met through the deliverables of HID. Here are some of the outcomes and deliverables of an extensive list: Collection of Schedule II, III, and IV drug data from dispensers; Creating editing processes for the importing of the pharmacy data to aid in the cleaning of the data to ensure it is as accurate and complete as possible; development of a secure database to manage the data collected from the pharmacies; loading of the pharmacy data into the database must take place at least once a week; programming, development, and mailing of at least three sets of notification reports that will show unacceptable thresholds of prescription use on a variety of levels.

Treatment: A combination of compliance and outcome measures via the treatment data system database. In addition, OSA staff (assigned responsibility for contract oversight, management, and technical assistance) conduct site visits, work with the Division of Licensing and Regulatory Services and the Office of Maine Care services to ensure quality programming is occurring.

3). Please describe the measurable outcomes of the program:

Prevention: The outcomes are based on addressing risk and protective factors that and in turn changes in attitudes, behaviors, and prevalence rates of use of substances. The outcomes are measured through program level surveys, local level surveys, or surveillance surveys depending on the reach and impact of the program and availability of data. An example of a long term outcome is: By the end of the academic year, 75% of SIRP participants will report a decrease in their frequency and/or quantity of their use of alcohol, tobacco, and other drugs. This will be measured by the pre-survey and the 90-day survey.

Intervention: The PMP has the following board outcomes that the HID contract assists in meeting: Accurate background information on a new patient can be obtained. Current patients can be monitored. Threshold reports provide warnings on patients who may be misusing or diverting prescription drugs and can assist prescribers in coordination of care. Reports are automatically sent to prescribers when threshold numbers of prescribers and pharmacies have been reached or exceeded by a patient during a given quarter. Contract specific outcomes and deliverables are monitored by the PMP Coordinator to ensure that deliverables are being met by HID.

Treatment: (Collect data that is ultimately reflected in the National Outcome Measures and per SAPTBG Statutory requirements regardless of payer source)

Outpatient

- Time from first call to first face to face: 5 days
  Time to first treatment appointment: 14 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Intensive Outpatient

- Time from first call to first face to face: 4 days
- Time to first treatment appointment: 7 days
- A minimum of 50% of OP & 85% of IOP clients stay 4 sessions
- At minimum of 30% of OP clients stay 90 days or more; and 50% of IOP clients complete treatment

Tracking measures:

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment

Referral to Mental Health Services

Substance Abuse Residential Programming:

There are varying levels of residential care (LOC) based on medical necessity. There are also population specific measures. The most common indicators are below with minimum standards set for each based on LOC and population

PERFORMANCE INDICATORS

Abstinence/drug free 30 days prior to discharge
Reduction of use of primary substance abuse problem
Employability
Participation in self-help during treatment
Referral in the Continuum of Care
Completed Treatment

TRACKING ONLY

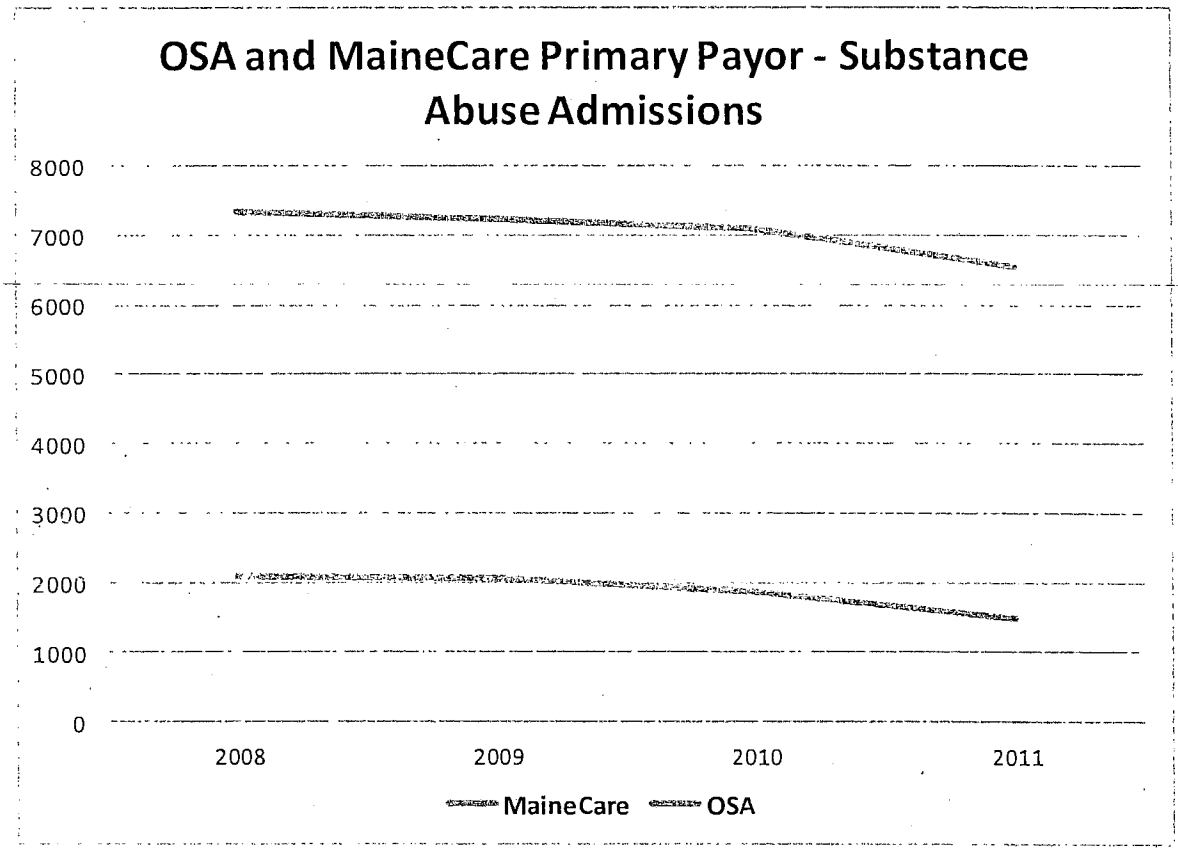
Average Time in Treatment for Completed Clients (Weeks)
Global Assessment of Functioning Improvement
Conduct follow up contact (phone, text, email) with client 1x a week for first 30 days, then 60 days, 90 days, and 1 year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine program effectiveness, as this may be requested by OSA.

Commission Requests for Further Information from 11/17/2011 Meeting

Question # 10:
Please provide information on how many people receive treatment services paid for with FHM funds under Office of Substance Abuse Services. Please separate MaineCare and non-MaineCare services.

Answer:
With the amount of funds shifting unpredictably yearly the ability to trend the data over time by the agency and the payer source is not possible. Additionally the contracts are blended with General, FHM, SAPT Block Grant, and possibly other grant funds. A number of agencies that receive OSA funds may be MaineCare providers and are reimbursed with these funds.

State Fiscal Year: 2008, 2009, 2010, 2011 AND Payer Code: Medicaid, OSA/DMH/MRSAS



Primary Expected Source of Pay at Admission	*2008*	*2009*	*2010*	*2011*	***Summary***
MaineCare	7338	7239	7101	6543	**28221**
OSA	2089	2063	1865	1500	**7517**
Summary	**9427**	**9302**	**8966**	**8043**	**35738**

Nov 23, 2011
Admissions (excludes detox and shelter)

Question # 11:
Please provide information on which higher education campuses receive substance abuse prevention funding under the HEAPP program. If there are additional higher education campuses that previously received HEAPP funding and continued prevention programs without the funding, please provide information on those campuses.

Answer:
College and University Utilization of HEAPP Resources: HEAPP and the resources and funding it provides to colleges and universities is supported by braided funding from the Fund for Healthy Maine (FHM) ($80,000 per year) and the federal Enforcing the Underage Drinking Laws (EUDL) Block Grant ($120,000 per year). In the past, HEAPP has leveraged additional funding from the U.S. Department of Education's Office of Safe and Drug-free Schools, but that program has been eliminated at the federal level (FFY11).

On the next page is information about which Maine colleges and universities have received HEAPP funding, training and technical assistance (TA), materials and other resources. Further information in Appendix.

County	Institution of Higher Education	*HEAPP funding provided 2010 through present*	*HEAP funding provided prior to 2010*	*HEAPP funded training and TA utilized*	*HEAPP funded materials and resources utilized*
Androscoggin	Bates College (via Lewiston PD)	X	X	X	X
	Central Maine Community College	X	X	X	X
Aroostook	Northern Maine Community College*	X	X	X	X
	University of Maine at Fort Kent*	X	X	X	X
	University of Maine at Presque Isle*	X	X	X	X
Cumberland	University of Southern Maine	X	X	X	X
	Southern Maine Community College	X		X	X
	Maine College of Art			X	X
	Saint Joseph's College		X[1]	X	X
	Bowdoin College	X	X	X	X
Franklin	University of Maine at Farmington		X[2]	X	X
Hancock	Maine Maritime Academy**	X	X	X	X
	College of Atlantic **	X	X	X	X
Kennebec	Thomas College	X	X	X	X
	Colby College			X	X
Penobscot	University of Maine	X	X	X	X
	Husson University	X	X	X	X
	Eastern Maine Community College		X[3]	X	X
Waldo	Unity College	X	X	X	X
Washington	University of Maine at Machias	X	X	X	X
	Washington County Community College			X	X
York	University of New England	X	X	X	X
	York County Community College			X	X

* Some funding subcontracted directly to HMP, Community Voices (coalition), & Presque Isle PD

** Some funding subcontracted directly to Hancock County Sheriff's Office

[1] Saint Joseph's College is sustaining some prevention & intervention efforts previously funded by HEAPP prior to 2010 with student judicial fees and institutional budgets; some initiatives have not continued due to staffing changes/reductions

[2] HEAPP Director believes UMF has not continued to utilize HEAPP funding due to staff turnover and restructuring; some prevention and intervention efforts have been sustained from institutional resources

[3] HEAPP Director believes EMCC has not sustained prevention and intervention efforts previously funded; institution has attributed no longer having capacity to utilize HEAPP funding to staffing reductions and restructuring

Question 12 included several components and is answered as follows:

With regard to federal funding for substance abuse services please provide information on the federal match requirements for state funding. Can Maine decrease its financial commitment without losing federal funds?

The answer to this question depends on the requirements of the various federal funding opportunities that are made available to the states and that states have the capacity to complete the application process and receive an award. In regards to the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant there is a Maintenance of Effort (MOE) requirement. The guidance for the MOE is found in Federal Title 45; Subtitle A, Part 96, Subpart L, Sec. 96.134.

What is the point at which a financial penalty is applied? OSA for each fiscal year must maintain aggregate State expenditures for Substance Abuse Services at a level that is not less than the average level of such expenditures maintained by the State for the two years preceding the fiscal year for which the State is applying for the grant. In simple terms, if OSA received $3,000,000 in state funds for substance abuse services for 2010 and $2,500,000 in 2011, OSA must receive at least 2,750,000 in 2012 to meet the MOE.

"With respect to the principal agency of a State for carrying out authorized activities, the agency shall for each fiscal year maintain aggregate State expenditures by the principal agency for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the two year period preceding the fiscal year for which the State is applying for the grant."

Maine can apply for a waiver, but must demonstrate that extraordinary economic conditions existed in the State during either of the two State fiscal years preceding the Federal fiscal year for which a State is applying for a grant. The term extraordinary economic conditions means a financial crisis in which the total tax revenue declines at least one and one-half percent, and either unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent (45 C.F.R. 96.134(b)). Based on this Maine did not meet definition of "extraordinary economic conditions" for the 2011 Block Grant, and did not meet the MOE by $945,114 and for SFY 2012 it is projected that Maine will not meet MOE by $3,413, 492.

What is the nature of the penalty? The DHHS Secretary has delegated the responsibility to determine if a State has failed to maintain such compliance to the Administrator of SAMHSA. The Administrator shall reduce the amount of the allotment for the State for the fiscal year for which the grant is being made by an amount equal to the amount constituting such failure for the previous fiscal year. Based on the example above, OSA must receive at least 2,750,000 in 2012 to meet the MOE, if they only received $2,500,000 the SAPT BG could be reduced by $250,000.

Is it full or partial loss of federal funds? It is a partial loss of federal funds base on the proportional formula above.

Conversely could Maine increase its financial commitment and gain extra federal funds? No; in the case of the SAMHSA SAPT Block Grant it is a formula grant based on population and other factors, not including the state's financial capacity. Other federal grant opportunities that require a match will have an award funding range, depending on the amount specified in the grant application. In order to meet the match requirement it may be the state's or grantee's contribution that may be "in kind" or "in-direct" that could count toward match, as well as available monies for a direct match for the state's portion. This is often to leverage the funding, but is foundational in sustaining the activities of the grant to some degree after the end of the grant.

Question # 13:

Please provide data on outcomes/performance measures for substance abuse treatment programs funded through OSA.

Non- Intensive Outpatient Level of Care Access and Retention Measures* Projected Outcomes	State Fiscal Year			
	2008	2009	2010	2011
Access: **Median Time to 1st Face to Face - Assessment (measure = 5 days):	4	4	5	4
Access: **Median Time to 1st Treatment Session (measure = 14 days):	0	0	0	0
Average Time (days) to 1st Face to Face - Assessment	6.76	8.4	8.64	8.35
Average time (days) to 1st Treatment Session	1.53	4.28	5.42	5.78
Retention: Clients complete 4 Sessions (measure 50% minimum):	66.46%	71.35%	70.35%	72.90%
Retention: Clients stay 90 days (measure 30% minimum):	36.89%	41.86%	43.25%	47.46%
*OSA Funded Agencies Only				
** Median is used to measure time to assessment and time to treatment in OSA Funded contracts; Using Median rather than Average prevents outliers (usually caused by data entry errors) from skewing the overall outcome of the measure				

Intensive Outpatient Level of Care Access and Retention Measures* Projected Outcomes	State Fiscal Year			
	2008	2009	2010	2011
Access: **Median Time to 1st Face to Face - Assessment (measure = 4 days):	2	2	2	2
Access: **Median Time to 1st Treatment Session (measure = 7 days):	0	1	1	1
Average Time (days) to 1st Face to Face - Assessment	8.79	9.23	6.2	5.73
Average time (days) to 1st Treatment Session	5.06	4.77	4.17	6.21
Retention: Clients complete 4 Sessions (measure 85% minimum):	89.11 %	92.10%	93.45%	93.00 %
Retention: Clients complete treatment (measure 50% minimum):	47.08 %	55.20%	56.79%	54.45 %
*OSA Funded Agencies Only				
** Median is used to measure time to assessment and time to treatment in OSA Funded contracts; Using Median rather than Average prevents outliers (usually caused by data entry errors) from skewing the overall outcome of the measure				

OSA Funded Treatment Services - Effectiveness Tracking

Level of Care	Indicator	Minimum Standard	State Average			
			2008	2009	2010	2011
Adolescent Residential Rehab	Abstinence	75%	70.90%	86.40%	83.50%	78.60%
	Reduction of Use	80%	78.60%	82.70%	83.90%	78.60%
	Referral @ Discharge	25%	47.50%	30.90%	36.70%	50.00%
	Self Help Attendance	90%	58.80%	67.90%	88.60%	94.30%
Extended Care	Abstinence	90%	67.70%	63.40%	71.60%	83.30%
	Completed Treatment	55%	33.30%	33.80%	35.30%	41.20%
	Reduction of Use	85%	74.60%	74.50%	82.00%	86.40%
	Referral @ Discharge	50%	45.30%	46.00%	50.00%	51.60%
	Self Help Attendance	95%	53.10%	63.20%	71.20%	95.20%
Extended Shelter	Abstinence	80%	82.90%	83.50%	91.60%	86.90%
	Completed Treatment	70%	72.60%	73.70%	71.00%	76.10%
	Reduction of Use	90%	85.50%	85.50%	83.20%	89.60%
	Referral @ Discharge	70%	51.00%	39.70%	58.70%	83.10%
	Self Help Attendance	95%	80.80%	86.70%	73.90%	93.90%
Halfway House	Abstinence	85%	79.90%	82.70%	83.60%	86.10%
	Completed Treatment	45%	61.30%	63.30%	65.40%	67.80%
	Employability	30%	66.00%	51.00%	31.60%	37.90%
	Reduction of Use	85%	80.00%	88.10%	90.70%	87.70%
	Referral @ Discharge	70%	40.10%	44.00%	42.50%	48.20%
	Self Help Attendance	95%	78.30%	73.80%	70.50%	84.50%
Short Term Residential	Abstinence	85%	93.60%	93.60%	93.10%	87.10%
	Completed Treatment	75%	82.40%	74.80%	75.60%	73.80%
	Employability	3%	22.10%	15.80%	22.50%	12.20%
	Reduction of Use	90%	95.80%	94.20%	93.20%	92.10%
	Referral @ Discharge	75%	84.20%	71.00%	62.40%	55.30%
	Self Help Attendance	90%	39.70%	33.30%	39.10%	90.30%

Level of Care	Indicator	Minimum Standard	State Average			
			2008	2009	2010	2011
Outpatient	Abstinence	70%	63.80%	65.50%	66.10%	66.50%
	Completed Treatment	60%	52.30%	53.10%	49.90%	47.60%
	Employability	3%	11.40%	14.40%	14.10%	16.60%
	Maintained Employment	90%	94.50%	93.40%	91.50%	91.60%
	No OUI During Treatment	95%	98.30%	98.30%	98.40%	98.80%
	Reduction of Use	60%	48.90%	55.90%	54.40%	57.40%
	Self Help	45%	33.50%	36.00%	42.00%	42.50%
Intensive Outpatient	Abstinence	70%	54.50%	63.80%	65.50%	62.70%
	Completed Treatment	60%	56.00%	66.90%	65.00%	64.20%
	Employability	15%	22.40%	21.10%	17.40%	15.30%
	Maintained Employment	90%	92.70%	90.40%	88.80%	90.30%
	No OUI During Treatment	90%	98.30%	98.20%	98.50%	99.70%
	Reduction of Use	80%	64.70%	76.50%	77.00%	77.00%
	Referral @ Discharge	40%	43.00%	40.50%	37.90%	36.50%
	Self Help	85%	49.90%	57.50%	57.60%	70.60%

Opiate Treatment Programs			
ORT Admission & Annual Update Data - Statewide Report	2009	2010	~2011
% Client Living Independent at ADM	94.93%	94.99%	97.63%
% Clients Living Independent at ORT	97.58%	97.26%	97.36%
% Employed at ADM	2.64%	38.04%	33.77%
% Employed at ORT	1.10%	45.89%	43.01%
% w/Arrests in Prior 12 mos at ADM	19.82%	16.12%	11.61%
% w/Arrests in 30 Days Prior to ORT	2.86%	2.42%	3.17%
% Dependents w/ Client at ADM	37.96%	46.01%	45.16%
% Dependents WITH THE CLIENT at ORT	50.00%	47.78%	44.66%
% Clients Using at ADM	79.07%	84.98%	84.70%
% Clients Using at ORT	7.49%	4.32%	3.06%
Date ranges for years are 10-1 to 9-30; ~ 2011 partial data			

APPENDIX A – Higher Education Alcohol Prevention Partnership Supporting Data

High-risk alcohol use by college students is a nation-wide challenge with many negative consequences on students' health, safety, and success, and Maine is not immune.
A national snapshot from a federal taskforce found that alcohol use by college students has resulted in:

- **Death:** 1,700 college students between the ages of 18 and 24 die each year from alcohol-related unintentional injuries, including motor vehicle crashes (Hingson et al., 2005).
- **Injury:** 599,000 students between the ages of 18 and 24 are unintentionally injured under the influence of alcohol (Hingson et al., 2005).
- **Assault:** More than 696,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking (Hingson et al., 2005).
- **Sexual Abuse:** More than 97,000 students between the ages of 18 and 24 are victims of alcohol-related sexual assault or date rape (Hingson et al., 2005).
- **Academic Problems:** About 25 percent of college students report academic consequences of their drinking including missing class, falling behind, doing poorly on exams or papers, and receiving lower grades overall (Engs et al., 1996; Presley et al., 1996a, 1996b; Wechsler et al., 2002).
- **Health Problems/Suicide Attempts:** More than 150,000 students develop an alcohol-related health problem (Hingson et al., 2002) and between 1.2 and 1.5 percent of students indicate that they tried to commit suicide within the past year due to drinking or drug use (Presley et al., 1998).
- **Drunk Driving:** 2.1 million students between the ages of 18 and 24 drove under the influence of alcohol last year (Hingson et al., 2002).
- **Vandalism:** About 11 percent of college student drinkers report that they have damaged property while under the influence of alcohol (Wechsler et al., 2002).
- **Property Damage:** More than 25 percent of administrators from schools with relatively low drinking levels and over 50 percent from schools with high drinking levels say their campuses have a "moderate" or "major" problem with alcohol-related property damage (Wechsler et al., 1995).
- **Police Involvement:** About 5 percent of 4-year college students are involved with the police or campus security as a result of their drinking (Wechsler et al., 2002) and an estimated 110,000 students between the ages of 18 and 24 are arrested for an alcohol-related violation such as public drunkenness or driving under the influence (Hingson et al., 2002).
- **Alcohol Abuse and Dependence:** 31 percent of college students met criteria for a diagnosis of alcohol abuse and 6 percent for a diagnosis of alcohol dependence in the past 12 months, according to questionnaire-based self-reports about their drinking (Knight et al., 2002).

Estimates from: http://www.collegedrinkingprevention.gov/StatsSummaries/snapshot.aspx

Today's college students are Maine's future business people, educators, technical and trades professionals, health care providers, parents, and community members, so can our state afford not to invest in efforts to reduce high-risk drinking and its impact on their health, safety, and success?

Commission to Study Allocations of the FFHM
Additional Information Requested on 11/17/2011
Questions Not Associated With Fact Sheets

14. Please provide information on the focus of Healthy Maine Partnership funding historically, starting from the focus this biennium 50-40-10 (50% tobacco prevention, 40% obesity prevention and 10% chronic disease prevention) and working backwards in time. ***Kristen McAuley, CDC, DHHS***

2010 RFP funding HMP work which started July 2011:
To impact tobacco use and tobacco-related chronic disease, HMP grantees are expected to devote 50% of their chosen strategies to tobacco, 40% to obesity and 10% to chronic disease. A work plan matrix lists objectives with corresponding strategies that may be selected.

In addition, to the 50-40-10 for tobacco use and tobacco-related chronic disease, other funding streams have also identified requirements of effort:

- Office of Substance Abuse funds requires grantees to choose a minimum of two (2) objectives from the Substance Abuse section with a minimum of two (2) strategies per selected objective.
- Public Health Infrastructure funds require grantees to devote resources in the following percentages: Core Public Health Competencies: 20%, District Coordinating Council: 30%, and Community Public Health Improvement Plan: 50%.

2007 RFP funding HMP work from 2007 – 2011:
To impact tobacco use and tobacco-related chronic disease, HMP grantees were required to devote 50% of their chosen strategies to tobacco, 40% to obesity and 10% to chronic disease.

This RFP required multiple state programs to work together and to braid funds that were going to community coalition-based prevention. So, in addition to the Maine CDC, Office of Substance Abuse funds were braided into the RFP. In addition to the 50-40-10 for tobacco use and tobacco-related chronic disease, other funding streams identified requirements of effort for HMPs:

- Office of Substance Abuse funds required grantees to address certain required objectives using the Strategic Planning and Environmental Prevention data produced in the development of county strategic plans under a previous grant.
- Public Health Infrastructure funds required grantees to engage in the MAPP process, develop a Comprehensive Community Health Assessment and participate in the developing District structure.

2001 RFP funding HMP work from 2001 – 2007:
To impact tobacco use and tobacco-related chronic disease, HMP grantees were required to work on all objectives identified in the RFP. These objectives were focused on the three goals identified in the RFP.

Goal #1: To reduce tobacco use and tobacco related diseases through interventions developed and delivered across all community settings (schools, health facilities, worksites, etc.), with particular attention to high risk and disparate populations.

Goal #2: To ensure the accessibility of coordinated services for the early identification and referral for risk factors leading to tobacco-related chronic diseases (cardiovascular disease, cancer, lung disease and diabetes) with particular attention to disparate populations. These risk factors include tobacco addiction, elevated blood pressure, elevated blood cholesterol, poor nutrition, physical inactivity, overweight/obesity and family history.

Goal #3: To implement a Coordinated School Health Program in partnering schools that comprehensive school health education incorporating the CDC Division of Adolescent and School Health guidelines for tobacco use, physical activity and healthy eating.

15. Please provide information on how the 50-40-10 focus was established and by what entity. ***Kristen McAuley, CDC, DHHS***

2010 RFP funding HMP work starting July 2011:
The 50-40-10 percentage of effort was established in order to focus the work at the local HMP level into the focus areas that have the most significant impacts on health conditions and population health status. The metrics were identified following analysis of peer reviewed information. The reports most notably used were: The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors; Public Library of Science Medicine; April 2009; Volume 6, Issue 4 and Identifying the Leading Causes of Death in the United States; Journal of the American Medical Association; March 10, 2004; Vol. 291, No. 10. These metrics were developed by staff in the Division of Chronic Disease and presented for approval to Maine CDC Director, Dr. Dora Mills and Director of the Governor's Office of Health Policy and Finance, Trish Riley.

2007 RFP funding HMP work from 2007 – 2011:
The 50-40-10 percentage of effort was established as a guideline based on the actual causes of death in the United States as reported by the article, Identifying the Leading Causes of Death in the United States; Journal of the American Medical Association; March 10, 2004; Vol. 291, No. 10. These metrics were developed by staff in the Division of Chronic Disease and presented for approval to Maine CDC Director, Dr. Dora Mills and Director of the Governor's Office of Health Policy and Finance, Trish Riley.

2001 RFP funding HMP work from 2001 – 2007:
All grantees were required to work on all identified objectives under the three goals of the RFP. These objectives were developed by program staff and approved by Maine CDC Director, Dr. Dora Mills.

16. Please provide information on expenditures from the FHM-Family Planning account. Please provide information on other accounts that pay for family planning services and what services are provided through the use of those funds. ***Valerie Ricker, CDC, DHHS***

Program Title:	Family Planning		
Account:			
State	01410A956001	Fund for Healthy Maine	$401,430
	01010A885101	Purchased Social Services	$281,599
	01010A203001	Community Family Planning	$225,322
	01010A203301	MCHBG Match	$306,843
Federal	01510A884301	Social Services Block Grant	$410,274
	01310A213601	PREP	$241,317
			$1,866,785
Direct federal funding to the FPA - Title X			$2,015,434

1) Overview of the program:

- The State contracts with one agency (Family Planning Association or FPA). They subcontract with a statewide network of community-based, nonprofit organizations that collectively operate 46 clinics, providing reproductive health and other basic health services to men, women and teens in Maine. They also provide training, technical assistance and support for evidence-based teen pregnancy prevention programs as well as education on adolescent health issues.

2) Who is served with these funds:

- Publicly funded family planning services support services to women ages 13-44, with household incomes below 250% of poverty, who are sexually active, are not pregnant or trying to become pregnant. Federal Title X funds target men and women between the ages of 12 and 45 at less than 150% of the federal poverty level and all teens at-risk of unintended pregnancy and in need of subsidized services. Maine's family planning system serves about 35% of eligible females, or approximately 27,000 people. 82% of family planning's clients are below 250% of poverty and qualify for free or reduced-cost services (sliding fee scale). Professionals in approximately 200 schools and youth serving organizations are served through training, technical assistance and education.

3) What is purchased with these funds:

All funding sources are blended together to provide an array of services, except for PREP funds which are restricted to teen pregnancy prevention. Research has shown that there needs to be a comprehensive approach that includes direct and preventative services in order to have a positive impact on unintended pregnancies. Clinical services include basic health screenings, gynecological services, contraceptive care, cancer screening, testing and treatment for sexually transmitted infections, pregnancy testing and pre-conception counseling. Teen pregnancy prevention services include training and technical assistance to community-based organizations and schools to help them choose and implement evidence-based teen pregnancy prevention programs; working with Jobs For Maine Graduates to implement an EBP in communities they serve that also have high teen pregnancy rates (PREP funds); and providing support and training to professionals in schools and youth serving organizations.

Fund for a Healthy Maine Fact Sheet

Office: Maine CDC **Date:** November 17, 2011

Program Title: Family Planning

Account: 01410A095601

Program Description:

Overview of the program: The FHM funds supplement the clinical family planning services that are purchased through Maine CDC and OCFS blended funding. The supplemental work that FHM supports focuses upon adolescent pregnancy prevention by providing training and professional development opportunities to teachers, school nurses, guidance counselors, school health coordinators and community-based organizations regarding puberty, adolescent development, and the delivery of age appropriate health and sexuality education to Maine youth. To supplement clinical services, teen pregnancy/STI prevention activities are targeted toward high teen pregnancy rate areas of the State that have hard-to-reach and vulnerable populations. Training on how to engage their communities in addressing the multiple factors that can play a role in teen pregnancy and sexually transmitted infections (STIs) is provided along with how to identify and implement evidence-based programs that have been proven effective. Print and web-based materials are made available to family and community members.

Who is served with these funds (i.e. # of people, # of programs, etc.): Last year 8 schools/community-based organizations (CBOs) were served, reaching over 500 youth. 144 school and CBO staff participated in training and professional development opportunities. This does not include youth and staff served with federal PREP funding. Over 800 FACTS (Families And Children Talking About Sexuality) magazines were distributed to parents

What is purchased with these funds: What is the service delivery (i.e. state personnel, contracted services, etc.): contracted services.

Department Program Staff: 0
Number of employees: Cost of employees: $

Relevant Legislative History: **(See funding table below) In FY09, the allocation for family planning within the Social Services Block Grant was reduced by $415,000. In response, the legislature approved a one-time increase within family planning's Fund for a Healthy Maine appropriation. In the FY10-11 biennium, the State Social Services line received a one-time increase of $300,000 per year, intended to offset the end of that one-time FHM increase. That increase does not affect the baseline funding and will not be carried into the FY 12-13 biennium.*

The State Purchased Social Services account also received a decrease in FY 08 due to a 4th quarter curtailment and a $90,000 one-time reduction in the FY10 Curtailment Order.

Financial Information:

4 Years of Spending and SFY12 & 13 Budget:

	SFY08 Actual	SFY09 Actual	SFY10 Actual	SFY11 Actual	SFY12 Actual	SFY13 Actual
FHM Fund	468,942	884,240*	448,183	425,061	401,430	401,430
General Fund:**						
SPSS	205,055	273,406	573,406	505,155	281,599	281,599
MCHBG match	285,843	285,843	306,843	329,965	306,843	306,843
Community FP	225,322	225,322	225,322	225,322	225,322	225,322
Federal Funds: ***						
SSBG	525,552	110,274	110,274	110,274	410,274	410,274
PREP					241,317	241,317
Total	1,710,714	1,779,085	1,664,028	1,595,777	1,866,785	1,866,785

* See above "legislative history"

** SPSS - State Purchased Social Services
MCHBG - Maternal and Child Health Block Grant
Community Family Planning

*** SSBG - Social Services Block Grant
PREP – Personal Responsibility Education Program

Note: SPSS and SSBG funds are administered by the Office of Child and Family Services, Maine DHHS, and blended with Maine CDC funding

Percent of the Fund for a Healthy Maine funding vs. total funding for the program: average of 22% to 26%

Program Eligibility Criteria: Schools and CBOs statewide are eligible to participate. Parent information is available to anyone that requests it.

Are the Fund for a Healthy Maine funds used to meet MOE Requirements? ☐ Yes **X** No

If yes, please explain:

Goals & Outcomes of the program:

Please describe the goals of the program: Increase knowledge, skills and attitudes around teen pregnancy and STI/HIV prevention. Increase understanding of evidence-based programs and how to select them based on community needs and how to implement them with fidelity. Support parents by enhancing their knowledge of sexual development and encouraging communication with their children around their health issues and healthy relationships. Provide on-line information for professionals, parents, adults and teenagers.

Please describe how the outcomes are measured: Baselines were established at the start of the contract period and we review reports to establish whether or not goals have been met. Pre and post surveys assess changes in knowledge, attitudes, skills and/or intended behaviors. Attendance at educational offerings. Tracking of materials distributed. Web hits and feedback received. A Grants Management Team meets

regularly to monitor and evaluate efficiency and effectiveness of programs through reports, site visits and analysis of data.

Please describe the measurable outcomes of the program: Outcomes include 1) increasing the number of schools and CBOs selecting and implementing evidence-based approaches to preventing teen pregnancies and STIs, 2) increasing the knowledge, skills and comfort level of teachers and youth serving CBO staff in delivering comprehensive health and sexuality education to Maine youth, and 3) improving the knowledge, skills and attitudes of Maine parents, family members and community members around the issues of sexuality and reproductive health.

For activities under this funding three objectives have been established and eleven activities will be implemented to meet those objectives. Reports will be reviewed twice yearly for compliance with contract commitments.

17. Please provide information on the rates of adolescent pregnancy in different parts of Maine. If information is available on rates over a time period please provide that information. ***Valerie Ricker, CDC, DHHS***

Between 1989 and 2009, Maine's adolescent pregnancy rate decreased by 48.1% from 64.2 per 1,000 females aged 15-19 years to 33.3 per 1,000. The adolescent birth rate decreased 35.6% over this time period. Between 2007 and 2009, Maine's pregnancy rates among adolescents aged 15-19 years were higher than the state average in Androscoggin and Somerset counties and lower than the state average in Cumberland County. Analyses of adolescent pregnancy rates by town were conducted in 2008 using data from 2003-2007. These analyses were used to identify towns with pregnancy rates higher than the state average. With additional time, these analyses could be done using more recent data.

The attached report shows a compilation of several charts related to adolescent pregnancy.

Adolescent pregnancy and births in Maine

Data on live births come from birth certificates collected as part of Maine's vital statistics system. However, not all pregnancies result in a live birth. The components of Maine's pregnancy count are live births, reported fetal deaths of 20 weeks gestation or more, and reported induced abortions occurring in the state. Because Maine's pregnancy count excludes fetal losses occurring prior to 20 weeks gestation, the reported count is an undercount of the true number of pregnancies.

Between 1989 and 2009, Maine's adolescent pregnancy rate decreased by 48.1% from 64.2 per 1,000 females aged 15-19 years to 33.3 per 1,000. The adolescent birth rate decreased 35.6% over this time period.

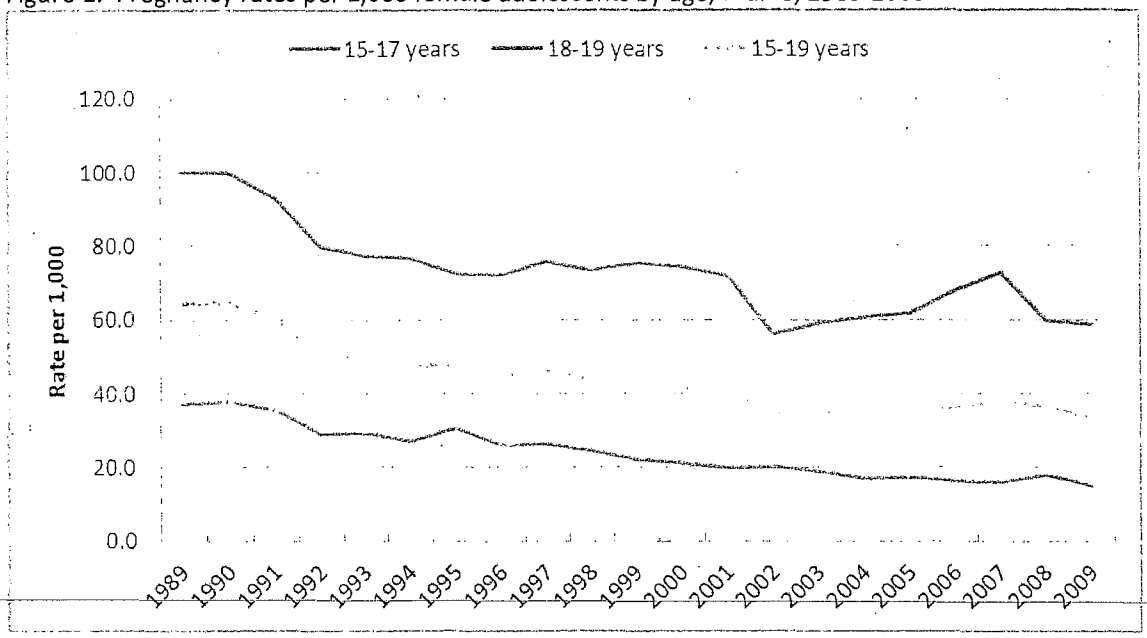
Table 1. Rates (per 1,000 female population aged 15-19 years) of pregnancy outcomes among adolescents aged 15-19 years, Maine residents, 1989-2009

Year	Pregnancy Rate	Live Birth Rate	Abortion Rate	Fetal Death Rate
1989	64.2	42.2	21.8	0.2
1990	64.7	42.9	21.4	0.4
1991	60.2	41.7	18.1	0.3
1992	50.6	37.5	12.9	0.2
1993	49.5	34.8	14.6	0.2
1994	47.6	33.7	13.8	0.1
1995	47.7	32.5	15.0	0.2
1996	44.6	30.8	13.7	0.1
1997	46.1	31.8	14.0	0.3
1998	43.7	30.5	12.9	0.2
1999	42.9	30.1	12.6	0.2
2000	41.8	29.0	12.6	0.2
2001	39.8	27.5	12.1	0.2
2002	36.0	25.4	10.4	0.1
2003	35.0	24.9	9.9	0.1
2004	34.8	24.1	10.5	0.2
2005	35.1	24.4	10.6	0.1
2006	36.1	25.7	10.2	0.2
2007	37.8	26.8	10.7	0.2
2008	36.7	26.0	10.5	0.1
2009	33.3	24.2	9.0	0.1
2010	n/a	n/a	n/a	n/a

n/a=not yet available

Pregnancy rates among 15-17 year olds and 18-19 year olds have decreased significantly over the past 20 years. In Maine, as well as the U.S, the adolescent pregnancy rate increased slightly in 2006 and 2007, which was driven by an increase in adolescent pregnancies among those aged 18 and 19 years (Figure 1). However, since that time, the pregnancy rate has resumed its decline.

Figure 1. Pregnancy rates per 1,000 female adolescents by age, Maine, 1989-2009



Maine's teen birth rate has been consistently lower than the U.S. rate. Based on the most recent data available, the 2008 birth rate for adolescents aged 15-19 in the U.S. was 41.5 per 1,000; the Maine rate in 2008 was 25.3 per 1,000. Among non-Hispanic Whites, the U.S. adolescent birth rate for 15-19 year olds was 26.7 per 1,000. In 2008, only five states reported lower adolescent birth rates than Maine's.

Over the past two-three years, Maine's pregnancy rates among adolescents aged 15-19 years have been higher than the state average in Androscoggin and Somerset counties and lower than the state average in Cumberland county. Three years of data are presented to demonstrate that the rates vary significantly over time.

Table 2. Adolescent pregnancy rates among females aged 15-19 years by county, 2007-2009

	2007			2008			2009		
Androscoggin	46.5	H	(51.8,67.4)	37.1	H	(40,54.1)	37.2	H	(40,54.1)
Aroostook	31.1		(27.9,42.8)	27.2		(24.8,39.2)	31.5		(27.9,42.9)
Cumberland	17.5	L	(28.5,35.8)	16.4	L	(26.8,34)	14.8	L	(23.5,30.2)
Franklin	20.1		(18.8,36.3)	19.4		(18.8,36.4)	19.5	L	(15.2,31.4)
Hancock	26.7		(24.8,42.9)	20.8		(22.7,40.4)	21.4		(22.6,40.3)
Kennebec	29.2		(34.3,46.6)	32.7		(35.4,48)	29.1		(33.4,45.5)
Knox	40.5	H	(42.1,68.7)	26.1		(24.4,46.5)	30.3		(31.9,56.2)
Lincoln	16.9		(19.3,40.4)	28.4		(32,58.4)	19.1		(16.2,36)
Oxford	33.2		(33.9,53)	31.7		(35.9,55.7)	27.3		(27,43.8)
Penobscot	24.8		(29.1,38.6)	24.3		(27.5,36.9)	24.7		(29.2,38.9)
Piscataquis	25.2		(16.1,46)	44.4		(31,70.5)	38.4		(29.6,66.3)
Sagadahoc	15.4	L	(13.8,30.8)	21.4		(21.7,41.8)	23.5		(20.6,41.4)
Somerset	39.9		(38.1,59.2)	48.7	H	(43.8,66.4)	41.0	H	(38,59)
Waldo	34.8		(34.5,57.9)	41.7	H	(41.3,66.7)	23.0		(22.1,41.9)
Washington	35.3		(30.7,55.3)	40.4		(34.2,60.7)	37.6		(29.2,54.2)
York	22.9		(30,38.7)	20.2		(28.1,36.5)	18.0	L	(22,29.5)
STATE	26.8		(36,39.6)	26.0		(34.9,38.4)	24.2		(31.6,35)

H=higher than the state average; L=lower than the state average

Similar to adolescent pregnancy rates, the birth rate among adolescents aged 15-19 years has been consistently higher in Androscoggin and Somerset counties compared to the state average. Rates have been consistently lower than the state average in Cumberland county.

Table 3. Birth rates among females aged 15-19 years by county, Maine, 2007-2009

	2007			2008			2009		
Androscoggin	46.5	H	(39.5,53.5)	37.1	H	(30.8,43.3)	37.2	H	(30.9,43.5)
Aroostook	31.1		(24,38.1)	27.2		(20.5,33.9)	31.5		(24.4,38.6)
Cumberland	17.5	L	(14.8,20.2)	16.4	L	(13.7,19)	14.8	L	(12.3,17.3)
Franklin	20.1		(12.6,27.6)	19.4		(12,26.8)	19.5		(12.1,27)
Hancock	26.7		(18.6,34.8)	20.8		(13.6,28.1)	21.4		(14.1,28.7)
Kennebec	29.2		(24,34.4)	32.7		(27.1,38.3)	29.1		(23.8,34.3)
Knox	40.5	H	(29,51.9)	26.1		(16.6,35.7)	30.3		(20.1,40.4)
Lincoln	16.9		(8.9,24.9)	28.4		(17.8,38.9)	19.1		(10.6,27.6)
Oxford	33.2		(24.8,41.6)	31.7		(23.4,40)	27.3		(19.9,34.7)
Penobscot	24.8		(20.7,28.9)	24.3		(20.2,28.4)	24.7		(20.5,28.8)
Piscataquis	25.2		(11.7,38.7)	44.4		(25.8,63)	38.4		(21.9,54.9)
Sagadahoc	15.4	L	(8.4,22.5)	21.4		(13.1,29.8)	23.5		(14.4,32.5)
Somerset	39.9	H	(30.3,49.5)	48.7	H	(38,59.4)	41.0	H	(31.3,50.7)
Waldo	34.8		(24.6,45)	41.7	H	(30.5,52.9)	23.0		(14.6,31.4)
Washington	35.3		(24.2,46.5)	40.4		(28.1,52.6)	37.6	H	(25.7,49.5)
York	22.9		(19.3,26.5)	20.2	L	(16.9,23.6)	18.0	L	(14.9,21.2)
STATE	26.8		(25.3,28.3)	26.0		(24.5,27.5)	24.2		(22.8,25.7)

H=higher than the state average, L=lower than the state average

Analyses were conducted using data from 2003-2007 to examine pregnancy rates by town. Those towns higher than the state average are presented below:

Table 4 Maine Pregnancies Number and Rates for Ages 15-19
2003-2007 (5 combined years) By Mother's Town of Residence

Note: Rates based on small numbers are unreliable and should be used with caution

Est. female pop. 15-19	Town	Per 1000 females
Maine Total		**35.7**
National 2006		**71.5**
Androscoggin County		
3,890	Auburn	52.2
6,764	Lewiston	64.5
504	Livermore Falls	65.5
501	Mechanic Falls	59.9
18,502	County	49.83
Aroostook County		
241	Ashland	66.4
1,016	Houlton	62
278	Mars Hill	50.4
12,352	County	32.55
Cumberland County		
464	Naples	56
8,959	Portland	52.5
2,244	Westbrook	50.8
45,044	County	31.08
Franklin County		
138	Rangeley	79.7
179	Strong	61.5
6,905	County	28.67
Hancock County		
835	Ellsworth	58.7
266	Gouldsboro	56.4
203	Stonington	54.2
8,283	County	31.63
Kennebec County		
2,886	Augusta	62
366	Chelsea	60.1
630	Clinton	52.4
497	Farmingdale	54.3
21,136	County	36.67
Knox County		
140	Cushing	92.9
1,164	Rockland	83.3
336	St. George	53.6
528	Thomaston	60.6
5,983	County	49.47

Est. female p. 15-19	Town	Per 1,000 females
Maine Total		**35.7**
National 2006		**71.5**
Lincoln County		
133	South Bristol	60.2
817	Waldoboro	56.3
5,198	County	32.13
Oxford County		
534	Mexico	56.2
771	Norway	66.1
669	Oxford	53.8
248	West Paris	76.6
9,203	County	40.53
Penobscot County		
115	Alton	87
259	Bradford	61.8
124	Clifton	72.6
353	Greenbush	70.8
513	Newport	81.9
28,760	County	31.71
Piscataquis County		
377	Milo	71.6
126	Parkman	71.4
175	Sangerville	80
2,766	County	37.96
Sagadahoc County		
468	Bowdoinham	57.7
597	Richmond	50.3
5,983	County	36.27
Somerset County		
427	Anson	53.9
351	Canaan	62.7
1,214	Fairfield	51.1
382	Hartland	57.6
627	Madison	60.6
124	New Portland	80.6
370	Palmyra	51.4
1,375	Skowhegan	64
116	Solon	60.3
112	Starks	89.3
8,555	County	47.34

Table 4 (cont.) Maine Pregnancies Number and Rates for Ages 15-19
2003-2007 (5 combined years) By Mother's Town of Residence

Note: Rates based on small numbers are unreliable and should be used with caution

Est. female population age 15-19	Town	Per 1000 females age 15-19
Maine Total		**35.7**
National 2006		**71.5**
Waldo County		
1,068	Belfast	54.3
97	Belmont	82.5
152	Brooks	85.5
65	Freedom	123.1
150	Morrill	60
401	Searsport	62.3
270	Swanville	63
141	Thorndike	63.8
6,330	County	43.92

Est. female population age 15-19	Town	Per 1,000 females age 15-19
Maine Total		**35.7**
National 2006		**71.5**
Washington County		
563	Calais	63.9
126	Milbridge	127
118	Pembroke	59.3
130	Princeton	130.8
121	Steuben	74.4
5,739	County	39.90
York County		
3,993	Biddeford	52.3
33,316	County	31.58

Jane Orbeton's Data Request From the 11/28/2011 e-mail

Maintenance of effort and federal match information on programs funded from the Fund for a Healthy Maine, including:

1. Any programs in which FHM funding is used to qualify the State for federal funds with which there is a maintenance of effort requirement; and
2. Any programs in which FHM funding is used as the state match for federal funds?

Home visiting

Home visiting does not have a match.

Substance abuse services

Answers related to the federal funds and state match for substance abuse services are found in the Commission Q&A Document, Question 12, and are repeated in Attachment B here.

Head Start

The match question is answered in the Commission Q&A document, Question # 8. It is repeated as Attachment A here.

MaineCare substance abuse services

Answers related to the federal funds and state match for substance abuse services are found in the Commission Q&A document, Question 12, and are repeated in Attachment B here.

Regarding recommending realignment of the FHM funding, the commission will need to know whether any action they might take would jeopardize federal funding or result in the loss of federal funding or services or programs.

Attachment A

The Head Start Act stipulates that the Federal share of the total costs of the Head Start program will not exceed 80 percent of the total grantee budget unless a waiver has been granted (Head Start Act Section 640(b)). If the grantee agency fails to obtain and document the required 20 percent, or other approved match, a disallowance of Federal funds may be taken. Non-Federal share must meet the same criteria for allowability as other costs incurred and paid with Federal funds.

While state funds are one way to make the required match, other items that can be used toward match are:

- In-kind contributions
- Volunteer time
- Donated supplies
- Donated equipment
- Donated land/buildings
- Cash contributions (from non-federal sources, such as private and corporate contributions)

Waivers are also granted to grantees that are not able to make their match. The criteria for receiving a waiver include:

- Lack of community resources.
- Impact of cost an agency may incur in the early days of the program
- Impact of an unanticipated increase in cost
- Community affected by disaster
- Impact upon the community if the program is discontinued

To receive a waiver - or a reduction in the required non-Federal share, the grantee agency must provide the ACF Regional Office written documentation of need. This request may be submitted with the grant proposal document or during the budget period if a situation arises that will make it impossible to meet the requirement. Approval of the waiver request cannot be assumed by the grantee agency without written notice from the ACF Regional Office.

Failure to meet the non-Federal share requirement can have a severe impact on the grantee agency. If it is determined that the requirement has not been met, the grantee agency may be required to repay $4 for every $1 of shortfall. For example, a shortfall of $10,000 could result in a disallowance of $40,000 of Federal funds. This amount must be repaid by the grantee agency from agency funds. Federal funds may not be used to repay the disallowance. The shortfall may be the result of a failure to accumulate the match, lack of documentation or incorrect valuation that results in a subsequent disallowance. While not required, it is advisable to accumulate extra match that may be used in this situation as replacement to avoid possible repayment.

http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/operations/Fiscal/Financial%20Management/Budgets/Non-Federal%20Share.htm

Attachment B

With regard to federal funding for substance abuse services please provide information on the federal match requirements for state funding. Can Maine decrease its financial commitment without losing federal funds? The answer to this question depends on the requirements of the various federal funding opportunities that are made available to the states and that states have the capacity to complete the application process and receive an award. In regards to the Substance Abuse and Mental Health Services Administration's Substance Abuse Prevention and Treatment Block Grant there is a Maintenance of Effort (MOE) requirement. The guidance for the MOE is found in Federal Title 45; Subtitle A, Part 96, Subpart L, Sec. 96.134.

What is the point at which a financial penalty is applied? OSA for each fiscal year must maintain aggregate State expenditures for Substance Abuse Services at a level that is not less than the average level of such expenditures maintained by the State for the two years preceding the fiscal year for which the State is applying for the grant. In simple terms, if OSA received $3,000,000 in state funds for substance abuse services for 2010 and $2,500,000 in 2011, OSA must receive at least 2,750,000 in 2012 to meet the MOE.

"With respect to the principal agency of a State for carrying out authorized activities, the agency shall for each fiscal year maintain aggregate State expenditures by the principal agency for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the two year period preceding the fiscal year for which the State is applying for the grant."

Maine can apply for a waiver, but must demonstrate that extraordinary economic conditions existed in the State during either of the two State fiscal years preceding the Federal fiscal year for which a State is applying for a grant. The term extraordinary economic conditions means a financial crisis in which the total tax revenue declines at least one and one-half percent, and either unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent (45 C.F.R. 96.134(b)). Based on this Maine did not meet definition of "extraordinary economic conditions" for the 2011 Block Grant, and did not meet the MOE by $945,114 and for SFY 2012 it is projected that Maine will not meet MOE by $3,413, 492.

What is the nature of the penalty? The DHHS Secretary has delegated the responsibility to determine if a State has failed to maintain such compliance to the Administrator of SAMHSA. The Administrator shall reduce the amount of the allotment for the State for the fiscal year for which the grant is being made by an amount equal to the amount constituting such failure for the previous fiscal year. Based on the example above, OSA must receive at least 2,750,000 in 2012 to meet the MOE, if they only received $2,500,000 the SAPT BG could be reduced by $250,000.

Is it full or partial loss of federal funds? It is a partial loss of federal funds base on the proportional formula above.

Conversely could Maine increase its financial commitment and gain extra federal funds? No; in the case of the SAMHSA SAPT Block Grant it is a formula grant based on population and other factors, not including the state's financial capacity. Other federal grant opportunities that require a match will have an award funding range, depending on the amount specified in the grant application. In order to meet the match requirement it may be the state's or grantee's contribution that may be "in kind" or "in-direct" that could count toward match, as well as available monies for a direct match for the state's portion. This is often to leverage the funding, but is foundational in sustaining the activities of the grant to some degree after the end of the grant.

APPENDIX J

Department of Health and Human Services, Office of Substance Abuse
"Substance Abuse in Maine: What does it cost us?"

Substance Abuse in Maine: What does it cost us?
Office of Substance Abuse
Maine Department of Health and Human Services

The Issue in Maine:

- Crime:

  Approximately half of Maine prisoners are diagnosed with substance dependency or abuse. Between 1 out of 3 and 1 out of 4 inmates were drunk or high at the time of their offense.

- Death:

  In 2005, 681 persons died of substance-related causes. This number represents 15,750 years of potential life lost.

- Medical Care:

  In 2005, 8350 hospitalizations were directly or indirectly related to substance abuse.

  Health problems from immediate use include injury and overdose.

  Health problems from long-term use include: Certain cancers; Damage to liver and pancreas; Psychoses.

Office of Substance Abuse
An Office of the Department of Health and Human Services

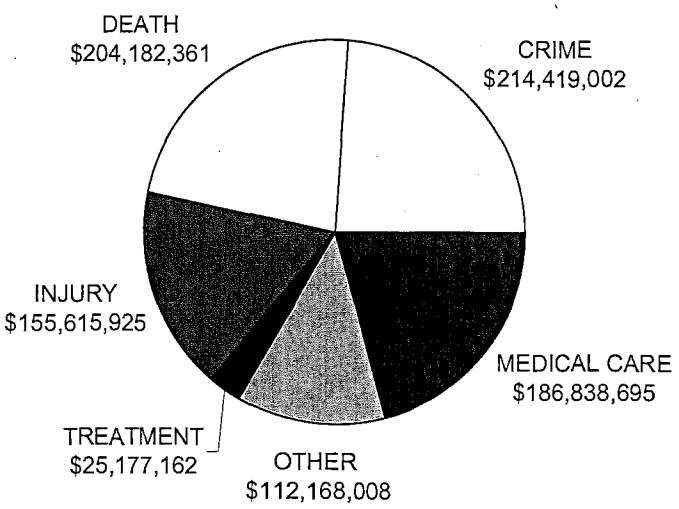
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Guy R. Cousins, Director
41 Anthony Ave.,
11 State House Station
Augusta, Maine 04333-0011
Telephone: 207-287-2595
TTY: 207-287-4475
Fax: 207-287-8910
Guy.Cousins@maine.gov

For more information: www.maineosa.org

In 2005, the total estimated cost of substance abuse in Maine was nearly $900,000,000. This cost translates into $682 for every man, woman and child in Maine. The 3 largest costs are substance abuse related crime 24%, death 23%, and medical care 21%.

Costs of Substance Abuse
Maine, 2005 Estimate



- Other Costs consisted of:

  Child Welfare - $53,000,000
  Social Welfare Programs - $2,000,000
  Fires - $9,000,000
  Car Crashes - $48,000,000

- The least amount was spent on substance abuse treatment, 3%.

- The estimated cost of Substance Abuse in 2010 is $1,180,000,000. The estimated cost of Substance Abuse in 2015 for the citizens of the state of Maine is one billion, four hundred fifty eight million dollars ($1,458,000,000).*

The escalating cost of substance abuse could be offset by increasing the implementation of effective prevention, intervention, treatment and recovery policies and programs across the state.

* Estimate based on projection from 2000 and 2005 estimates.

January 2011

APPENDIX K

Department of Health and Human Services, Maine Center for Disease Control and Prevention Response on Match and Maintenance of Effort, November 29, 2011

Maine CDC Response on Match and Maintenance of Effort for FHM Commission

1) **Any programs in which FHM funding is used to qualify the State for federal funds with which there is a maintenance of effort requirement.**

   None of the FHM funding dedicated to the Maine CDC is used for maintenance of effort requirements.

2) **Any program in which FHM funding is used as the state match for federal funds?**

   The Partnership for a Tobacco-Free Maine uses $243,350 as match for the annual U.S. CDC tobacco grant at a 4:1 rate.

   The Healthy Maine Partnerships request permission to use some of their FHM funding for match; these are primarily for Safe and Drug Free Communities grants through SAMHSA (Substance Abuse and Mental Health Services Administration). Currently 3 HMPs are using a total of $246,255. The HMPs are Healthy Communities of the Capitol Area (Augusta), Washington County (Lubec), and Healthy Rivers (PROP Portland)

   Currently FAME uses $72,000 of its FHM funding as match to a HRSA, Bureau of Health Professions grant that is managed by the Oral Health Program within the Maine CDC. This grant ends August 31, 2012.

   Healthy Communities uses $10,000 of FHM funding as match for the Collaborative Grant.

   The Cardiovascular Health Program uses $225,718 of FHM funding as match to the US CDC Cooperative Agreement.

   The Diabetes Prevention and Control Program uses $11,139 of the FHM funding as match to the US CDC Cooperative Agreement.

   The Division of Population Health uses an additional $3,513 as match for the federal cardiovascular grant.

   Currently none of the FHM funding for family planning is used as match. These funds would be used for match if Maine decided to utilize the provision in the Affordable Care Act for family planning. The family planning provision in the ACA would provide a 9:1 match (9 federal to 1 state).

APPENDIX L

Suggested legislation from the Commission to Study Allocations of the Fund for a Healthy Maine

Title: An Act to Revise the Laws Regarding the Fund for a Healthy Maine and Provide A Separate Budget Program for Overweight and Obesity Prevention, Education and Treatment Activities

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1511 is amended to read:

§1511. Fund for a Healthy Maine established

1. Fund established. The Fund for a Healthy Maine, referred to in this chapter as the "fund," is established as ~~an Other Special Revenue~~ a separate fund for the purposes specified in this chapter.

2. Sources of fund. The State Controller shall credit to the fund:

A. All money received by the State in settlement of or in relation to the lawsuit State of Maine v. Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134;

B. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and

C. Interest earned or other investment income on balances in the fund.

3. Allocation; amounts.

3-A. Unencumbered balances. Any unencumbered balance remaining at the end of any fiscal year lapses back to the Fund for a Healthy Maine, the account within the Department of Administrative and Financial Services established pursuant to this section, and may not be made available for expenditure without specific legislative approval.

3-B. Departmental indirect cost allocation plans. Any revenue transfer made on or after July 1, 2000 from a Fund for a Healthy Maine account to another account pursuant to an approved departmental indirect cost allocation plan is determined by the Legislature to be an authorized use of revenue credited to the Fund for a Healthy Maine. The State Budget Officer shall reduce allotment for the amount of any transfer made from a Fund for a Healthy Maine account for the purpose authorized in this subsection.

4. Restrictions. This section does not require the provision of services for the purposes specified in subsection ~~6~~ 6-A. When allocations are made to direct services, services to lower income consumers must have priority over services to higher income consumers. Allocations from the fund must be used to supplement, not supplant, appropriations from the General Fund.

5. General Fund limitation. Notwithstanding any provision to the contrary in this section, any program, expansion of a program, expenditure or transfer authorized by the Legislature

using the Fund for a Healthy Maine may not be transferred to the General Fund without specific legislative approval.

~~**6. Health purposes.** Allocations are limited to the following health-related purposes:~~

~~A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State;~~

~~B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;~~

~~C. Child care for children up to 15 years of age, including after-school care;~~

~~D. Health care for children and adults, maximizing to the extent possible federal matching funds;~~

~~E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds;~~

~~F. Dental and oral health care to low-income persons who lack adequate dental coverage;~~

~~G. Substance abuse prevention and treatment; and~~

~~H. Comprehensive school health and nutrition programs, including school-based health centers.~~

6-A. Health purposes. Allocations are limited to the following prevention and health promotion purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State;

B. Overweight and obesity prevention, education and treatment activities;

C. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;

D. Child care for children up to 15 years of age, including after-school care;

E. Health care for children and adults, maximizing to the extent possible federal matching funds;

F. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds;

G. Dental and oral health care to low-income persons who lack adequate dental coverage;

H. Substance abuse prevention and treatment; and

I. Comprehensive school health and nutrition programs, including school-based health centers.

7. Investment; plan; report.

8. Report by Treasurer of State. The Treasurer of State shall report at least annually on or before the 2nd Friday in December to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters. The report must summarize the activity in any funds or accounts directly related to this section.

9. Working capital advance. Beginning July 1, 2003, the State Controller is authorized to provide an annual advance up to $37,500,000 from the General Fund to the fund to provide

money for allocations from the fund. This money must be returned to the General Fund as the first priority from the amounts credited to the fund pursuant to subsection 2, paragraph A.

10. Restricted accounts.

11. Restricted accounts. The State Controller is authorized to establish separate accounts within the fund in order to segregate money received by the fund from any source, whether public or private, that requires as a condition of the contribution to the fund that the use of the money contributed be restricted to one or more of the purposes specified in subsection ~~6~~ 6-A. Money credited to a restricted account established under this subsection may be applied only to the purposes to which the account is restricted.

12. Adjustment to allocations. For state fiscal years beginning on or after July 1, 2008, the State Budget Officer is authorized to adjust allocations if actual revenue collections for the fiscal year are less than the approved legislative allocations. The State Budget Officer shall review the programs receiving funds from the fund and shall adjust the funding in the All Other line category to stay within available resources. These adjustments must be calculated in proportion to each account's allocation in the All Other line category in relation to the total All Other allocation for fund programs. Notwithstanding any other provision of law, the allocation for the identified amounts may be reduced by financial order upon the recommendation of the State Budget Officer and approval of the Governor. The State Budget Officer shall report annually on the allocation adjustments made pursuant to this subsection to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters by May 15th.

13. Separate accounts; annual reporting. All state agencies that receive allocations from the fund and contractors and vendors that receive funding allocated from the fund shall maintain money received from the Fund for a Healthy Maine in separate accounts and shall report by September 1 each year to the Commissioner of Administrative and Financial Services providing a description of how their funding from the fund for the prior State fiscal year was targeted to the prevention and health promotion purposes listed in subsection 6-A. The Commissioner shall by October 1 each year compile the reports provided under this subsection and forward the information in a report to the Legislature.

14. Legislative committee review of legislation. Whenever a legislative proposal in a resolve or bill before the Legislature, including but not limited to a budget bill, affects the fund, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among members of the committee. If there is support for the proposal among a majority of the members of the committee, the committee shall request the joint standing committee of the Legislature having jurisdiction over health and human services matters to review and evaluate the proposal as it pertains to the fund. The joint standing committee of the Legislature having jurisdiction over health and human services matters shall conduct the review and report back to the committee of jurisdiction and to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.

Sec. 2. 22 MRSA section 1511-A is enacted to read:

§1511-A. Periodic study commission review.

Beginning in 2015 and every 4 years thereafter, the Legislature shall establish a study commission, hereinafter referred to as "the commission," to review allocations of the fund and to report by December 7 of the year in which the commission is established to the joint standing committee having jurisdiction over appropriations and financial affairs and the joint standing committee having jurisdiction over health and human services matters.

1. Commission membership. The commission consists of no more than 13 members appointed as follows.

1. The President of the Senate shall appoint:

A. Three members of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature. At least one of the appointees must serve on the Joint Standing Committee on Appropriations and Financial Affairs and at least one of the appointees must serve on the Joint Standing Committee on Health and Human Services; and

B. One person representing municipal public health departments and one person representing a major voluntary nonprofit health organization.

2. The Speaker of the House of Representatives shall appoint:

A. Four members of the House of Representatives, including members from each of the 2 parties holding the largest number of seats in the Legislature. At least one of the appointees must serve on the Joint Standing Committee on Appropriations and Financial Affairs and at least one of the appointees must serve on the Joint Standing Committee on Health and Human Services; and

B. One person representing a statewide organization of public health professionals;

C. One person representing a public health organization or agency operating in a rural community;

D. One person representing the organizations providing services supported by funds from the Fund for a Healthy Maine; and

E. One person who possesses expertise in the subject matter of the study.

2. Chairs. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

3. Appointments; convening of commission. All appointments must be made no later than June 1 in the year in which the study is being performed. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. The chairs of the commission shall call and convene the first meeting of the commission within 15 days of notification that all appointments have been made.

4. Meetings. The commission may meet only when the Legislature is not in regular or special session. The commission is authorized to meet up to 6 times to accomplish its duties.

5. Duties. The commission shall review the alignment of allocations from the Fund for a Healthy Maine, established in section 1511, with the State's current public health care and preventive health priorities and goals. The commission shall gather information and data from public and private entities as necessary to:

A. Identify or review the State's current public health care and preventive health priorities and goals;

B. Identify or review strategies for addressing priorities and goals and potential effectiveness of those strategies;

C. Assess the level of resources needed to properly pursue the strategies identified in paragraph B;

D. Make recommendations for how Fund for a Healthy Maine funds should be allocated to most effectively support the State's current public health and preventive health priorities, goals and strategies; and

E. Make recommendations for processes to be used to ensure that Fund for a Healthy Maine allocations stay aligned with the State's health priorities and goals.

6. Cooperation. The Commissioner of Administrative and Financial Services, the Commissioner of Education, the Commissioner of Health and Human Services and the Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services shall provide information and data to the commission as necessary for its work.

7. Staff assistance. The Legislative Council shall provide necessary staffing services to the commission.

Sec. 3. Review and report. The Commissioner of Administrative and Financial Services shall review program structure for the programs of the Fund for a Healthy Maine and shall recommend a new program structure, including a program for overweight and obesity prevention, education and treatment, to be used in the State budget beginning in state fiscal year 2014-2015. The new program structure must include funding from the Fund for a Healthy Maine for overweight and obesity prevention, education and treatment from funding provided from the Fund for a Healthy Maine for these purposes under other existing programs. By October 1, 2012 the Commissioner shall report on the review and recommendations under this section to the Legislature.

SUMMARY

This bill proposes changes to the laws on the Fund for a Healthy Maine as recommended by the Commission to Study Allocations of the Fund for a Healthy Maine. The bill changes the Fund for a Healthy Maine from an Other Special Revenue account to a separate fund. It changes reference to health-related purposes to reference to prevention and health-related purposes. It adds a new separate health purpose: overweight and obesity prevention, education and treatment activities. It requires annual report on targeted uses of fund money to the Commissioner of Administrative and Financial Services and provides for an annual report to the Legislature. It

places in law review by the joint standing committee having jurisdiction over health and human services matters of legislative proposals affecting the fund that are currently in effect through Joint Rule 317. It requires the Legislature to establish a study commission to review allocations of the fund every 4 years in the same manner in which they were reviewed in 2011 and to report with recommendations to the joint standing committee having jurisdiction over appropriations and financial affairs and the joint standing committee having jurisdiction over health and human services matters. It requires the Commissioner of Administrative and Financial Services to review program structure for the programs of the Fund for a Healthy Maine and to recommend a new program structure, including a program for overweight and obesity prevention, education and treatment, to be used in the State budget beginning in state fiscal year 2014-2015. It directs the Commissioner to report to the Legislature on the review and recommendations by October 1, 2012.