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

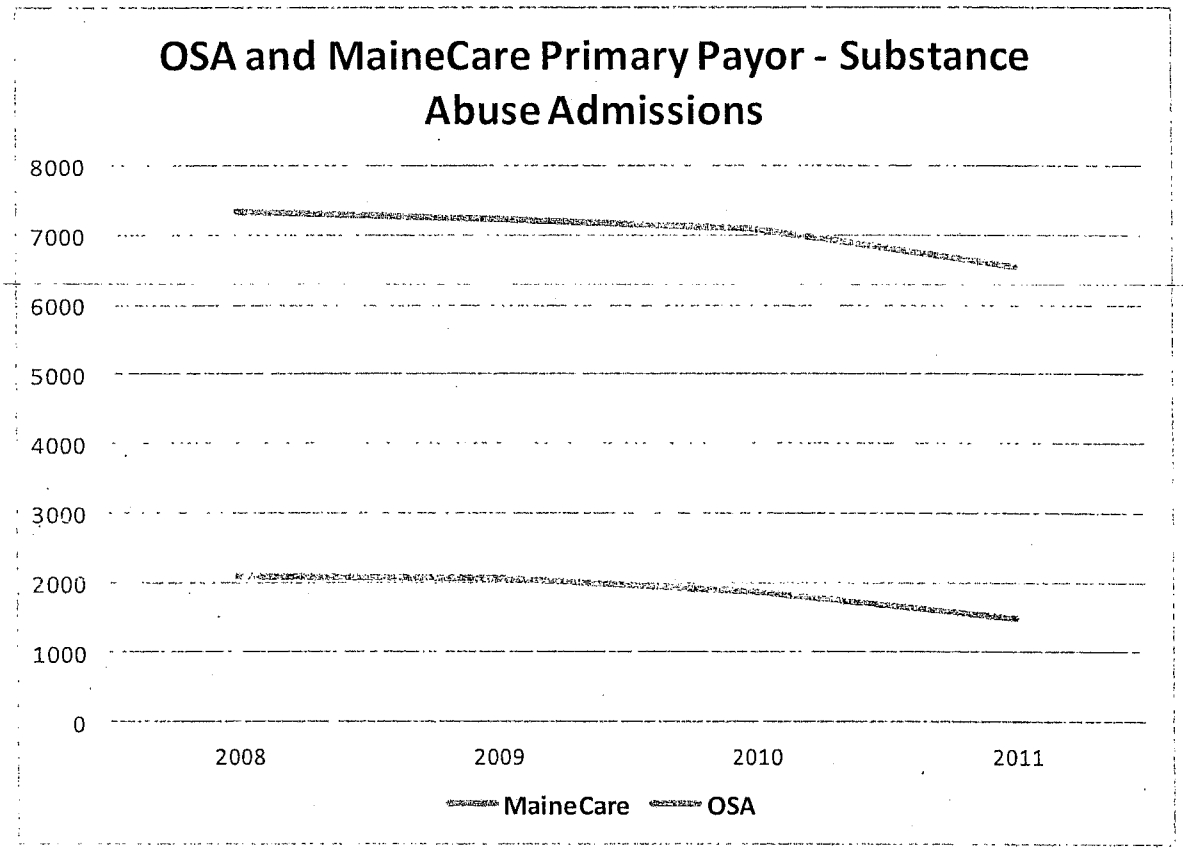
Average Time in Treatment for Completed Clients (Weeks)
Global Assessment of Functioning Improvement
Conduct follow up contact (phone, text, email) with client 1x a week for first 30 days, then 60 days, 90 days, and 1 year post treatment episode to assess sustained progress. Maintain a log in client 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.

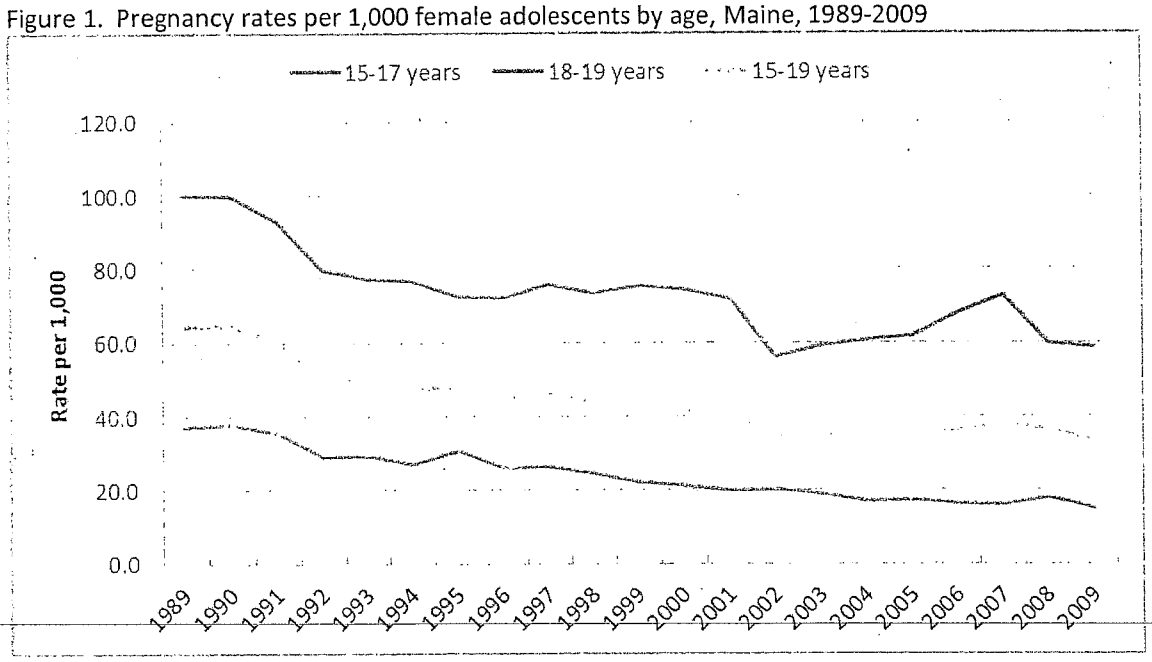
Table 1. Rates (per 1,000 female population aged 15-19 years) of pregnancy outcomes among adolescents aged 15-19 years, Maine residents, 1989-2009

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

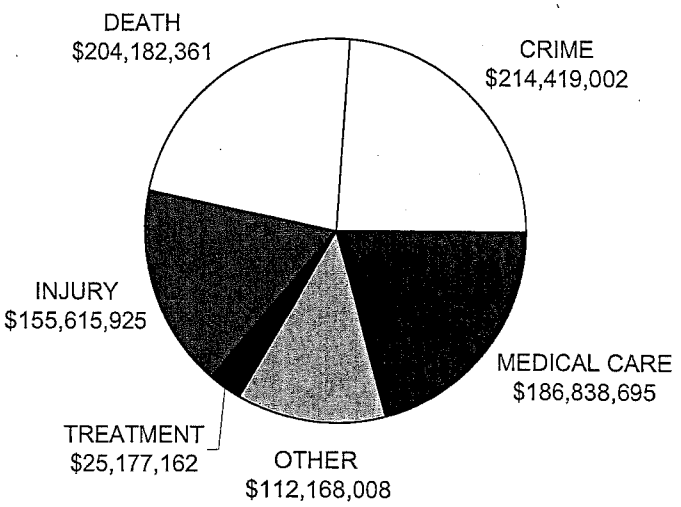
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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.