First Meeting

Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

(Resolve 2023, c. 100)

Tuesday, October 24th, 2023
10:00 am

State House, Room 228 (AFA Committee Room)
Hybrid Meeting (In-person and Remote Participation Available)

AGENDA

I. Welcome – Chairs Senator Peggy Rotundo and Representative Anne Graham

II. Member Introductions

III. Overview of Committee's Responsibilities Under Resolve 2023, chapter 100

- Review of commission duties
- Review of public records and public meeting laws

IV. Review of Background Materials

V. Presentations on the Background of The Fund for Healthy Maine

i. Samuel Senft, OPLA – FHM brief review
ii. Luke Lazure, OFPR – FHM financial status

VI. Discussion and Next Steps

PLEASE READ

This meeting will be held in the State House, Room 228, the Committee on Appropriations and Financial Affairs Room. However, remote participation will be available for commission members and speakers over Zoom. Members of the public can attend the meeting either in-person or view the meeting over the Legislature's streaming platform at this link.

LAW WITHOUT GOVERNOR'S SIGNATURE

JULY 19, 2023

CHAPTER 100 RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 685 - L.D. 1722

Resolve, to Establish the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve establishes the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities; and

Whereas, tobacco users are switching to electronic cigarettes, which are not included in the tobacco Master Settlement Agreement pursuant to the lawsuit *State of Maine v. Philip Morris, et al.*, Kennebec County Superior Court, Docket No. CV-97-134; and

Whereas, the switch to electronic cigarettes has diminished the payments to the tobacco Master Settlement Agreement and therefore reduced the funds received by the Fund for a Healthy Maine without reducing the harm to public health from tobacco; and

Whereas, more funds are allocated through the Fund for a Healthy Maine baseline budget than the State receives from the tobacco Master Settlement Agreement, resulting in an unsustainable structural deficit in the Fund for a Healthy Maine; and

Whereas, Fund for a Healthy Maine funds are essential for funding tobacco prevention and treatment, other chronic disease prevention initiatives and health promotion efforts in the State, particularly for the benefit of children and families in the State; and

Whereas, public health problems are seldom solved and health and economic benefits are rarely measurable within a 2-year state budget cycle; and

Whereas, the structural limitations of the State's 2-year budget cycle result in an ongoing loss of opportunities to plan and invest in long-term, evidence-informed primary and secondary chronic disease prevention initiatives; and

Whereas, the State receives funds from multiple legal settlements with manufacturers and excise taxes on products that affect public health and well-being but lacks the system

and structure necessary to maximize benefit through coordinated planning and sustained investment in preventing disease and improving the health of communities in the State; and

Whereas, the work of the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities must be initiated before the 90-day period expires in order that the commission's work may be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 15 members as follows:

1. Six members appointed by the President of the Senate as follows:

A. One member of the Senate from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs;

B. One member of the Senate from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services;

C. One member with policy expertise or experience in state budgeting and funding improved access to health care for low-income individuals and other populations experiencing inequitable access to health care;

D. One member who has a minimum of 8 years of experience leading a community health coalition and experience working with rural populations;

E. One member who manages a public health endowment for a health system in the State and has experience developing statewide plans for improving health and prosperity; and

F. One member who is currently or was formerly employed as senior staff or faculty for a university in the State with expertise in public health, rural health and health equity financing models;

2. Seven members appointed by the Speaker of the House of Representatives as follows:

A. One member of the House of Representatives from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services;

B. One member of the House of Representatives from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs;

C. One member who represents a statewide association of public health professionals that works to improve and sustain the health and well-being of all people in the State through health promotion, disease prevention and the advancement of health equity;

D. One member who has a minimum of 8 years of experience serving in the Legislature, including service on both the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services;

E. One member who is employed by a philanthropic organization in the State with experience or expertise funding initiatives in public health and primary prevention that advance racial health equity or reduce health disparities;

F. One member who represents a community development financial institution that advances health and economic equity for people and communities in the State through the integration of finance, business expertise and policy solutions; and

G. One member who serves as senior staff for a municipal or county health department;

3. The Director of the Office of Policy Innovation and the Future or the director's designee; and

4. The Attorney General or the attorney general's designee.

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

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the commission shall evaluate funding models and structures that allow for the sustained investment in the health and prosperity of youth and families in the State and make recommendations for further legislative action. The commission shall prioritize research and recommendations that:

1. Resolve the structural deficit in the Fund for a Healthy Maine;

2. Identify sources of sustained funding for reducing tobacco use, improving public health, preventing chronic illness, reducing health disparities across demographic and geographic populations and improving the community conditions that support good health and wellness;

3. Identify strategies and structural changes that resolve structural inequities and allow funding and investment plans to extend beyond the Legislature's 2-year budget cycle when doing so is necessary for accomplishing their intents and purposes;

4. Advance the long-term goals established by the Legislature for funds received from legal settlements with manufacturers and excise taxes on products that affect public health and well-being;

5. Identify policy and funding models that maximize alignment between the purpose and intent of public health funding sources and the investments in public health and prevention initiatives those funds support;

6. Identify how funding from various public health-related sources could be blended or pooled to achieve common aims in preventing chronic disease, reducing health disparities among historically disenfranchised and vulnerable populations and improving the community conditions that support the health and resilience of youth in the State; and

7. Identify strategies and system changes that would allow for the calculation of return on investment of all proposed public health and prevention measures over a period of time using the projected health and productivity benefits of those investments.

Sec. 6. Staff assistance. Resolved: That, notwithstanding Joint Rule 353, the Legislative Council shall provide necessary staffing services to the commission except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than December 6, 2023, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services. After receipt and review of the report, one or both of the joint standing committees may submit legislation relating to the subject matter of the report to any regular or special session of the 131st Legislature.

Sec. 8. Outside funding. Resolved: That the commission may seek funding contributions to fully or partially fund the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Membership List

The Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

One member of the Senate from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs	**Sen. Peggy Rotundo, chair**
One member of the House of Representatives from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services	**Rep. Anne Graham, chair**
One member of the Senate from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services	**Sen. Rick Bennett**
One member of the House of Representatives from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs	**Rep. John Ducharme**
One member with policy expertise or experience in state budgeting and funding improved access to health care for low-income individuals and other populations experiencing inequitable access to health care	**Alex Carter (Maine Equal Justice)**
One member who manages a public health endowment for a health system in the State and has experience developing statewide plans for improving health and prosperity	**Barbara Crowley, M.D.**
One member who is currently or was formerly employed as senior staff or faculty for a university in the State with expertise in public health, rural health and health equity financing models	**Yvonne Jonk (Maine Rural Health Research Center)**

One member who has a minimum of 8 years of experience leading a community health coalition and experience working with rural populations	**Elsie Flemings (Healthy Acadia)**
One member who represents a statewide association of public health professionals that works to improve and sustain the health and well-being of all people in the State through health promotion, disease prevention and the advancement of health equity	**Rebecca Boulos (Maine Public Health Association)**
One member who has a minimum of 8 years of experience serving in the Legislature, including service on both the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services	**Linda Sanborn**
One member who is employed by a philanthropic organization in the State with experience or expertise funding initiatives in public health and primary prevention that advance racial health equity or reduce health disparities	**Barbara Leonard (Maine Health Access Foundation)**
One member who represents a community development financial institution that advances health and economic equity for people and communities in the State through the integration of finance, business expertise and policy solutions	**Keith Bisson (Coastal Enterprises)**
One member who serves as senior staff for a municipal or county health department	**Liz Blackwell Moore (Cumberland County Public Health)**
The Director of the Office of Policy Innovation and the Future or the director's designee	**Ana Hicks**
The Attorney General or the attorney general's designee	**Attorney General Aaron Frey**

Maine's Freedom of Access Act and the Conduct of the Business of the Legislature

Prepared for the Right to Know Advisory Committee
by the Office of Policy and Legal Analysis and the Office of the Attorney General
Updated December 2020

The Maine Freedom of Access Act requires governmental entities to conduct public business in the open and to provide access to public records. Legislative meetings and records are subject to the law and must be open to the public, with some limited exceptions set forth in the law.

Intent of the Freedom of Access Law
The Maine Freedom of Access Act provides that it is the intent of the Legislature that "actions [involving the conduct of the people's business] be taken openly and that the records of their actions be open to public inspection and their deliberations be conducted openly." The Freedom of Access Act, found in Title 1 of the Maine Revised Statutes, chapter 13, applies to all governmental entities, including the Legislature.

Public Proceedings
Under state law, all meetings of the Legislature, its joint standing committees and legislative subcommittees are public proceedings. A legislative subcommittee is a group of 3 or more committee members appointed for the purpose of conducting legislative business on behalf of the committee.

The public must be given notice of public proceedings and must be allowed to attend. Notice must be given in ample time to allow the public to attend and in a manner reasonably calculated to notify the general public. The public is also allowed to record the proceedings as long as the activity does not interfere with the orderly conduct of the proceedings.

Party caucuses are not committees or subcommittees of the Legislature, so their meetings do not appear to be public proceedings. Similarly, informal meetings of the members of a committee who are affiliated with the same party are not public proceedings as these members are not designated by the committee as a whole to conduct business of the committee. However, committee members should be careful when they caucus not to make decisions or otherwise use the caucus to circumvent the public proceeding requirements.

Limited Exception to Public Proceedings (Executive Sessions)
In very limited situations, joint standing committees may hold executive sessions to discuss certain matters. State law is quite specific as to those matters that may be deliberated in executive sessions. The executive session must not be used to defeat the purpose of the Act, which is to ensure that the people's business is conducted in the open.

The permitted reasons for executive session are set forth in the law, Title 1, section 405 and Title 3, section 156. The reasons most relevant to legislative work are discussion of confidential records and pre-hearing conferences on confirmations.

An executive session may be called only by a public, recorded vote of 3/5 of the members, present and voting, of the committee. The motion to go into executive session must indicate the precise nature of the business to be discussed and no other matters may be discussed. A committee may not take any votes or other official action in executive sessions.

If a committee wants to hold an executive session, the committee should discuss the circumstances with an attorney from the Office of Policy and Legal Analysis or the Office of Fiscal and Program Review who can provide the committee with guidance about whether an executive session is permitted and, if so, how to proceed.

Public Records
The Freedom of Access Act defines "public records" broadly, to include all material in possession of public agencies, staff and officials if the materials were received or prepared for use in, or relate to, the transaction of public or governmental business. The scope of the definition means that most, if not all, papers and electronic records relating to legislative business are public records. This includes records that may be stored on an individual legislator's personal computer, tablet or smartphone if they relate to or were prepared for use in the transaction of public business, *e.g.*, constituent inquiries, emails, text messages or other correspondence about legislative matters. Information contained in a communication between a constituent and a legislator may be confidential if it meets certain narrow requirements.

Time-limited Exception from Public Disclosure for Certain Legislative Records
The Freedom of Access Act contains exceptions to the general rule that public records must be made available for public inspection and copying. One exception that is relevant to legislative work allows certain legislative papers to be withheld from public disclosure until the end of the legislative session in which they are being used. The exceptions are as follows:

- Legislative papers and reports (e.g. bill drafts, committee amendments and the like) are not public records until signed and publicly distributed; and
- Working papers, drafts, records, and memoranda used to prepare proposed legislative papers or reports are not public records until the end of the legislative session in which the papers or reports are prepared or considered or to which they are carried over.

The Legislative Council's Confidentiality Policy and the Joint Rules provide guidance to legislative staff about how such records are to be treated before they become public records.

Confidential Records in the Possession of Committees
Committees may also need to be prepared to deal with other types of non-public records, such as individual medical or financial records that are classified as confidential under state or federal law.

If the committee comes into possession of records that are declared confidential by law, the Freedom of Access Act allows the committee to withhold those records from the public and to go into executive session to consider them (see discussion above for the proper process).

In addition, the committee should also find out whether there are laws that set specific limitations on, and penalties for, dissemination of those records. The Office of the Attorney General or an attorney from the Office of Policy and Legal Analysis or the Office of Fiscal and Program Review can help the committee with these records.

Joint Rule 313 also sets forth procedures to be followed by a committee that possesses confidential records.

Legislative Review of Public Record Exceptions
All exceptions to the public records law are subject to a review process. A legislative committee that considers a legislative measure proposing a new statutory exception must refer the measure to the Judiciary Committee if a majority of the committee supports the proposed exception. The Judiciary Committee will review and evaluate the proposal according to statutory standards, then report findings and recommendations to the committee of jurisdiction. The Judiciary Committee regularly seeks input from the Right to Know Advisory Committee on public records, confidentiality and other freedom of access issues.

Public Access Ombudsman
The Public Access Ombudsman, an attorney located in the Department of the Attorney General, is available to provide information about public meetings and public records, to help resolve complaints about accessing proceedings and records and to help educate the public as well as public agencies and officials. Legislators may contact the Public Access Ombudsman, Brenda Kielty, at Brenda.Kielty@maine.gov, or (207) 626-8577 for assistance.

§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 for the purposes specified in this chapter as a separate and distinct fund for accounting and budgetary reporting purposes.
[PL 2011, c. 701, §1 (AMD).]

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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

B. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and [PL 1999, c. 401, Pt. V, §1 (NEW).]

C. Interest earned or other investment income on balances in the fund. [PL 1999, c. 401, Pt. V, §1 (NEW).]
[PL 1999, c. 401, Pt. V, §1 (NEW).]

3. Allocation; amounts.
[PL 2001, c. 358, Pt. Q, §1 (RP).]

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.
[PL 2001, c. 559, Pt. AA, §3 (NEW); PL 2001, c. 559, Pt. AA, §5 (AFF).]

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.
[PL 2003, c. 513, Pt. Y, §1 (NEW).]

4. Restrictions. This section does not require the provision of services for the purposes specified in subsection 6. 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.
[PL 1999, c. 401, Pt. V, §1 (NEW).]

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.
[PL 1999, c. 401, Pt. V, §1 (NEW).]

6. Health promotion 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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

A-1. Prevention, education and treatment activities concerning unhealthy weight and obesity; [PL 2011, c. 617, §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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

C. Child care for children up to 15 years of age, including after-school care; [PL 1999, c. 401, Pt. V, §1 (NEW).]

D. Health care for children and adults, maximizing to the extent possible federal matching funds; [PL 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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

F. Dental and oral health care to low-income persons who lack adequate dental coverage; [PL 1999, c. 401, Pt. V, §1 (NEW).]

G. Substance use disorder prevention and treatment; and [PL 2017, c. 407, Pt. A, §71 (AMD).]

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

[PL 2017, c. 407, Pt. A, §71 (AMD).]

7. Investment; plan; report.

[PL 2001, c. 358, Pt. Q, §3 (RP).]

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.

[PL 2001, c. 358, Pt. Q, §4 (NEW).]

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.

[PL 2001, c. 714, Pt. OO, §1 (NEW).]

10. Restricted accounts.

[PL 2003, c. 687, Pt. B, §6 (RP); PL 2003, c. 687, Pt. B, §11 (AFF).]

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. Money credited to a restricted account established under this subsection may be applied only to the purposes to which the account is restricted.

[PL 2003, c. 687, Pt. A, §9 (NEW); PL 2003, c. 687, Pt. B, §11 (AFF).]

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.

[PL 2009, c. 1, Pt. F, §1 (NEW).]

13. Separate accounts; annual reporting. A state agency that receives allocations from the fund and a contractor or vendor that receives funding allocated from the fund shall maintain that money in a separate account and shall report by September 1st of each year to the Commissioner of Administrative and Financial Services providing a description of how those funds for the prior state fiscal year were targeted to the prevention and health-related purposes listed in subsection 6. The Commissioner of Administrative and Financial Services shall by October 1st of each year compile the reports provided under this subsection and forward the information in a report to the Legislature.
[PL 2011, c. 701, §2 (NEW).]

REVISOR'S NOTE: (Subsection 13 as enacted by PL 2011, c. 655, Pt. M, §1 is REALLOCATED TO TITLE 22, SECTION 1511, SUBSECTION 15)

14. Legislative committee review of legislation. Whenever a 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 to the committee of jurisdiction and to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.
[PL 2011, c. 701, §2 (NEW).]

15. (REALLOCATED FROM T. 22, §1511, sub-§13) Attrition adjustment. For state fiscal years beginning on or after July 1, 2012, the State Budget Officer is authorized to adjust allocations to address shortfalls that occur as a direct result of Personal Services allocation reductions for projected vacancies. Accrued savings generated from vacant positions within a Fund for a Healthy Maine account's allocation for Personal Services or available balances in the Fund for a Healthy Maine program within the Department of Administrative and Financial Services may be transferred by financial order to offset Personal Services shortfalls in other Fund for a Healthy Maine accounts except that these transfers are subject to review by the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.
[RR 2011, c. 2, §24 (RAL).]

SECTION HISTORY

PL 1999, c. 401, §V1 (NEW). PL 2001, c. 358, §§Q1-4 (AMD). PL 2001, c. 559, §AA3 (AMD). PL 2001, c. 559, §AA5 (AFF). PL 2001, c. 714, §OO1 (AMD). IB 2003, c. 1, §6 (AMD). PL 2003, c. 513, §Y1 (AMD). PL 2003, c. 687, §§A9,B6 (AMD). PL 2003, c. 687, §B11 (AFF). PL 2007, c. 539, Pt. IIII, §3 (AMD). PL 2009, c. 1, Pt. F, §1 (AMD). RR 2011, c. 2, §24 (COR). PL 2011, c. 617, §1 (AMD). PL 2011, c. 655, Pt. M, §1 (AMD). PL 2011, c. 701, §§1, 2 (AMD). PL 2017, c. 407, Pt. A, §71 (AMD).

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Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
DEPARTMENT OF THE ATTORNEY GENERAL										
024-26A-0947-01 FHM - ATTORNEY GENERAL (FORMERLY 011-26A-0947)										
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)
Pers. Serv.	116,600	$118,540	121,765	$127,517	140,826	$147,220	109,765	$115,063	144,239	$151,768
All Other	21,542	19,628	19,628	19,628	20,860	20,860	21,164	21,164	23,456	23,456
Program Total	138,142	138,168	141,393	147,145	161,686	168,080	130,929	136,227	167,695	175,224
Annual % Increase	-8.11%	0.02%	2.33%	4.07%	9.88%	3.95%	-22.10%	4.05%	23.10%	4.49%
DEPARTMENT OF THE ATTORNEY GENERAL										
Pos. - Leg.	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**
Pers. Serv.	**116,600**	**118,540**	**121,765**	**127,517**	**140,826**	**147,220**	**109,765**	**115,063**	**144,239**	**151,768**
All Other	**21,542**	**19,628**	**19,628**	**19,628**	**20,860**	**20,860**	**21,164**	**21,164**	**23,456**	**23,456**
Dept. Total	**138,142**	**138,168**	**141,393**	**147,145**	**161,686**	**168,080**	**130,929**	**136,227**	**167,695**	**175,224**
Annual % Increase	**-8.11%**	**0.02%**	**2.33%**	**4.07%**	**9.88%**	**3.95%**	**-22.10%**	**4.05%**	**23.10%**	**4.49%**
DEPARTMENT OF EDUCATION										
024-05A-Z068-01 FHM - SCHOOL BREAKFAST PROGRAM (FORMERLY 011-05A-Z068-01)										
All Other	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720
Program Total	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DEPARTMENT OF EDUCATION										
Pos. - Leg.	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Dept. Total	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Annual % Increase	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
FINANCE AUTHORITY OF MAINE										
024-94F-0950-02 FHM - HEALTH EDUCATION CENTERS (FORMERLY 011-94F-0950-02)										
All Other	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000
Program Total	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

		2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
024-94F-0951-01	FHM - DENTAL EDUCATION										
All Other		237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740
Program Total		237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-94F-Z229-01	MAINE HARVESTED FOOD PRODUCTS FOR RESIDENTS WITH FOOD INSECURITY										
All Other		0	3,000,000	0	0	0	0	0	0	0	0
Program Total		0	3,000,000	0	0	0	0	0	0	0	0
Annual % Increase		0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FINANCE AUTHORITY OF MAINE											
Pos. - Leg.		**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pos. - Other		**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
All Other		**347,740**	**3,347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**
Dept. Total		**347,740**	**3,347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**
Annual % Increase		**0.00%**	**862.71%**	**-89.61%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)											
024-10A-0143-25	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: ORAL HEALTH) (FORMERLY FHM - BUREAU OF HEALTH - ORAL HEALTH 011-10A-0953-01)										
All Other		300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Program Total		300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-30	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: TOBACCO PREVENTION AND CONTROL) (FORMERLY FHM - BUREAU OF HEALTH - TOBACCO PREVENTION AND CONTROL 011-10A-0953-02)										
Pos. - Leg.		(6.000)	(6.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)
Pers. Serv.		485,716	500,277	421,714	433,766	429,777	455,616	461,328	471,236	480,330	497,608
All Other		5,821,987	5,821,987	3,824,805	3,825,247	8,825,247	8,825,247	3,825,247	11,325,247	11,325,247	11,325,247
Program Total		6,307,703	6,322,264	4,246,519	4,259,013	9,255,024	9,280,863	4,286,575	11,796,483	11,805,577	11,822,855
Annual % Increase		-1.71%	0.23%	-32.83%	0.29%	117.30%	0.28%	-53.81%	175.20%	0.08%	0.15%
024-10A-0143-31	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: FHM - SUBSTANCE ABUSE PREVENTION)										
All Other		0	0	777,504	777,504	777,504	777,504	777,504	777,504	777,504	777,504
Program Total		0	0	777,504	777,504	777,504	777,504	777,504	777,504	777,504	777,504
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
024-10A-0143-26	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: COMMUNITY/ SCHOOL GRANTS & STATEWIDE COORDINATION) (FORMERLY FHM - BUREAU OF HEALTH - COMMUNITY/SCHOOL GRANTS 011-10A-0953-07)									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	204,118	212,539	256,270	262,731	272,447	286,307	295,591	298,900	308,406	313,114
All Other	4,781,144	4,781,144	1,750,939	2,351,108	2,511,108	2,511,108	2,511,108	2,511,108	2,511,108	2,511,108
Program Total	4,985,262	4,993,683	2,007,209	2,613,839	2,783,555	2,797,415	2,806,699	2,810,008	2,819,514	2,824,222
Annual % Increase	-0.67%	0.17%	-59.81%	30.22%	6.49%	0.50%	0.33%	0.12%	0.34%	0.17%
024-10A-0143-27	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: PUBLIC HEALTH INFRASTRUCTURE) (FORMERLY FHM - PUBLIC HEALTH INFRASTRUCTURE 011-10A-0953-08)									
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(7.000)	(7.000)	(7.000)	(7.000)	(8.000)	(8.000)
Pers. Serv.	544,187	714,255	524,984	545,296	1,270,949	1,356,042	606,688	623,348	766,294	784,245
All Other	1,990,109	1,944,926	1,638,542	1,594,225	2,057,483	2,237,980	2,237,980	2,237,980	2,244,581	2,244,585
Program Total	2,534,296	2,659,181	2,163,526	2,139,521	3,328,432	3,594,022	2,844,668	2,861,328	3,010,875	3,028,830
Annual % Increase	86.91%	4.93%	-18.64%	-1.11%	55.57%	7.98%	-20.85%	0.59%	5.23%	0.60%
024-10A-0143-28	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: DONATED DENTAL) (FORMERLY FHM - DONATED DENTAL 011-10A-0958-01)									
All Other	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463
Program Total	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0545-04	HEAD START (FORMERLY FHM - HEAD START 011-10A-0959-01)									
All Other	1,929,580	1,929,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580
Program Total	1,929,580	1,929,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580
Annual % Increase	42.45%	0.00%	-29.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0147-01	MEDICAL CARE - PAYMENTS TO PROVIDERS (FORMERLY FHM - MEDICAL CARE 011-10A-0960-01)									
All Other	25,901,244	26,036,930	31,036,930	31,036,930	31,036,930	27,118,732	25,618,328	26,261,358	31,028,356	32,022,910
Program Total	25,901,244	26,036,930	31,036,930	31,036,930	31,036,930	27,118,732	25,618,328	26,261,358	31,028,356	32,022,910
Annual % Increase	-6.39%	0.52%	19.20%	0.00%	0.00%	-12.62%	-5.53%	2.51%	18.15%	3.21%
024-10A-0228-01	PURCHASED SOCIAL SERVICES (FORMERLY FHM - PURCHASED SOCIAL SERVICES 011-10A-0961-01)									
All Other	1,971,118	1,971,118	1,971,118	1,971,118	4,471,118	4,471,118	1,971,118	1,971,118	1,971,118	1,971,118
Program Total	1,971,118	1,971,118	1,971,118	1,971,118	4,471,118	4,471,118	1,971,118	1,971,118	1,971,118	1,971,118
Annual % Increase	0.00%	0.00%	0.00%	0.00%	126.83%	0.00%	-55.91%	0.00%	0.00%	0.00%

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

		2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
024-10A-0202-01	LOW-COST DRUGS TO MAINE'S ELDERLY (FORMERLY FHM - DRUGS OF THE ELDERLY AND DISABLED 011-10A-Z015-01)										
All Other		6,217,798	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095
Program Total		6,217,798	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095
Annual % Increase		-9.86%	-2.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-Z202-41	OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED (FORMERLY OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED 024-14G-0844-01)										
All Other		1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,141,178	1,078,041	1,105,099	1,305,698	1,347,550
Program Total		1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,141,178	1,078,041	1,105,099	1,305,698	1,347,550
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	-12.62%	-5.53%	2.51%	18.15%	3.21%
024-10A-Z199-01	OFFICE OF SUBSTANCE ABUSE (FORMERLY OFFICE OF SUBSTANCE ABUSE 024-14G-0679-01)										
All Other		1,848,306	1,848,306	1,070,802	1,070,802	1,698,223	2,075,644	1,070,802	1,070,802	1,070,802	1,070,802
Program Total		1,848,306	1,848,306	1,070,802	1,070,802	1,698,223	2,075,644	1,070,802	1,070,802	1,070,802	1,070,802
Annual % Increase		0.00%	0.00%	-42.07%	0.00%	58.59%	22.22%	-48.41%	0.00%	0.00%	0.00%
024-10A-Z199-02	OFFICE OF SUBSTANCE ABUSE (FORMERLY OFFICE OF SUBSTANCE ABUSE 024-14G-0679-01)										
All Other		0	0	0	0	2,000,000	3,500,000	1,000,000	1,000,000	0	0
Program Total		0	0	0	0	2,000,000	3,500,000	1,000,000	1,000,000	0	0
Annual % Increase		0.00%	0.00%	0.00%	0.00%	100.00%	75.00%	-71.43%	0.00%	-100.00%	0.00%
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)											
Pos. - Leg.		**(7.000)**	**(7.000)**	**(6.000)**	**(6.000)**	**(12.000)**	**(12.000)**	**(12.000)**	**(12.000)**	**(13.000)**	**(13.000)**
Pers. Serv.		**1,234,021**	**1,427,071**	**1,202,968**	**1,241,793**	**1,973,173**	**2,097,965**	**1,363,607**	**1,393,484**	**1,555,030**	**1,594,967**
All Other		**52,103,808**	**52,058,608**	**51,149,837**	**51,706,131**	**62,456,810**	**60,431,649**	**47,863,266**	**56,033,354**	**60,007,552**	**61,043,962**
Dept. Total		**53,337,829**	**53,485,679**	**52,352,805**	**52,947,924**	**64,429,983**	**62,529,614**	**49,226,873**	**57,426,838**	**61,562,582**	**62,638,929**
Annual % Increase		**-3.47%**	**0.28%**	**-2.12%**	**1.14%**	**21.69%**	**-2.95%**	**-21.27%**	**16.66%**	**7.20%**	**1.75%**

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
MAINE STATE HOUSING AUTHORITY										
024-99H-Z267-01 LEAD ABATEMENT FUND										
All Other	0	0	0	4,000,000	0	0	0	0	0	0
Program Total	0	0	0	4,000,000	0	0	0	0	0	0
Annual % Increase	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MAINE STATE HOUSING AUTHORITY										
All Other	**0**	**0**	**0**	**4,000,000**	**0**	**0**	**0**	**0**	**0**	**0**
Dept. Total	**0**	**0**	**0**	**4,000,000**	**0**	**0**	**0**	**0**	**0**	**0**
Annual % Increase	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**-100.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
GRAND TOTALS - ALL DEPARTMENTS										
Pos. - Leg.	**(8.000)**	**(8.000)**	**(7.000)**	**(7.000)**	**(13.000)**	**(13.000)**	**(13.000)**	**(13.000)**	**(14.000)**	**(14.000)**
Pers. Serv.	**1,350,621**	**1,545,611**	**1,324,733**	**1,369,310**	**2,113,999**	**2,245,185**	**1,473,372**	**1,508,547**	**1,699,269**	**1,746,735**
All Other	**52,686,810**	**55,639,696**	**51,730,925**	**56,287,219**	**63,039,130**	**61,013,969**	**48,445,890**	**56,615,978**	**60,592,468**	**61,628,878**
Grand Total	**54,037,431**	**57,185,307**	**53,055,658**	**57,656,529**	**65,153,129**	**63,259,154**	**49,919,262**	**58,124,525**	**62,291,737**	**63,375,613**
Annual % Increase	**-3.45%**	**5.83%**	**-7.22%**	**8.67%**	**13.00%**	**-2.91%**	**-21.09%**	**16.44%**	**7.17%**	**1.74%**

Notes:

[1]FHM programs and allocations have been modified to reflect the transfer of all FORMERLY BDS funding to new accounts in the FORMERLY DHS Department.

Appendix C

Fund for a Healthy Maine Summary Table

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2023 FORECAST

Source	FY19 Actual	% Chg.	FY20 Actual	% Chg.	FY21 Actual	% Chg.	FY22 Actual	% Chg.	FY23 Budget	% Chg.	Recom. Chg.	FY23 Revised	% Chg.
Tobacco Settlement Payments:													
- Base Payments	45,465,742	-2.6%	46,272,664	1.8%	48,584,349	5.0%	49,858,288	2.6%	48,227,310	-3.3%	4,006,743	52,234,053	4.8%
- One-time DPA Settlements *	32,488,828	52.9%	0	-100.0%	0	N/A	0	N/A	0	N/A	0	0	N/A
- Strategic Contribution Payments **	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	0	N/A
Subtotal TSPs	77,954,570	14.8%	46,272,664	-40.6%	48,584,349	5.0%	49,858,288	2.6%	48,227,310	-3.3%	4,006,743	52,234,053	4.8%
Casino Revenue ***	3,640,004	-1.09%	2,773,875	-23.79%	3,376,375	21.7%	4,446,875	31.7%	4,776,003	7.4%	(147,190)	4,628,813	4.1%
Income from Investments	583,469	298.5%	496,816	-14.9%	115,798	-76.7%	160,121	38.3%	613,583	283.2%	84,525	698,108	336.0%
Other Adjustments ****	0	N/A	0	N/A	(994,035)	N/A	272,464	127.4%	0	-100.0%	0	0	-100.0%
Total - FHM Revenue	**82,178,042**	**14.6%**	**49,543,354**	**-39.7%**	**51,082,487**	**3.1%**	**54,737,748**	**7.2%**	**53,616,896**	**-2.0%**	**3,944,078**	**57,560,974**	**5.2%**

* FY 18 and 19 include a “one-time” settlement payment from tobacco manufacturers to settle the NPM Adjustment dispute for the years 2004 through 2017.

** Beginning in FY 18, the ten-year strategic contribution payment ended with the funding nationally for this purpose returned to the regular distribution pool.

*** Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the Hollywood Casino in Bangor designated for the Fund for a Healthy Maine.

****Adjustments for prior year balances forward and audit settlements

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2023 FORECAST

Source	FY24 Budget	% Chg.	Recom. Chg.	FY24 Revised	% Chg.	FY25 Budget	% Chg.	Recom. Chg.	FY25 Revised	% Chg.
Tobacco Settlement Payments:										
- Base Payments	34,725,954	-28.0%	0	34,725,954	-33.5%	32,277,028	-7.1%	0	32,277,028	-7.1%
- One-time DPA Settlements *	0	N/A	0	0	N/A	0	N/A	0	0	N/A
- Strategic Contribution Payments **	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Subtotal TSPs	34,725,954	-28.0%	0	34,725,954	-33.5%	32,277,028	-7.1%	0	32,277,028	-7.1%
Casino Revenue ***	5,157,870	8.0%	163,367	5,321,237	15.0%	5,157,921	0.0%	163,369	5,321,290	0.0%
Income from Investments	745,802	21.5%	38,191	783,993	12.3%	329,402	-55.8%	22,623	352,025	-55.1%
Other Adjustments ****	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**40,629,626**	**-24.2%**	**201,558**	**40,831,184**	**-29.1%**	**37,764,351**	**-7.1%**	**185,992**	**37,950,343**	**-7.1%**
Change in Biennial Totals								**387,550**		

* FY 18 and 19 include a “one-time” settlement payment from tobacco manufacturers to settle the NPM Adjustment dispute for the years 2004 through 2017.

** Beginning in FY 18, the ten-year strategic contribution payment ended with the funding nationally for this purpose returned to the regular distribution pool.

*** Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the Hollywood Casino in Bangor designated for the Fund for a Healthy Maine.

****Adjustments for prior year balances forward and audit settlements

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2023 FORECAST

Source	FY26 Budget	% Chg.	Recom. Chg.	FY26 Revised	% Chg.	FY27 Budget	% Chg.	Recom. Chg.	FY27 Revised	% Chg.
Tobacco Settlement Payments:										
- Base Payments	32,277,028	0.0%	0	32,277,028	0.0%	32,277,028	0.0%	0	32,277,028	0.0%
- One-time DPA Settlements *	0	N/A	0	0	N/A	0	N/A	0	0	N/A
- Strategic Contribution Payments **	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Subtotal TSPs	32,277,028	0.0%	0	32,277,028	0.0%	32,277,028	0.0%	0	32,277,028	0.0%
Casino Revenue ***	5,157,973	0.0%	163,370	5,321,343	0.0%	5,158,025	0.0%	163,371	5,321,396	0.0%
Income from Investments	329,402	0.0%	(103,867)	225,535	-35.9%	329,402	0.0%	(171,757)	157,645	-30.1%
Other Adjustments ****	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**37,764,403**	**0.0%**	**59,503**	**37,823,906**	**-0.3%**	**37,764,455**	**0.0%**	**(8,386)**	**37,756,069**	**-0.2%**
Change in Biennial Totals								**51,117**		

* FY 18 and 19 include a “one-time” settlement payment from tobacco manufacturers to settle the NPM Adjustment dispute for the years 2004 through 2017.

** Beginning in FY 18, the ten-year strategic contribution payment ended with the funding nationally for this purpose returned to the regular distribution pool.

*** Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the Hollywood Casino in Bangor designated for the Fund for a Healthy Maine.

****Adjustments for prior year balances forward and audit settlements

STATE OF MAINE
127th LEGISLATURE
FIRST REGULAR SESSION

Joint Standing Committee on Health and Human Services

Study of Allocations of the Fund for a Healthy Maine

December 2015

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Executive Summary

The Joint Standing Committee on Health and Human Services (herein referred to as "the Committee") was authorized by the Maine Legislature to study allocations of the Fund for a Healthy Maine through the passage of Resolve 2015, chapter 47.[1] The bill that authorized the study, LD 905, was presented to the Legislature in response to recommendations of the 2011 Commission to Study Allocations of the Fund for a Healthy Maine. The 2011 Commission recommended the creation of a permanent commission to review the allocations of the Fund for a Healthy Maine (FHM) every four years but the recommendation was not enacted by the Legislature in 2012. However, the Committee, while considering LD 905, determined that another review of FHM allocations was appropriate but recommended that the Committee undertake it rather than a commission. Resolve 2015, chapter 47 directed the Committee to review the alignment of allocations from the FHM and report its findings and recommendations, including suggested legislation, for presentation to the Second Regular Session of the 127th Legislature. Specifically, the resolve directed the Committee to gather information and data from public and private entities as necessary to:

1. Identify or review the State's current public health care and preventative health priorities and goals;
2. Identify or review strategies for addressing priorities and goals and potential effectiveness of those strategies;
3. Assess the level of resources needed to properly pursue the strategies identified above;
4. Make recommendations for how FHM funds should be allocated to most effectively support the State's current public health and preventative health priorities, goals and strategies; and
5. Make recommendations for processes to be used to ensure that FHM allocations stay aligned with the State's health priorities and goals.

The Committee conducted four public meetings in the fall of 2015 to review the FHM allocations. Personnel from the Department of Health and Human Services (DHHS) did not attend any of these Committee meetings which made it difficult for the Committee to determine specific findings on which to base recommendations. In order to complete their duties, the Committee relied on three information sources. The Legislature's Office of Fiscal and Program Review (OFPR) provided overall revenue and allocation information. Contractors and vendors who contract with the State using FHM allocations briefed the Committee on their activities. These presentations were limited to those contractors and vendors who were aware that the study was taking place and were available and willing to brief the Committee. DHHS provided written presentations including some that had been previously provided to the Legislature in a different forum. The following recommendations were made unanimously by those Committee members present at the final meeting.[2]

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[1] See Appendix A for Resolve 2011, chapter 47.

[2] Nine members of the Committee were present at the final meeting; one absent member of the committee added his support to the unanimous recommendations.

1. **No recommendation to change allocations to the FHM.** The Committee makes no recommendation to change the allocations that currently go to FHM programs. Committee members are not in a position to recommend any changes to programs due to a lack of available information on how FHM funding is currently spent.

2. **Annual report from the Department of Health and Human Services on the FHM.** Require the Department to submit an annual report on the FHM to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs that is similar to the 2008 report of DHHS, "Challenges, results: an overview of Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention, Tobacco Settlement Fund (Fund for a Healthy Maine) allocations SFY 08 and SFY09."

   The report should include the following information:

   - Detailed spending of FHM funding showing annual expenditures on each program;
   - Progress that DHHS is making towards the health priorities contained in the Maine State Health Improvement Plan 2013-2017 (SHIP);
   - Any information regarding audits conducted in the previous year by DHHS, the Department of Administrative and Financial Services (DAFS) or the Office of the State Auditor of programs funded using FHM funding either directly by executive departments or through contracts with vendors. This includes summary information, frequency of audits, the level of detail of audits, how often an agency or vendor is out of compliance and how often corrective action plans are developed and applied; and
   - Data submitted to DAFS pursuant to Public Law 2011, chapter 701 that provides a description of how FHM funds in the prior state fiscal year were targeted to the prevention and health-related purposes listed in Title 22, section 1511, subsection 6.

   As part of this recommendation, the Committee believes it would be useful to examine the list of reports due to the Committee from DHHS and repeal any requirements for existing reports that are not helpful to the Legislature (with a minimum of two reports to be eliminated). The Committee does not wish to increase the number of reports DHHS compiles absent a compelling reason.

3. **Support the task on the Office of Program Evaluation and Government Accountability work plan to study the Department of Health and Human Services auditing functions.** Send a letter to the Government Oversight Committee expressing support for the Office of Program Evaluation and Government Accountability's planned work to study the effectiveness of the audit functions in DHHS for identifying and addressing fraud, waste and abuse in programs administered by DHHS. The letter will also convey the Committee's conversations about auditing specifically related to FHM funding.

4. **Fully implement certain provisions from the 2011 Commission.** Send a letter to the Commissioner of Administrative and Financial Services requesting an update on the progress implementing certain provisions of Public Law 2011, chapters 617 and 701. Section 2 of Public Law 2011, chapter 617 requires DAFS to create a separate budget entry or new account for prevention, education and treatment activities concerning unhealthy weight and obesity. Section 2 of Public Law 2011, chapter 701 enacted Title 22, section 1511, subsection 13 requiring state agencies, contractors and vendors receiving funding from the FHM to describe how those funds were targeted to the prevention and health promotion purposes listed in Title 22, section 1511, subsection 6.

5. **Issue a statement of support regarding the principles of the FHM statute for the expenditure of the State's Master Settlement Agreement dollars.** The Committee recommends issuing a statement of support for the principles of the FHM statute. Specifically, the Committee supports the State's use of Master Settlement Agreement dollars from tobacco companies through the FHM for prevention and health promotion purposes. The Committee also reinforces support for the provision in the statute that requires FHM dollars to be used to supplement, not supplant, appropriations from the General Fund.

6. **Request regular updates for information from the Department of Health and Human Services on the Request for Proposals that are expected to be issued in the near future for Healthy Maine Partnership contracts.** Send a letter to DHHS requesting regular updates during session for information in order to keep the Committee apprised of the progress and content of the Requests for Proposals that will be issued in the near future for Healthy Maine Partnership contracts, replacing those that will end on June 30, 2016.

I. INTRODUCTION

Tobacco Master Settlement

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

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

Fund for a Healthy Maine

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

Expenditures from the FHM must be authorized by the Legislature in budget bills and other bills. Since 2012, the FHM is its own fund and is no longer an Other Special Revenue fund. Expenditures are made through spending decisions called allocations. Allocations from the FHM are subject to four statutory provisions contained in Title 22, section 1511.

- Subsection 4 requires allocations to be used to supplement, not supplant, appropriations from the General Fund.

- Subsection 5 requires specific legislative approval to change the source of funding for a program or activity funded from the FHM.
- Subsection 6 limits the purposes for which allocations may be made to a list of nine 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;
    - A-1. Prevention, education and treatment activities concerning unhealthy weight and obesity;
    - B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;
    - C. Child care for children up to 15 years of age, including after-school care;
    - D. Health care for children and adults, maximizing to the extent possible federal matching funds;
    - E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds;
    - F. Dental and oral health care to low-income persons who lack adequate dental coverage;
    - G. Substance abuse prevention and treatment; and
    - H. Comprehensive school health and nutrition programs, including school-based health centers.
- Subsection 12, requires that beginning in state fiscal year 2009, the State Budget Officer review programs receiving funds and adjust downward funding in the All Other line category if actual revenue collections for the FHM for the fiscal year are less than allocations approved by the Legislature. The State Budget Officer is required to calculate reductions for all programs with All Other allocations in proportion to the All Other allocations of all funded programs. Following the recommendation of the State Budget Officer and approval by the Governor, the allocations of all programs with All Other allocations must then be reduced by financial order. The law requires the State Budget Officer to report by May 15th each year on allocation adjustments made under the law to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services.
- Subsection 13 requires state agencies, contractors and vendors that receive funding allocated from the fund to maintain the money in a separate account and report annually to the Commissioner of DAFS with a description of how the funds were targeted to prevention and the health promotion purposes in subsection 6.

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

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

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

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

1. The Government Oversight Committee (GOC) be requested to authorize the Office of Program Evaluation and Governmental Accountability (OPEGA) to review the efficacy, efficiency and accountability of the programs and expenditures funded from the FHM and compare the degree to which preventive health is prioritized in the expenditure of tobacco settlement dollars in Maine and other states. On October 2, 2008 Senator Joseph Brannigan and Representative Anne Perry, co-chairs of the Committee, sent a letter to Beth Ashcroft, Director of OPEGA, requesting the reviews recommended by the Committee. In response to this letter, OPEGA performed a review entitled "Fund for a Healthy Maine Programs – Frameworks Adequate for Ensuring Cost-Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved."[3]
2. The 124th Legislature establish a FHM subcommittee, consisting of three members of the Joint Standing Committee on Health and Human Services and two members of the Joint Standing Committee on Appropriations and Financial Affairs. The subcommittee would jointly discuss all budget proposals and work together to begin fiscal planning for the eventual end to the portion of the tobacco settlement payments designated as "strategic contribution payments." The Joint Standing Committee on Appropriations and Financial Affairs of the 124th Legislature considered this recommendation and the Legislature did not establish a subcommittee.
3. A new Joint Rule be established for the 124th Legislature to provide for review of all proposed FHM allocations and deallocations and all proposed changes in the law governing the fund and its governing statutes. On January 15, 2009, the Maine House of Representatives and Maine Senate, as recommended and adopted by the Joint Select Committee on Joint Rules, adopted Joint Rule 317. Joint Rule 317 requires the committee having jurisdiction over a proposal that affects the FHM or funding from the fund to hold a public hearing on the proposal and to determine the level of support for the proposal within the committee of jurisdiction. If a majority of the Committee

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

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

Office of Program Evaluation and Governmental Accountability Reports

As requested in the letter from Senator Joseph Brannigan and Representative Anne Perry, co-chairs of the Health and Human Services Committee in the 123rd Legislature, the GOC authorized OPEGA to conduct reviews of state prioritization of preventive health and the efficacy, efficiency and accountability of the programs and expenditures funded from the FHM. OPEGA performed two reviews and issued two reports to the GOC as described below.

In performing the first review requested by the GOC, OPEGA utilized past studies conducted by the U.S. Government Accountability Office and received survey responses from 33 states that receive tobacco master settlement agreement funds. The first report, "Fund for a Healthy Maine Programs: A Comparison of Maine's Allocations to Other States and a Summary of Programs," was completed by OPEGA and presented to the GOC in March 2009.[4] This first report includes an inventory of programs funded from the FHM, lists their State budget account numbers and the agencies responsible for the programs and describes the program activities. The report includes a comparison of spending on preventive health services and concludes with the following statements: "Maine has consistently prioritized preventive health services more than other states … allocating 99.8% in 2005 and 99.7% in 2009. In 2005, the other 33 states reviewed allocated an average of 54% of their TMSA funds to preventive health services and an average of just 45% in 2009. Nine of the 33 states reviewed allocated none of their settlement funds to preventive health services in 2009."

The second review undertaken by OPEGA for the GOC studied the efficacy, efficiency and accountability of programs and expenditures funded from the FHM, and resulted in the report entitled "Fund for a Healthy Maine Programs – Frameworks Adequate for Ensuring Cost Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved" which was released in October 2009.[5] In this report, OPEGA focused on whether existing managerial and oversight systems are adequate to help ensure that activities funded by the FHM are cost-effective and carried out economically and efficiently and have sufficient transparency and accountability. In performing the review for this report OPEGA reviewed in depth four programs funded from the FHM: Community/School Grants; Public Health Infrastructure; Tobacco Prevention and Control; and Substance Abuse. OPEGA concluded that the programs do have defined purposes and stated goals for activities that generally align with the program purposes and that responsible agency managers are working to maximize effectiveness, that performance measures are used and that frameworks for managing cost-effectiveness are reasonably adequate. OPEGA noted that meaningful conversations about cost-effectiveness are challenged by reluctance to deviate from the original funding agreement, inability to place responsibility for the FHM in one State entity, lack of activity level financial

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

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

and performance data, unclear budgetary descriptions and lack of alignment between budgetary programs and their activities and financial and performance information. The OPEGA recommendations in the October 2009 report include the following.

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

The Commission to Study Allocations of the Fund for a Healthy Maine

Resolve 2011, chapter 112 established the Commission to Study Allocations of the Fund for a Healthy Maine. This 13-member study commission was directed to review the alignment of allocations from the Fund for a Healthy Maine and report its findings and recommendations to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services. The report was completed in December 2011 with the following unanimous recommendations:[6]

1. Change the FHM to a separate fund from a group of programs within Other Special Revenue;
2. Include health promotion and prevention of obesity to the list of health-related purposes within the FHM law;
3. Require contractors, vendors and state agencies receiving funding from the FHM to maintain separate accounts for the funding and submit annual reports with descriptions of how FHM funds were targeted to the prevention and health promotion purposes specified in the law. The Commissioner of Administrative and Financial Services shall compile the annual reports and forward them to the Legislature;
4. Require the enactment of Joint Rule 317 in the FHM statute. Joint Rule 317 requires the review by the Health and Human Services Committee of any bill with majority support in another committee that affects the FHM;
5. Establish a study commission to review allocations of the FHM beginning in 2015 and every four years thereafter. The composition and duties of the commission would mirror those under Resolve 2011, chapter 112;

[6] In addition to the unanimous recommendations of the Commission, there were two minority report recommendations: (1) Shift FHM funding for family planning services to the child care subsidy program and consider a Medicaid State Plan amendment for family planning services with enhanced federal financial participation; and (2) Raise tobacco and alcohol taxes and direct the revenues to substance abuse prevention, education and treatment services.

6. Direct the Commissioner of Administrative and Financial to review program structure for FHM programs and recommend a new program structure, including a program for overweight and obesity prevention, education and treatment beginning in state fiscal year 2014-15;
7. Issue a statement of support for the funding of continued enforcement by the Office of the Attorney General; and
8. Issue a statement of support for investments in public health and prevention and for the original intent of the funding and for efforts to be made to eliminate health disparities.

During the second regular session of the 125th Legislature, two laws were enacted implementing several of the recommendations of the Commission:

1. Public Law 2011, chapter 617 (from LD 1855) enacted recommendations (2) and (6) above. "Prevention, education and treatment activities concerning unhealthy weight and obesity" was added to the prevention and health promotion purposes in Title 22, section 1511, subsection 6. It does not appear that a separate account was ever established for this health purpose as required by this law; and
2. Public Law 2011, chapter 701 (from LD 1884) enacted recommendations (1), (3) and (4). It established the FHM as a separate fund; required separate accounting by agencies, vendors, and contractors, and separate reporting on how FHM funding is targeted to prevention and health promotion purposes; and enacted Joint Rule 317 into the FHM statute. LD 1884 had also included recommendation (5) establishing a permanent study commission but this was removed on the study table and enacted without this language.

The final two recommendations did not require legislative language.

Health and Human Services Committee Study of the Allocations of the Fund for a Healthy Maine, 2015

Resolve 2015, chapter 47 directed the Health and Human Services Committee to study the allocations of the Fund for a Healthy Maine. LD 905 was sponsored by Rep. Roberta Beavers. The original language was modeled on the recommendation from the 2011 commission and LD 1884, as a permanent on-going commission in statute requiring a review of the FHM allocations every four years. During its consideration of LD 905, the Committee amended the bill with a resolve that directed the Committee to examine the FHM allocations with the duties remaining the same. The resolve was finally passed by the Legislature on June 30, 2015. It became law without the Governor's signature on July 7, 2015. The resolve directs the Committee to gather information and data from public and private entities as necessary to:

1. Identify or review the State's current public health care and preventative health priorities and goals;
2. Identify or review strategies for addressing priorities and goals and potential effectiveness of those strategies;
3. Assess the level of resources needed to properly pursue the strategies identified above;

4. Make recommendations for how FHM funds should be allocated to most effectively support the State's current public health and preventative health priorities, goals and strategies; and
5. Make recommendations for processes to be used to ensure that FHM allocations stay aligned with the State's health priorities and goals.

II. COMMITTEE PROCESS

The Joint Standing Committee on Health and Human Services was authorized to conduct four public meetings during the fall of 2015 to study the allocations of the FHM. The Legislature received a letter from the Governor's office that required any legislative committee to submit a letter to the Governor's office with any requests for executive personnel to attend any legislative meeting as well as questions in writing for which the Committee required answers. The Committee complied with the Governor's request prior to the first three meetings (there was no request for the fourth meeting). However, no personnel from DHHS attended any of the Committee meetings (although written responses to the Committee's questions were received). Lack of full participation by some agencies that administer the FHM made it difficult for the Committee to determine specific findings on which to base recommendations. The Committee relied on three information sources. The Legislature's OFPR provided overall revenue and allocation information. Contractors and vendor who contract with the State using FHM allocations briefed the Committee on their activities. These presentations were limited to those contractors and vendors who were aware that the study was taking place and were available and willing to brief the Committee. DHHS provided written presentations including some that had been previously provided to the Legislature in a different forum.

Meeting One

The first meeting took place on September 28, 2015. The Committee reviewed the resolve, the Fund for a Healthy Maine law in Title 22, Maine Revised Statutes, section 1511, and the previous studies of the FHM including those undertaken by OPEGA and the 2011 Commission to Study the Allocations of the Fund for a Healthy Maine.

Luke Lazure, the Committee's fiscal analyst from the Office of Fiscal and Program Review, briefed the Committee on the revenues and allocations of the FHM for state fiscal years 2016 and 2017 and provided a historical perspective for spending since the fund was enacted in 2000. Mr. Lazure's historical document is included as Appendix B.

The Committee was briefed by Christopher Taub, Assistant Attorney General, regarding the legal background of the tobacco master settlement agreement and current litigation. Mr. Taub explained that Maine had been found to be diligently enforcing the escrow accounts from nonparticipating manufacturers in the Master Settlement Agreement for 2003 resulting in the state receiving approximately $5.5 million in 2014.[7] Six states were found not diligent and those states lost their payment and it was reallocated to other states. Accounts from 2004 onward are

[7] There is currently a 12 year delay for litigation related to diligent enforcement of the master settlement agreement.

still in dispute and the states are now in the process of determining the outcome for the 2004 escrow accounts.

The Office of the Attorney General was allocated $138,142 in state fiscal year 2016 and $138,168 in state fiscal year 2017 from the FHM to enable an Assistant Attorney General to do the legal work related to the tobacco master settlement agreement. In addition, a paralegal is employed to work on tobacco master settlement agreement issues funded by the General Fund. Members of the Committee had a number of questions related to the costs of arbitration of diligent enforcement. Mr. Taub explained that the states involved share the costs of the arbitrators and Maine contributes to that proportionately. Maine began incurring costs related to the 2003 arbitration proceeding in the summer of 2010 until the spring of 2013. Maine incurred approximately $169,000 in costs over that period. The costs were due to: fees charged by the arbitrators; contributions to a fund established on the part of participating states to pay various common expenses such as rental of arbitration space, audiovisual equipment and document management costs; travel expenses; and court reporter fees. Of the $169,000, approximately $65,000 was paid with FHM funding and the remainder was paid for with other Attorney General funds.

The Committee submitted written questions based on the duties in the Resolve, as well as a request for attendance by key members of the Maine Center for Disease Control and Prevention, to the Governor's office. DHHS submitted written testimony on the six priorities contained in Maine's 2013-2017 State Health Improvement Plan (SHIP) and the alignment of FHM appropriations with those goals from two programs: Community School Grants and Statewide Coordination; and Tobacco Prevention and Control. This testimony on the SHIP is included as Appendix C.

Tina Pettingill from the Maine Public Health Association and Lance Boucher from the American Lung Association of the Northeast, representing the Friends for a Fund for a Healthy Maine, presented an overview of the FHM program. Ms. Pettingill and Mr. Boucher stressed the importance to the Friends of reducing tobacco use and obesity. They stated that tobacco use is a major preventable cause of premature death and disease worldwide and argued that tobacco is a winnable battle. They outlined the extent of tobacco use in Maine and improvements in the levels of youth smoking. In addition, Ms. Pettingill and Mr. Boucher also outlined the historical uses for the FHM particularly for preventative programs including for school based health centers, the public health infrastructure, oral health, teen pregnancy, child care and home visiting. They stated that prevention is an investment that provides a return on investment of at least $7.50 for each $1 spent from FHM prevention programs. The presentation included a bar graph that showed the changes in purposes for allocations of FHM from 2008-2009 to 2014-15. This presentation is included as Appendix D.

Meeting Two

The second meeting of the Committee took place on October 13, 2015. At this meeting, Commissioner Rosen of DAFS briefed the Committee on the progress of the implementation of Public Law 2011, chapter 701. As noted above, section 1 of that law required that the FHM be established as a separate and distinct fund for accounting and budgetary purposes. Prior to

Public Law 2011, chapter 701, section 1 becoming effective, the FHM funds were recorded as Other Special Revenue funds. Budget documents using a FHM fund account rather than an OSR fund account began in 2013 for SFY 2014.

Commissioner Rosen presented DAFS's first report required by Public Law 2011, chapter 701, section 2. That section of law enacted Title 22, section 1511, subsection 13 requiring a state agency receiving FHM allocations or a contractor or vendor receiving FHM allocations to maintain the money in a separate account and report by September 1st of each year to the Commissioner of DAFS providing a description of how those funds in the prior state fiscal year were targeted to the prevention and health-related purposes listed in Title 22 section 1511, subsection 6. The Commissioner would forward this report to the Legislature. On October 1, 2015, the Commissioner of DAFS produced the first report under subsection 13 for FHM expenditures in state fiscal year 2015. The report included expenditures from state agencies but not from contractors and vendors. The report is included as Appendix E.[8]

Luke Lazure from OFPR reorganized the existing OFPR expenditure chart within the health purposes categories, as much as possible. For example, although subsection 6-A and 6-A-1 separate smoking prevention from obesity prevention, the accounting system does not separate these two health purposes. In response to questions from committee members, Mr. Lazure stated that it should be possible to match the numbers from DAFS and OFPR. In general, the numbers match when expenditures are compared with expenditures and budgeted numbers are compared with budgeted numbers. So although it may appear that MaineCare and the Drugs for the Elderly program amounts are different in the two documents, there is not a disagreement on the reality of the numbers.

The Committee reviewed the written documents delivered by DHHS. DHHS stated that the State Health Improvement Plan (SHIP) outlines the state's current health priorities and goals. The SHIP and the implementation plan are both available on the Maine CDC's website: http://www.maine.gov/dhhs/mecdc/ship/. In particular, Committee members had questions about how FHM funding that went to MaineCare is used. DHHS stated that the funding is transferred directly to Medicaid to be used to fund Medicaid reimbursable services.

In response to Committee questions, DAFS outlined the process of contracting because much of the FHM funding is allocated through contracts with vendors. DHHS stated that contracting is a shared process between programs and the Maine Department of Health and Human Services, Division of Contract Management. They provide contractual oversight of agreements including contract language and budget development. Management tools are provided for recording agreement information and performance as well as technical assistance. The Department Agreement Administrator monitors the timeliness, completeness and accuracy of all financial expenditure reports, service delivery reports, performance-based contracting reports, and any other reports required in the agreement. Further specific information is available on the DHHS

[8] Please note that expenditure categories for subsections 6-D and 6-E have been transposed in the DAFS report. Subsection 6-D refers to MaineCare with expenditures of $27,846,495 in SFY 2015 and subsection 6-E refers to the Drugs for the Elderly program with expenditures of $7,286,781 including the Office of MaineCare Services and the Maine Center for Disease Control and Prevention.

website. The testimony provided by DHHS is available on the study website at: http://legislature.maine.gov/legis/opla/fhmstudy2015dhhsresponses.pdf.

The majority of the second meeting included presentations from contractors or vendors who currently receive FHM funding from DHHS.[9] The Committee requested the following information from those organizations that presented: how much funding was received, the services provided, any additional cost information, the number of people served, and any outcome data collected by the organization. All the testimony given is posted on the study website at: http://legislature.maine.gov/legis/opla/fhmstudy2015mtrls.htm.

The first health-related purpose for FHM funding outlined under Title 22, section 1511, subsection 6 is smoking prevention, cessation and control activities in paragraph A. The Committee received testimony from several programs focused on this issue. Laura Davis and Nikki Jarvais from Rinck (Partnership for a Tobacco Free Maine) presented on their counter-marketing campaigns to prevent, educate and reduce tobacco-use. Kenneth Lewis presented on behalf of the Center for Tobacco Independence which has the contract for the statewide tobacco treatment initiative. Beth Yvonne, on behalf of the Maine Youth Action Network, presented on their efforts to support youth engagement in tobacco and substance abuse prevention, health promotion and positive community change (including tobacco free ordinances) across Maine.

Melissa Fochesato, Director of Access Health and Jamie Comstock, Director of Bangor Public Health, presented information on the Healthy Maine Partnerships (HMPs). HMPs have a contract with DHHS to deliver tobacco, obesity and substance abuse prevention programming across the state (health-purposes outlined in paragraphs A, A-1 and G).[10] Work plans include statewide strategies such as free retail training to stores selling tobacco and SNAP education (through UNE) and tailored local strategies such as working with towns in Sagadahoc County to create smoke-free events or responding to the bath salts threat in the Bangor area. However, the menu of strategies provided by HMPs has decreased as budgets have decreased.

Rick McCarthy presented testimony for programs that focus on child care and development. He was asked a number of questions about the Head Start program that required follow-up information that Doug Orville brought to the third meeting. On behalf of the Maine Affordable Housing Coalition, Mr. McCarthy updated the Committee on the Part LLLL initiative contained in the 2016-17 biennial budget allocating funding for the hiring of additional lead inspectors using FHM funds. Prior to filling these positions, DHHS still needs to complete rulemaking and issue a Request for Proposals for the lead inspection work. Mr. McCarthy organized a presentation for the third meeting that focused on child care vouchers.

The majority of the FHM funding that goes to Title 22, section 1511, subsection 6, paragraph D goes into the MaineCare account. However, included in other health initiatives is funding to the

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[9] Not all FHM funding is dispensed through DHHS. For example, there is also funding to the Attorney General's Office as presented by Mr. Christopher Taub and funding through the Department of Education for specific programs such as the school breakfast program.

[10] The contract is included in the meeting materials on the study website: http://legislature.maine.gov/legis/opla/fhmstudy2015mtrls.htm In addition, follow up information was provided electronically and is also available on the study website.

Maine Area Health Education (AHEC) Network. Karen O'Rourke, the Director of the Network, presented information to the Committee on AHEC's mission to alleviate shortages of health professionals in rural and underserved communities of Maine by developing a career pipeline, providing clinical training experiences for students and supporting health professionals with continuing education and distance learning opportunities.

The Committee received testimony from several programs providing dental and oral health care. Ann Caron, of the Dental Lifeline Network and the Donated Dental Services Program, coordinates donated dental care to those in financial need and are particularly vulnerable. Lisa Kavanaugh, CEO of Community Dental, provided information on the subsidized dental care Community Dental provides at 5 dental centers around the state. Judy Feinstein, presented testimony on behalf of the Maine Oral Health Coalition (a broad-based statewide group of organizations and individuals), Sunrise Opportunities Oral Health Program and the Aroostook County Action Program. Ms. Feinstein stated that FHM supports school-based preventative oral care programs in elementary schools, health education programs, sealants, and a subsidy program to help offset the costs incurred by nonprofit clinics providing care to uninsured lower-income adults. Claude Roy and Bill Norbert presented on the FAME program that provides loans to needs based students for dental school and loan repayments to attract dentists to practice in underserved areas. The Committee also received written testimony from the Maine Dental Association supporting the Dental Lifeline Network and Maine CDC's School Oral Health Program which supports the Dental Sealant Program.

Pat Kimball, the president of the Maine Association of Substance Abuse Providers (MASAP), provided testimony on her organization's work in supporting prevention and treatment contracts with MASAP members. Members include the Mid-Coast Hospital's Addiction Resource Center, Crossroads, Catholic Charities Maine, Day One, Maine General Hospital, Aroostook Mental Health Center and Wellspring. These organizations provide residential substance abuse and co-occurring treatment services. In addition, MASAP has a braided contract (the total contract has different funding sources) with the Maine Alliance for Prevention of Substance Abuse for education programs for the Methamphetamine Watch Program. This program, as well as other prevention programs will no longer be offered due to the elimination of the contract.

Title 22, section 1511, subsection 6, paragraph H establishes school health and nutrition programs as a health-purpose for FHM. George Shaler presented testimony on the School Based Health Centers which are similar to a doctor's office within the school enabling students to stay at school while receiving health care services. Mr. Shaler is at the Muskie School at the University of Southern Maine, which conducts the evaluations of the School Based Health Centers.

Members of the Committee were concerned that the organizations that gave testimony were subject to scrutiny that those who did not attend the meeting, including those that were simply unaware of the meeting, were not subject to. Therefore, the Committee requested, through a letter to the Governor's office, a list of all contractors or vendors with funding from the FHM and a breakdown of all FHM funds spent directly by DHHS.

Meeting Three

The third meeting of the Committee took place on November 9, 2015. At this meeting, Luke Lazure referred back to a Committee request at the second meeting to compare the expenditure groupings presented in the DAFS report to the information presented by OFPR at the first meeting. Mr. Lazure stated that although the total expenditures between the two reports do match, the groupings cannot be linked. DHHS has additional information on the actual spending of each FHM dollar, via the contracts, and uses this information to group the expenditures. OFPR only has the titles of the allocations in the accounting system to group expenditures. Without more detail in the accounting system, this discrepancy will continue to exist. As in the past, OFPR will continue to compare expenditure totals and review the groupings for reasonableness.

The Committee received testimony from Doug Orville from Head Start who had not been available for the second meeting. He presented follow-up information related to outcomes. Mr. Orville stated that children who received Head Start are ready to learn by the time they arrive at kindergarten, have better high school and college graduation rates, are less likely to rely on welfare, are less likely to smoke as adults and are less likely to commit a crime as adults. He discussed the waitlist for Head Start positions in both early Head Start and Head Start programs, the impact of uncertain funding and sequestration on Head Start programs and the concern that new FHM funding in the 2016-2017 biennial budget had not resulted in amendments to their contract. Mr. Orville also noted that the list of contractors and vendors supplied by DHHS omitted Head Start.

DHHS provides child care funding through vouchers from the FHM of $1.9 million a year. Lori Moses presented testimony on the importance of early childhood education and quality child care as well as the impact on parents able to maintain stable employment. In the past, the federal government focused on parental employment but more recently the focus has been broadened to include the best interests of the child. Ms. Moses talked about reductions in reimbursement for quality child care and issues with eligible individuals struggling with administrative barriers such as proving eligibility, receiving inaccurate information, being unable to get calls returned and experiencing delays in payment.

Hilary Schneider, Director of Government Relations for the American Cancer Society Cancer Action Network, a leading member of the Friends of the FHM, raised questions and presented testimony to the Committee. She noted that it was unclear exactly what was included in the list of vendors provided by DHHS. Ms. Schneider stated that the list included vendors that had not appeared to have contracts with DHHS in several years, omitted other vendors, and included organizations such as the American Lung Association who had never received FHM funding. In addition, Ms. Schneider wanted to draw attention to the process of developing the SHIP. The Cancer Action Network, American Heart Association, American Stroke Association, the American Lung Association of the Northeast, the Maine Medical Association, the Maine Public Health Association and the Maine Osteopathic Association were all invited to participate in the development of the SHIP because of their expertise. All agreed that the document would be evidence-based. However, these organizations were upset with the process including the removal of goals that had been in the working documents from the final plan. The six

organizations removed their names from the final SHIP, and Ms. Schneider recommended that the Committee not rely on the SHIP for the health priorities duty laid out in the Resolve establishing the FHM study.

The Committee also heard from Raya Kouletsis of the Maine Alliance to Prevent Substance Abuse, Ed Miller a consultant for the American Lung Association, Representative Beavers (the sponsor of LD 905 that lead to Resolve 2015, chapter 47), and Vanessa Santorelli representing the Federally Qualified Health Centers. Ms. Santorelli informed the Committee that FQHCs had received a letter from the Immunization Program stating that adult influenza vaccines would no longer be provided free for adults who are uninsured or underinsured. This added an unexpected cost to centers that often have less than 30 days of cash on hand. She said they are currently working with the Maine CDC to try and remedy the situation.

The Committee decided at the end of the meeting that a reporting extension to December 15, 2015 would be requested. The Legislative Council approved the request on November 19.

Meeting Four

The fourth meeting of the Committee took place on November 30, 2015. At this meeting the Committee made the following unanimous recommendations (9-0 of those members present).[11]

III. RECOMMENDATIONS

1. **No recommendation to change allocations to the FHM.** The Committee makes no recommendation to change the allocations that currently go to FHM programs. Committee members are not in a position to recommend any changes to programs due to a lack of available information on how FHM funding is currently spent.

2. **Annual report from the Department of Health and Human Services on the FHM.** Require DHHS to submit an annual report on the FHM to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs that is similar to the 2008 DHHS report, "Challenges, results: an overview of Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention, Tobacco Settlement Fund (Fund for a Healthy Maine) allocations SFY 08 and SFY09." Suggested legislation to accomplish this recommendation is attached as Appendix F.

   The report should include the following information:

   - Detailed spending of FHM funding showing annual expenditures on each program;
   - Progress that DHHS is making towards the health priorities contained in the Maine State Health Improvement Plan 2013-2017 (SHIP);

[11] One absent member of the committee added his support to the unanimous recommendations.

- Any information regarding audits conducted in the previous year by DHHS, DAFS or the Office of the State Auditor of programs funded using FHM funding either directly by executive departments or through contracts with vendors. This includes summary information, frequency of audits, the level of detail of audits, how often an agency or vendor is out of compliance and how often corrective action plans are developed and applied; and
- Data submitted to DAFS pursuant to Public Law 2011, chapter 701 that provides a description of how FHM funds in the prior state fiscal year were targeted to the prevention and health promotion purposes listed in Title 22, section 1511, subsection 6.

As part of this recommendation, the Committee believes it would be useful to examine the list of reports due to the Committee from DHHS and repeal any requirements for existing reports that are not helpful to the Legislature (with a minimum of two reports to be eliminated). The Committee does not wish to increase the number of reports that DHHS compiles absent a compelling reason.

3. **Support the task on the OPEGA work plan to study the Department of Health and Human Services auditing functions.** Send a letter to the GOC expressing support of OPEGA's planned work to study the effectiveness of the audit functions in DHHS for identifying and addressing fraud, waste and abuse in programs administered by DHHS. The letter will also convey the Committee's conversations about auditing specifically related to FHM funding. The letter is included in Appendix G.

4. **Fully implement certain provisions from the 2011 Commission.** Send a letter to the Commissioner of DAFS requesting an update on their progress implementing certain provisions of Public Law 2011, chapters 617 and 701. Section 2 of Public Law 2011, chapter 617 requires DAFS to create a separate budget entry or new account for prevention, education and treatment activities concerning unhealthy weight and obesity. Section 2 of Public Law 2011, chapter 701 enacted Title 22, section 1511, subsection 13 requiring state agencies, contractors and vendors receiving funding from the FHM to describe how those funds were targeted to the prevention and health promotion purposes listed in Title 22, section 1511, subsection 6. The letter is included in Appendix G.

5. **Issue a statement of support regarding the principles of the FHM statute for the expenditure of the State's Master Settlement Agreement dollars.** The Committee recommends issuing a statement of support for the principles of the FHM statute. Specifically, the Committee supports the State's use of Master Settlement Agreement dollars from tobacco companies through the FHM for prevention and health promotion purposes. It also reinforces support for the provision in the statute that requires FHM dollars to be used to supplement, not supplant, appropriations from the General Fund.

6. **Request regular updates for information from DHHS on the Request for Proposals that are expected to be issued in the near future for Healthy Maine Partnership contracts.** Send a letter to DHHS requesting regular updates during session for information in order to keep the Committee apprised of the progress and content of the

Request for Proposals that will be issued in the near future for HMP contracts replacing those that will end on June 30, 2016. The letter is included in Appendix G.

APPENDIX A

Authorizing Joint Order, Resolve 2015, c. 47

LAW WITHOUT GOVERNOR'S SIGNATURE (Originals not returned by Governor) JULY 12, 2015

CHAPTER 47 RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND FIFTEEN

H.P. 624 - L.D. 905

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

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve directs the Joint Standing Committee on Health and Human Services to meet to review the alignment of allocations from the Fund for a Healthy Maine with the State's current public health care and preventive health priorities and goals; and

Whereas, the study must be initiated before the 90-day period expires in order that the study may be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Study established. Resolved: That the Joint Standing Committee on Health and Human Services, referred to in this resolve as "the committee," shall study allocations of the Fund for a Healthy Maine as required in this resolve; and be it further

Sec. 2. Convening of committee. Resolved: That the chairs of the committee shall call and convene the first meeting of the committee for the purposes of this resolve no later than 30 days following the effective date of this resolve; and be it further

Sec. 3. Meetings. Resolved: That the committee may meet for the purposes of this resolve only when the Legislature is not in regular or special session. The committee is authorized to meet up to 4 times to accomplish its duties; and be it further

Sec. 4. Duties. Resolved: That the committee shall review the alignment of allocations from the Fund for a Healthy Maine, established in the Maine Revised Statutes, Title 22, section 1511, with the State's current public health care and preventive health

priorities and goals. The committee shall gather information and data from public and private entities as necessary to:

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

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

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

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

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

Sec. 5. Cooperation. Resolved: That the Commissioner of Administrative and Financial Services, the Commissioner of Education, the Commissioner of Health and Human Services and the Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services shall provide information and data to the committee as necessary for its work; and be it further

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the committee; and be it further

Sec. 7. Report. Resolved: That, no later than December 2, 2015, the committee shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Second Regular Session of the 127th Legislature.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Office of Fiscal and Program Review charts and graphs of historical and current biennium revenues and allocations of the Fund for a Healthy Maine

Table OSR-4 Fund for a Healthy Maine (FHM) Revenue - Fiscal Years 2011 - 2015

REVENUE SOURCES	2011 $	2011 % of Total	2012 $	2012 % of Total	2013 $	2013 % of Total	2014 $	2014 % of Total	2015 $	2015 % of Total
Tobacco Settlement Payments:										
Base Payments	$41,484,712	76.3%	$42,306,831	76.2%	$42,276,735	82.9%	$47,833,255	79.0%	$40,779,184	76.1%
Strategic Contribution Payments	$8,544,647	15.7%	$8,702,217	15.7%	$8,709,923	17.1%	$8,559,647	14.1%	$8,696,498	16.2%
Tobacco Settlement Payments - Subtotal	**$50,029,359**	**92.0%**	**$51,009,048**	**91.9%**	**$50,986,658**	**100.0%**	**$56,392,902**	**93.1%**	**$49,475,682**	**92.3%**
Racino Revenue	$4,500,000	8.3%	$4,500,000	8.1%	$0	0.0%	$4,158,208	6.9%	$4,107,614	7.7%
Interest Earnings	$2,494	0.0%	$7,858	0.0%	$5,657	0.0%	$7,823	0.0%	$8,956	0.0%
Other Sources	($145,147)	-0.3%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
Total - All FHM Revenue	**$54,386,707**	**100.0%**	**$55,516,906**	**100.0%**	**$50,992,315**	**100.0%**	**$60,558,934**	**100.0%**	**$53,592,252**	**100.0%**

Table OSR-5 Fund for a Healthy Maine (FHM) Expenditures and Uses - Fiscal Years 2011 - 2015

EXPENDITURES/USES	2011 $	2011 % of Total	2012 $	2012 % of Total	2013 $	2013 % of Total	2014 $	2014 % of Total	2015 $	2015 % of Total
Expenditures										
Smoking Cessation and Prevention	$13,912,591	24.1%	$14,244,134	28.3%	$11,897,871	21.8%	$11,124,480	19.4%	$11,256,158	20.8%
Child Care and Child Development	$11,420,335	19.8%	$8,042,077	16.0%	$3,598,199	6.6%	$3,491,602	6.1%	$3,514,207	6.5%
Medicaid Initiatives	$5,588,780	9.7%	$7,932,557	15.8%	$19,599,226	35.9%	$26,046,891	45.3%	$27,668,899	51.1%
Prescription Drugs	$12,352,334	21.4%	$11,757,948	23.4%	$10,184,554	18.6%	$6,803,850	11.8%	$6,789,618	12.5%
Dirigo Health Program	$4,441,791	7.7%	$1,161,647	2.3%	$1,161,647	2.1%	$0	0.0%	$0	0.0%
Other Health Initiatives	$3,393,818	5.9%	$2,521,708	5.0%	$1,893,506	3.5%	$1,850,774	3.2%	$1,848,643	3.4%
Substance Abuse	$5,027,508	8.7%	$3,137,628	6.2%	$2,954,351	5.4%	$2,976,250	5.2%	$2,951,980	5.4%
Attorney General	$143,842	0.2%	$107,869	0.2%	$99,690	0.2%	$103,051	0.2%	$145,532	0.3%
Subtotal FHM Expenditures	**$56,281,000**	**97.5%**	**$48,905,568**	**97.3%**	**$51,389,044**	**94.1%**	**$52,396,899**	**91.2%**	**$54,175,037**	**100.0%**
Other Uses										
Transfers to (from) General Fund	$1,455,770	2.5%	$1,375,000	2.7%	$3,240,000	5.9%	$5,081,000	8.8%	$0	0.0%
Subtotal Other Uses	**$1,455,770**	**2.5%**	**$1,375,000**	**2.7%**	**$3,240,000**	**5.9%**	**$5,081,000**	**8.8%**	**$0**	**0.0%**
Total - All Uses	**$57,736,770**	**100.0%**	**$50,280,568**	**100.0%**	**$54,629,044**	**100.0%**	**$57,477,899**	**100.0%**	**$54,175,037**	**100.0%**

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2015 FORECAST

Source	FY11 Actual	FY12 Actual	% Chg.	FY13 Actual	% Chg.	FY14 Actual	% Chg.	FY15 Budget	% Chg.	Recom. Chg.	FY15 Revised	% Chg.
Tobacco Settlement Payments:												
- Base Payments	41,484,712	42,306,831	2.0%	42,276,735	-0.1%	47,833,255	13.1%	40,246,501	-15.9%	(4,377)	40,242,124	-15.9%
- Strategic Contribution Payments	8,544,647	8,702,217	1.8%	8,709,923	0.1%	8,559,647	-1.7%	8,581,965	0.3%	0	8,581,965	0.3%
Subtotal TSPs	50,029,359	51,009,048	2.0%	50,986,658	0.0%	56,392,902	10.6%	48,828,466	-13.4%	(4,377)	48,824,089	-13.4%
Casino Revenue *	4,500,000	4,500,000	0.0%	0	-100.0%	4,158,208	N/A	4,421,515	6.3%	(133,106)	4,288,409	3.1%
Income from Investments	2,494	7,858	215.0%	5,657	-28.0%	7,823	38.3%	5,310	-32.1%	2,516	7,826	0.0%
Attorney General Reimbursements and Other Income **	(145,147)	0	100.0%	0	N/A	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**54,386,707**	**55,516,906**	**2.1%**	**50,992,315**	**-8.1%**	**60,558,934**	**18.8%**	**53,255,291**	**-12.1%**	**(134,967)**	**53,120,324**	**-12.3%**

* Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the commercial race track in Bangor designated for the Fund for a Healthy Maine. For fiscal years 2009-10, 2010-11, and

** Beginning in FY10, this category reflects revenue transfers from the Fund for a Healthy Maine to General Fund undedicated revenue to offset revenue reductions from the implementation of PL 2007, c. 467, which

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2015 FORECAST

Source	FY16 Budget	% Chg.	Recom. Chg.	FY16 Revised	% Chg.	FY17 Budget	% Chg.	Recom. Chg.	FY17 Revised	% Chg.
Tobacco Settlement Payments:										
- Base Payments	40,957,942	1.8%	4,377	40,962,319	1.8%	40,091,251	-2.1%	0	40,091,251	-2.1%
- Strategic Contribution Payments	8,447,026	-1.6%	0	8,447,026	-1.6%	8,278,665	-2.0%	0	8,278,665	-2.0%
Subtotal TSPs	49,404,968	1.2%	4,377	49,409,345	1.2%	48,369,916	-2.1%	0	48,369,916	-2.1%
Casino Revenue *	4,473,646	1.2%	57,699	4,531,345	5.7%	4,518,382	1.0%	58,277	4,576,659	1.0%
Income from Investments	15,394	189.9%	3,979	19,373	147.5%	25,359	64.7%	6,220	31,579	63.0%
Attorney General Reimbursements and Other Income	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**53,894,008**	**1.2%**	**66,055**	**53,960,063**	**1.6%**	**52,913,657**	**-1.8%**	**64,497**	**52,978,154**	**-1.8%**
Change in Biennial Totals								**130,552**		

* Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the commercial race track in Bangor designated for the Fund for a Healthy Maine.

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2015 FORECAST

Source	FY18 Projections	% Chg.	Recom. Chg.	FY18 Revised	% Chg.	FY19 Projections	% Chg.	Recom. Chg.	FY19 Revised	% Chg.
Tobacco Settlement Payments:										
- Base Payments	43,942,686	9.6%	0	43,942,686	9.6%	43,012,837	-2.1%	0	43,012,837	-2.1%
- Strategic Contribution Payments **	0	-100.0%	0	0	-100.0%	0	N/A	0	0	N/A
Subtotal TSPs	43,942,686	-9.2%	0	43,942,686	-9.2%	43,012,837	-2.1%	0	43,012,837	-2.1%
Casino Revenue *	4,563,566	1.0%	58,859	4,622,425	1.0%	4,609,202	1.0%	59,448	4,668,650	1.0%
Income from Investments	25,359	0.0%	6,220	31,579	0.0%	25,359	0.0%	6,220	31,579	0.0%
Attorney General Reimbursements and Other Income	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**48,531,611**	**-8.3%**	**65,079**	**48,596,690**	**-8.3%**	**47,647,398**	**-1.8%**	**65,668**	**47,713,066**	**-1.8%**
Change in Biennial Totals								**130,747**		

* Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the commercial race track in Bangor designated for the Fund for a Healthy Maine.
** Beginning in FY 18, the ten-year strategic contribution payment will end with the funding nationally for this purpose returned to the regular distribution pool

FUND FOR A HEALTHY MAINE (FHM) STATUS

Through the end of the 127th Legislature, 1st Regular Session with FY 15 Closing Transactions

	FY 14	FY 15
FHM RESOURCES:		
Revenue:		
December 2012 Base Revenue Estimate	$53,899,312	$53,434,830
May 2013 Revenue Revision	($474,118)	($381,995)
Revenue Variances (Actual minus Budgeted Revenue)	$0	$0
Biennial Budget Bill (LD 1509 - PL 2013, c. 368)	$0	$0
December 2013 Revenue Revision	$1,280,588	$1,288,147
March 2014 Revenue Revision 1	$1,214,994	$6,343,549
Part F and FY 15 Supp. Budget Bill (LD 1858 - PL 2013, c. 595)	$0	$8,019
December 2014 Revenue Revision 2	$0	($7,437,259)
May 2015 Revenue Revision	$0	($134,967)
Revenue Variances (Actual minus Budgeted Revenue) 1	$4,638,158	$471,928
Subtotal - Revenue	$60,558,934	$53,592,252
Other Resources and Adjustments		
Adjustments to Prior Year Balances	$731,467	$430,390
Lapsed Balances from Unexpended Funds	$1,714,615	$2,297,521
Subtotal - Other Resources and Adjustments	$2,446,083	$2,727,911
Total FHM Resources	**$63,005,017**	**$56,320,163**
FHM ALLOCATIONS AND OTHER USES: 3		
Transfers		
FY 14 Supplemental Budget Bill (LD 1843 - PL 2013, c. 502)	$5,081,000	$0
Subtotal - Transfers	$5,081,000	$0
Allocations		
Appropriations through 125th Leg. / 2014-2015 Baseline	$51,058,419	$51,101,316
Biennial Budget Bill (LD 1509 - PL 2013, c. 368)	$3,203,493	$2,374,750
Special Appropriations Table Bills - 126th, 1st Reg. 4	$264,014	$14,014
Emergency FY 15 Budget Bill (LD 236, PL 2015, c. 16) 5	$0	$2,475,888
Subtotal - Allocations	$54,525,926	$55,965,968
Total Allocations and Other Uses	**$59,606,926**	**$55,965,968**
Net Change (Resources minus Allocations and Uses)	**$3,398,091**	**$354,195**
BEGINNING BALANCE	**$3,886,233**	**$7,284,324**
NET CHANGE (FROM ABOVE)	**$3,398,091**	**$354,195**
ENDING BALANCE	**$7,284,324**	**$7,638,519**

Notes:

[1] The March 2014 Revenue Revision for FY 15 had assumed collection of Maine's estimated $5.6 million share of the disputed payments from 2003 calendar year sales. These payments were actually included in the State's FY 14 payment and explain the positive variance in actual FY 14 revenue, although the amount attributed to the 2003 disputed payments

[2] The December 2014 Revenue Revision for FY 15 removes the disputed payment amount of $5.6 million that was paid in FY 14 instead of FY 15. In addition, confusion at the national level regarding the distribution of funds included in the April 2014 payments may have resulted in an overpayment to Maine of approximately $1.36 million in FY14. The FY 15 forecast assumes this $1.36 million FY 14 overpayment will be offset against Maine's April 2015 resulting in a further

[3] For the purposes of this summary, transfers out are treated as an expenditure/use and are positive amounts, while transfers in are negative amounts.

[4] PL 2013 c. 444 (LD 386) provided allocations of $264,014 in FY 14 and $14,014 in FY 15 for reimbursement for smoking cessation products under the MaineCare program. The Governor's veto of the bill was overridden on January 21, 2014. Given the general effective date for nonemergency laws passed in the Second Regular Session of the 126th Legislature was August 1, 2014, the FY 14 allocation was not available for use in FY 14 and was retained in the Fund for

[5] PL 2015, c. 16 (LD 236) adjusts fiscal year 2014-15 funding in the Medical Care - Payments to Providers program by $2,446,083 and provides $29,805 in fiscal year 2014-15 for Maine's portion of a multistate cost-sharing agreement related to the Tobacco Master Settlement Agreement diligent enforcement requirement.

FUND FOR A HEALTHY MAINE (FHM) STATUS

Through the end of the 127th Legislature, 1st Regular Session with FY 15 Closing Transactions1

	FY 16	FY 17
FHM RESOURCES:		
Revenue:		
December 2014 Revenue Estimate	$53,894,008	$52,913,657
May 2015 Revenue Estimate	$66,055	$64,497
Subtotal - Revenue	$53,960,063	$52,978,154
Other Resources and Adjustments		
2016-2017 Biennial Budget Bill (LD 1019 - PL 2015, c. 267)	$0	$0
Subtotal - Other Resources and Adjustments	$0	$0
Total FHM Resources	**$53,960,063**	**$52,978,154**
FHM ALLOCATIONS AND OTHER USES: 2		
Transfers		
2016-2017 Biennial Budget Bill (LD 1019 - PL 2015, c. 267)	$200,000	$0
Subtotal - Transfers	$200,000	$0
Allocations		
2016-2017 Biennial Budget Bill (LD 1019 - PL 2015, c. 267) - Baseline Budget	$53,484,347	$53,520,568
2016-2017 Biennial Budget Bill (LD 1019 - PL 2015, c. 267) - Adjustments to Basel	$553,084	$664,739
Subtotal - Allocations	$54,037,431	$54,185,307
Total Allocations and Other Uses	**$54,237,431**	**$54,185,307**
Net Change (Resources minus Allocations and Uses)	**($277,368)**	**($1,207,153)**
BEGINNING BALANCE 3	**$7,638,519**	**$7,361,151**
NET CHANGE (FROM ABOVE)	**($277,368)**	**($1,207,153)**
ENDING BALANCE	**$7,361,151**	**$6,153,998**

Notes:

[1] Based on all legislative changes through the 127th Legislature, 1st Regular Session and the May 2015 Revenue Forecast

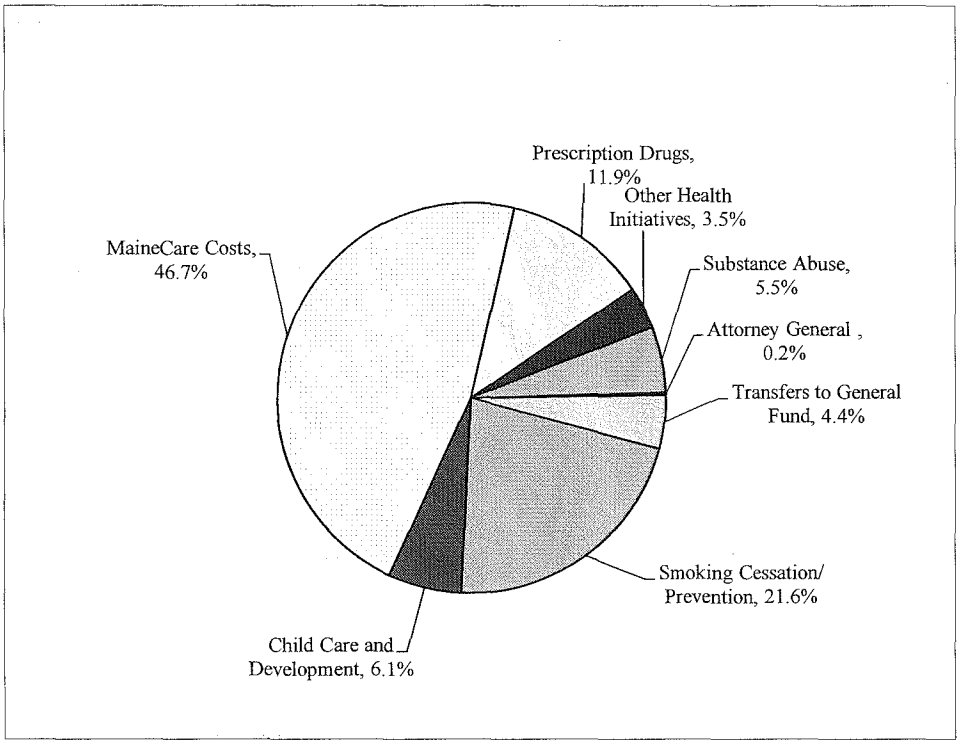
[2] For the purposes of this summary, transfers out are treated as an expenditure/use and are positive amounts, while transfers in are negative

[3] FY 2016 beginning balance reflects final FY 2015 closing transactions.

Fund for a Healthy Maine (FHM)

Budgeted Allocations and Uses *

2014-2015 Biennium



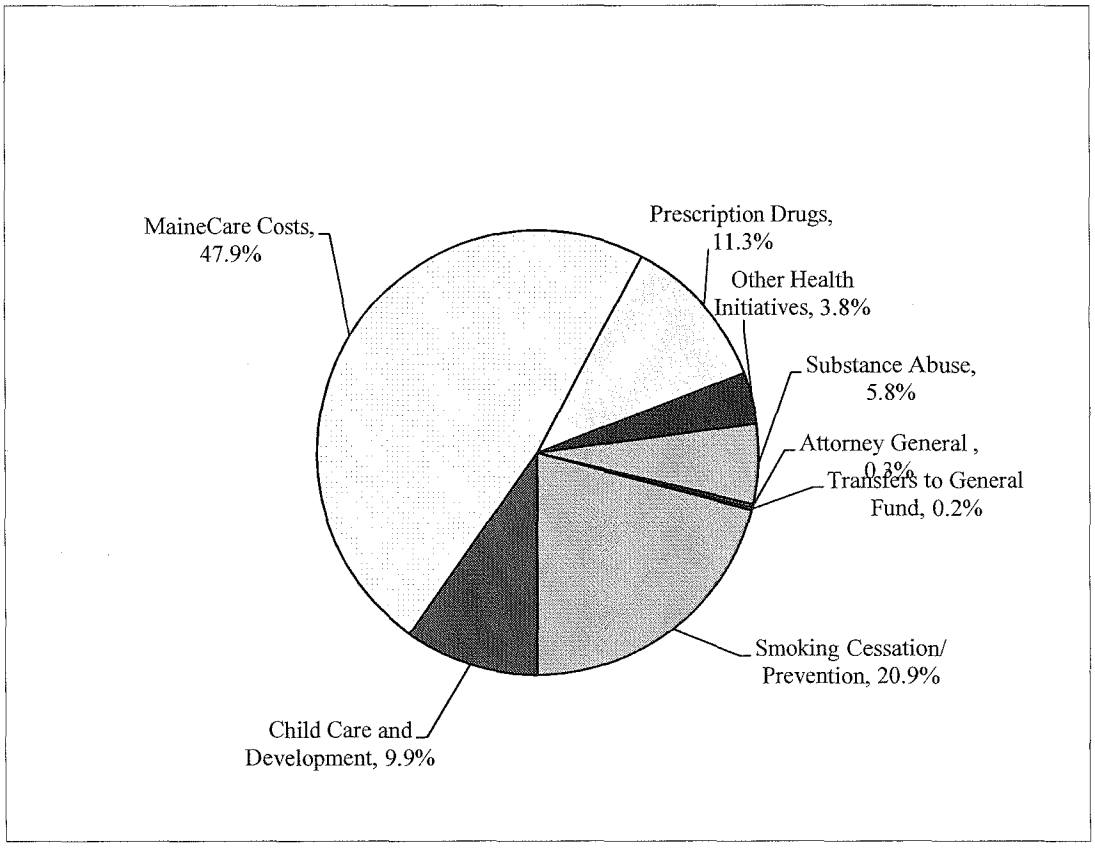
	2013-14	2014-15	Biennium	
Smoking Cessation/ Prevention	$12,484,274	$12,514,958	$24,999,232	21.6%
Child Care and Development	$3,539,418	$3,539,418	$7,078,836	6.1%
MaineCare Costs	$26,310,905	$27,668,900	$53,979,805	46.7%
Prescription Drugs	$6,897,869	$6,897,869	$13,795,738	11.9%
Other Health Initiatives	$2,028,907	$2,040,126	$4,069,033	3.5%
Substance Abuse	$3,150,020	$3,154,365	$6,304,385	5.5%
Attorney General	$114,533	$150,332	$264,865	0.2%
Transfers to General Fund	$5,081,000	$0	$5,081,000	4.4%
Totals	$59,606,926	$55,965,968	$115,572,894	100.0%

** Reflects Budgeted Allocations and Uses through the 127th Legislature, 1st Regular Session*

Fund for a Healthy Maine (FHM)

Budgeted Allocations and Uses *

2016-2017 Biennium



	2015-16	2016-17	Biennium	
Smoking Cessation/ Prevention	$11,292,965	$11,315,947	$22,608,912	20.9%
Child Care and Development	$5,293,993	$5,413,716	$10,707,709	9.9%
MaineCare Costs	$25,901,244	$26,036,930	$51,938,174	47.9%
Prescription Drugs	$6,217,798	$6,082,095	$12,299,893	11.3%
Other Health Initiatives	$2,038,924	$2,044,086	$4,083,010	3.8%
Substance Abuse	$3,154,365	$3,154,365	$6,308,730	5.8%
Attorney General	$138,142	$138,168	$276,310	0.3%
Transfers to General Fund	$200,000	$0	$200,000	0.2%
Totals	$54,237,431	$54,185,307	$108,422,738	100.0%

** Reflects Budgeted Allocations and Uses through the 127th Legislature, 1st Regular Session*

Fund for a Healthy Maine (FHM) Budgeted Allocations and Uses History

	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Smoking Cessation/ Prevention [2]	$3,500,000	$12,526,011	$13,755,488	$15,571,085	$14,938,883	$15,305,670	$15,545,990	$15,791,699	$16,544,452	$17,615,339	$16,966,317	$16,129,319
Child Care and Development	$0	$11,714,999	$9,352,516	$7,290,437	$10,472,121	$10,809,181	$10,797,869	$11,120,956	$12,680,798	$13,076,332	$13,610,918	$11,463,235
Medicaid Initiatives	$0	$5,115,425	$5,503,666	$6,442,570	$6,777,827	$6,138,563	$6,028,661	$9,816,920	$9,547,397	$7,609,885	$6,141,680	$5,589,839
Prescription Drugs	$0	$10,000,000	$10,000,000	$10,000,000	$10,410,000	$10,000,000	$9,664,409	$8,350,060	$11,824,840	$14,062,727	$13,031,892	$12,352,950
Dirigo Health Program	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,000,000	$4,683,443	$4,441,791
Other Health Initiatives	$0	$1,431,408	$1,688,873	$1,893,294	$1,890,374	$1,891,303	$1,895,542	$1,939,878	$3,733,770	$3,963,051	$3,394,913	$3,381,458
Substance Abuse	$0	$5,800,000	$4,317,725	$5,647,037	$5,653,108	$5,660,016	$5,741,915	$5,760,815	$6,563,613	$6,472,607	$6,417,713	$5,709,161
Attorney General	$0	$299,989	$49,372	$52,100	$57,024	$58,281	$68,551	$72,607	$189,045	$198,684	$168,946	$175,775
Unallocated Fund-wide Deallocation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Allocations	$3,500,000	$46,887,832	$44,667,640	$46,896,523	$50,199,337	$49,863,014	$49,742,937	$52,852,935	$61,083,915	$67,998,625	$64,415,822	$59,243,528
Advance to Maine Rx Dedicated Fund	$0	$0	$1,700,000	($1,700,000)	$0	$0	$0	$0	$0	$0	$0	$0
Transfers to (from) the General Fund	$0	$24,055,000	$10,000,000	$43,244,794	$6,736,628	$55,218	($1,895,717)	$2,571,648	$225,000	$1,464,406	$3,925,515	$1,455,770
Allocation to Healthy Maine Trust Fund [3]	$0	$11,094,848	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Other Uses	$0	$35,149,848	$11,700,000	$41,544,794	$6,736,628	$55,218	($1,895,717)	$2,571,648	$225,000	$1,464,406	$3,925,515	$1,455,770
Totals Allocations and Other Uses [4]	$3,500,000	$82,037,680	$56,367,640	$88,441,317	$56,935,965	$49,918,232	$47,847,220	$55,424,583	$61,308,915	$69,463,031	$68,341,337	$60,699,298

[1] Reflects all budgeted allocations and transfers through the close of the 1st Regular Session of the 127th Legislature.

[2] FY 1999-00 includes $3.5 million transferred from the FHM to the Bureau of Health for tobacco prevention and control initiatives.

[3] The $11,094,848 allocated to the Healthy Maine Trust Fund in FY 2000-01 was subsequently repealed and $11,099,592 was transferred to the General Fund in PL 2001, c. 358, Sec. Q-8.

[4] Does not include the $25,540,000 allocated to Biennial Reserve in FY 2000-01 and then subsequently deallocated in FY 2001-02 in PL 2001, c. 358, Sec. Q-12.

Fund for a Healthy Maine (FHM) Budgeted Allocations and Uses History

	2011-12	2012-13	2013-14	2014-15 [1]	2015-16 [1]	2016-17 [1]
Smoking Cessation/ Prevention [2]	$15,184,943	$12,481,354	$12,484,274	$12,514,958	$11,292,965	$11,315,947
Child Care and Development	$8,163,919	$3,539,418	$3,539,418	$3,539,418	$5,293,993	$5,413,716
Medicaid Initiatives	$7,932,557	$19,599,226	$26,310,905	$27,668,900	$25,901,244	$26,036,930
Prescription Drugs	$11,878,350	$10,244,920	$6,897,869	$6,897,869	$6,217,798	$6,082,095
Dirigo Health Program	$1,161,647	$1,161,647	$0	$0	$0	$0
Other Health Initiatives	$2,662,788	$2,038,871	$2,028,907	$2,040,126	$2,038,924	$2,044,086
Substance Abuse	$3,105,972	$3,123,948	$3,150,020	$3,154,365	$3,154,365	$3,154,365
Attorney General	$115,832	$126,452	$114,533	$150,332	$138,142	$138,168
Unallocated Fund-wide Deallocation	$0	$0	$0	$0	$0	$0
Subtotal Allocations	$50,206,008	$52,315,836	$54,525,926	$55,965,968	$54,037,431	$54,185,307
Advance to Maine Rx Dedicated Fund	$0	$0	$0	$0	$0	$0
Transfers to (from) the General Fund	$1,375,000	$3,240,445	$5,081,000	$0	$200,000	$0
Allocation to Healthy Maine Trust Fund [3]	$0	$0	$0	$0	$0	$0
Subtotal Other Uses	$1,375,000	$3,240,445	$5,081,000	$0	$200,000	$0
Totals Allocations and Other Uses [4]	$51,581,008	$55,556,281	$59,606,926	$55,965,968	$54,237,431	$54,185,307

[1] Reflects all budgeted allocations and transfers through the close of the 1st Regular Session of the 127th Legislature.

[2] FY 1999-00 includes $3.5 million transferred from the FHM to the Bureau of Health for tobacco prevention and control initiatives.

[3] The $11,094,848 allocated to the Healthy Maine Trust Fund in FY 2000-01 was subsequently repealed and $11,099,592 was transferred to the General Fund in PL 2001, c. 358, Sec. Q-8.

[4] Does not include the $25,540,000 allocated to Biennial Reserve in FY 2000-01 and then subsequently deallocated in FY 2001-02 in PL 2001, c. 358, Sec. Q-12.

Fund for a Healthy Maine (FHM) Allocations
Adjusted for Major Reorganizations*
Allocations through 127th Legislature 1st Regular Session
FY 2007-08 to FY 2016-17

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 **	2015-16	2016-17
DEPARTMENT OF THE ATTORNEY GENERAL										
024-26A-0947-01 FHM - ATTORNEY GENERAL (FORMERLY 011-26A-0947)										
Pos. - Leg.	(1.500)	(1.500)	(1.500)	(1.500)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)
Pers. Serv.	159,616	169,115	141,832	149,729	91,730	101,983	93,309	99,303	116,600	$118,540
All Other	29,429	29,569	27,114	26,046	24,102	24,469	21,224	51,029	21,542	19,628
Program Total	189,045	198,684	168,946	175,775	115,832	126,452	114,533	150,332	138,142	138,168
Annual % Increase	160.37%	5.10%	-14.97%	4.04%	-34.10%	9.17%	-9.43%	31.26%	-8.11%	0.02%
DEPARTMENT OF THE ATTORNEY GENERAL										
Pos. - Leg.	**(1.500)**	**(1.500)**	**(1.500)**	**(1.500)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**
Pers. Serv.	**159,616**	**169,115**	**141,832**	**149,729**	**91,730**	**101,983**	**93,309**	**99,303**	**116,600**	**118,540**
All Other	**29,429**	**29,569**	**27,114**	**26,046**	**24,102**	**24,469**	**21,224**	**51,029**	**21,542**	**19,628**
Dept. Total	**189,045**	**198,684**	**168,946**	**175,775**	**115,832**	**126,452**	**114,533**	**150,332**	**138,142**	**138,168**
Annual % Increase	**160.37%**	**5.10%**	**-14.97%**	**4.04%**	**-34.10%**	**9.17%**	**-9.43%**	**31.26%**	**-8.11%**	**0.02%**
DIRIGO HEALTH										
011-95D-Z070-01 FHM - DIRIGO HEALTH										
All Other	0	5,000,000	4,683,443	4,441,791	1,161,647	1,161,647	0	0	0	0
Program Total	0	5,000,000	4,683,443	4,441,791	1,161,647	1,161,647	0	0	0	0
Annual % Increase	0.00%	100.00%	-6.33%	-5.16%	-73.85%	0.00%	-100.00%	0.00%	0.00%	0.00%
DIRIGO HEALTH										
All Other	**0**	**5,000,000**	**4,683,443**	**4,441,791**	**1,161,647**	**1,161,647**	**0**	**0**	**0**	**0**
Dept. Total	**0**	**5,000,000**	**4,683,443**	**4,441,791**	**1,161,647**	**1,161,647**	**0**	**0**	**0**	**0**
Annual % Increase	**0.00%**	**100.00%**	**-6.33%**	**-5.16%**	**-73.85%**	**0.00%**	**-100.00%**	**0.00%**	**0.00%**	**0.00%**
DEPARTMENT OF EDUCATION										
011-05A-0949-01 FHM - SCHOOL NURSE CONSULTANT										
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	90,633	94,647	94,792	96,469	0	0	0	0	0	0
All Other	9,134	9,023	8,623	8,178	0	0	0	0	0	0
Program Total	99,767	103,670	103,415	104,647	0	0	0	0	0	0
Annual % Increase	10.51%	3.91%	-0.25%	1.19%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-05A-Z068-01 FHM - SCHOOL BREAKFAST PROGRAM (FORMERLY 011-05A-Z068-01)										
All Other	0	224,925	171,314	162,475	213,720	213,720	213,720	213,720	213,720	213,720
Program Total	0	224,925	171,314	162,475	213,720	213,720	213,720	213,720	213,720	213,720
Annual % Increase	0.00%	0.00%	-23.84%	-5.16%	31.54%	0.00%	0.00%	0.00%	0.00%	0.00%
DEPARTMENT OF EDUCATION										
Pos. - Leg.	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**

Prepared by the Office of Fiscal and Program Review

Fund for a Healthy Maine (FHM) Allocations
Adjusted for Major Reorganizations*
Allocations through 127th Legislature 1st Regular Session
FY 2007-08 to FY 2016-17

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 **	2015-16	2016-17
Pers. Serv.	**90,633**	**94,647**	**94,792**	**96,469**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**9,134**	**233,948**	**179,937**	**170,653**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Dept. Total	**99,767**	**328,595**	**274,729**	**267,122**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Annual % Increase	**10.51%**	**229.36%**	**-16.39%**	**-2.77%**	**-19.99%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
FINANCE AUTHORITY OF MAINE										
024-94F-0950-02 FHM - HEALTH EDUCATION CENTERS (FORMERLY 011-94F-0950-02)										
All Other	117,235	117,235	112,040	106,260	100,353	100,353	105,000	110,000	110,000	110,000
Program Total	117,235	117,235	112,040	106,260	100,353	100,353	105,000	110,000	110,000	110,000
Annual % Increase	13.56%	0.00%	-4.43%	-5.16%	-5.56%	0.00%	4.63%	4.76%	0.00%	0.00%
024-94F-0951-01 FHM - DENTAL EDUCATION (FORMERLY 011-94F-0951-01)										
All Other	277,735	277,735	265,428	251,735	237,740	237,740	237,740	237,740	237,740	237,740
Program Total	277,735	277,735	265,428	251,735	237,740	237,740	237,740	237,740	237,740	237,740
Annual % Increase	14.18%	0.00%	-4.43%	-5.16%	-5.56%	0.00%	0.00%	0.00%	0.00%	0.00%
011-94F-0952-03 FHM - QUALITY CHILD CARE										
All Other	167,792	167,792	160,358	152,084	0	0	0	0	0	0
Program Total	167,792	167,792	160,358	152,084	0	0	0	0	0	0
Annual % Increase	12.92%	0.00%	-4.43%	-5.16%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FINANCE AUTHORITY OF MAINE										
All Other	**562,762**	**562,762**	**537,826**	**510,079**	**338,093**	**338,093**	**342,740**	**347,740**	**347,740**	**347,740**
Dept. Total	**562,762**	**562,762**	**537,826**	**510,079**	**338,093**	**338,093**	**342,740**	**347,740**	**347,740**	**347,740**
Annual % Increase	**13.68%**	**0.00%**	**-4.43%**	**-5.16%**	**-33.72%**	**0.00%**	**1.37%**	**1.46%**	**0.00%**	**0.00%**
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY BDS)										
024-14G-0679-01 OFFICE OF SUBSTANCE ABUSE (FORMERLY FHM - SUBSTANCE ABUSE 011-14G-0948-01)										
All Other	6,466,079	6,361,921	6,297,305	5,589,908	1,848,306	1,848,306	1,848,306	1,848,306	1,848,306	1,848,306
Program Total	6,466,079	6,361,921	6,297,305	5,589,908	1,848,306	1,848,306	1,848,306	1,848,306	1,848,306	1,848,306
Annual % Increase	14.30%	-1.61%	-1.02%	-11.23%	-66.93%	0.00%	0.00%	0.00%	0.00%	0.00%
024-14G-0844-01 OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED (FORMERLY FHM - SUBSTANCE ABUSE 011-14G-0948-02)										
All Other	0	0	0	0	1,257,666	1,275,642	1,301,714	1,306,059	1,306,059	1,306,059
Program Total	0	0	0	0	1,257,666	1,275,642	1,301,714	1,306,059	1,306,059	1,306,059
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	1.43%	2.04%	0.33%	0.00%	0.00%
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY BDS)										
All Other	**6,466,079**	**6,361,921**	**6,297,305**	**5,589,908**	**3,105,972**	**3,123,948**	**3,150,020**	**3,154,365**	**3,154,365**	**3,154,365**
Dept. Total	**6,466,079**	**6,361,921**	**6,297,305**	**5,589,908**	**3,105,972**	**3,123,948**	**3,150,020**	**3,154,365**	**3,154,365**	**3,154,365**
Annual % Increase	**14.30%**	**-1.61%**	**-1.02%**	**-11.23%**	**-44.44%**	**0.58%**	**0.83%**	**0.14%**	**0.00%**	**0.00%**
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)										

Prepared by the Office of Fiscal and Program Review

Fund for a Healthy Maine (FHM) Allocations
Adjusted for Major Reorganizations*
Allocations through 127th Legislature 1st Regular Session
FY 2007-08 to FY 2016-17

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 **	2015-16	2016-17
024-10A-0143-25 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: ORAL HEALTH) (FORMERLY FHM - BUREAU OF HEALTH - ORAL HEALTH 011-10A-0953-01)										
All Other	1,113,797	973,897	930,744	927,726	600,000	300,000	300,000	300,000	300,000	300,000
Program Total	1,113,797	973,897	930,744	927,726	600,000	300,000	300,000	300,000	300,000	300,000
Annual % Increase	14.36%	-12.56%	-4.43%	-0.32%	-35.33%	-50.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-30 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: TOBACCO PREVENTION AND CONTROL) (FORMERLY FHM - BUREAU OF HEALTH - TOBACCO PREVENTION AND CONTROL 011-10A-0953-02)										
Pos. - Leg.	(4.000)	(4.000)	(7.000)	(7.000)	(7.000)	(7.000)	(7.000)	(7.000)	(6.000)	(6.000)
Pers. Serv.	282,364	302,007	603,169	599,750	541,050	568,379	574,885	595,191	485,716	500,277
All Other	6,493,345	7,075,589	6,496,640	6,164,756	5,822,030	5,822,114	5,821,987	5,821,987	5,821,987	5,821,987
Program Total	6,775,709	7,377,596	7,099,809	6,764,506	6,363,080	6,390,493	6,396,872	6,417,178	6,307,703	6,322,264
Annual % Increase	-0.48%	8.88%	-3.77%	-4.72%	-5.93%	0.43%	0.10%	0.32%	-1.71%	0.23%
024-10A-0143-26 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: COMMUNITY/ SCHOOL GRANTS & STATEWIDE COORDINATION) (FORMERLY FHM - BUREAU OF HEALTH - COMMUNITY/SCHOOL GRANTS 011-10A-0953-07)										
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	122,436	141,769	238,938	206,119	240,062	227,374	237,752	204,118	212,539
All Other	8,890,743	8,937,307	8,523,055	7,986,205	7,536,860	4,771,915	4,781,144	4,781,144	4,781,144	4,781,144
Program Total	8,890,743	9,059,743	8,664,824	8,225,143	7,742,979	5,011,977	5,008,518	5,018,896	4,985,262	4,993,683
Annual % Increase	12.78%	1.90%	-4.36%	-5.07%	-5.86%	-35.27%	-0.07%	0.21%	-0.67%	0.17%
024-10A-0143-27 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: PUBLIC HEALTH INFRASTRUCTURE) (FORMERLY FHM - PUBLIC HEALTH INFRASTRUCTURE 011-10A-0953-08)										
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)
Pers. Serv.	0	0	0	110,092	28,488	106,001	91,390	97,609	96,407	101,569
All Other	1,370,000	1,470,000	1,404,866	1,332,387	1,258,314	1,258,314	1,258,314	1,258,314	1,258,314	1,258,314
Program Total	1,370,000	1,470,000	1,404,866	1,442,479	1,286,802	1,364,315	1,349,704	1,355,923	1,354,721	1,359,883
Annual % Increase	100.00%	7.30%	-4.43%	2.68%	-10.79%	6.02%	-1.07%	0.46%	-0.09%	0.38%
024-10A-0143-28 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: DONATED DENTAL) (FORMERLY FHM - DONATED DENTAL 011-10A-0958-01)										
All Other	42,562	42,562	40,677	38,610	36,463	36,463	36,463	36,463	36,463	36,463
Program Total	42,562	42,562	40,677	38,610	36,463	36,463	36,463	36,463	36,463	36,463
Annual % Increase	14.53%	0.00%	-4.43%	-5.08%	-5.56%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-29 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: IMMUNIZATION) (FORMERLY FHM - IMMUNIZATION 011-10A-Z048-01)										
All Other	1,258,000	1,258,000	1,201,684	1,139,670	1,078,884	1,078,884	1,078,884	1,078,884	0	0
Program Total	1,258,000	1,258,000	1,201,684	1,139,670	1,078,884	1,078,884	1,078,884	1,078,884	0	0
Annual % Increase	100.00%	0.00%	-4.48%	-5.16%	-5.33%	0.00%	0.00%	0.00%	-100.00%	0.00%

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	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 **	2015-16	2016-17
024-10A-0143-08 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: LEAD POISONING PREVENTION FUND)										
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	447,780	612,686
All Other	0	0	0	0	0	0	0	0	731,795	686,612
Program Total	0	0	0	0	0	0	0	0	1,179,575	1,299,298
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.15%
011-10A-0953-06 FHM - BUREAU OF HEALTH - HOME VISITS										
All Other	5,382,713	5,432,713	5,191,997	4,924,134	2,653,383	0	0	0	0	0
Program Total	5,382,713	5,432,713	5,191,997	4,924,134	2,653,383	0	0	0	0	0
Annual % Increase	14.14%	0.93%	-4.43%	-5.16%	-46.11%	-100.00%	0.00%	0.00%	0.00%	0.00%
011-10A-0954-01 FHM - BFI - CENTRAL										
Pos. - Leg.	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	51,051	54,052	0	0	0	0	0	0	0	0
All Other	7,726	7,846	281	0	0	0	0	0	0	0
Program Total	58,777	61,898	281	0	0	0	0	0	0	0
Annual % Increase	20.28%	5.31%	-99.55%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
011-10A-0955-01 FHM - BUREAU OF MEDICAL SERVICES										
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	66,075	83,660	87,047	0	0	0	0	0	0	0
All Other	56,837	56,837	53,239	1,065	0	0	0	0	0	0
Program Total	122,912	140,497	140,286	1,065	0	0	0	0	0	0
Annual % Increase	29.57%	14.31%	-0.15%	-99.24%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
011-10A-0956-01 FHM - FAMILY PLANNING										
All Other	468,962	884,240	448,183	425,061	401,430	0	0	0	0	0
Program Total	468,962	884,240	448,183	425,061	401,430	0	0	0	0	0
Annual % Increase	14.36%	88.55%	-49.31%	-5.16%	-5.56%	-100.00%	0.00%	0.00%	0.00%	0.00%
011-10A-0957-01 FHM - SERVICE CENTER										
Pos. - Leg.	(10.000)	(10.000)	(10.000)	(5.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	652,570	673,752	719,569	340,530	0	0	0	0	0	0
All Other	46,438	46,349	61,072	19,123	0	0	0	0	0	0
Program Total	699,008	720,101	780,641	359,653	0	0	0	0	0	0
Annual % Increase	2.70%	3.02%	8.41%	-53.93%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0545-04 HEAD START (FORMERLY FHM - HEAD START 011-10A-0959-01)										
All Other	1,582,460	1,582,460	1,512,343	1,434,319	1,354,580	1,354,580	1,354,580	1,354,580	1,929,580	1,929,580
Program Total	1,582,460	1,582,460	1,512,343	1,434,319	1,354,580	1,354,580	1,354,580	1,354,580	1,929,580	1,929,580

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	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 **	2015-16	2016-17
Annual % Increase	14.34%	0.00%	-4.43%	-5.16%	-5.56%	0.00%	0.00%	0.00%	42.45%	0.00%
024-10A-0147-01 MEDICAL CARE - PAYMENTS TO PROVIDERS (FORMERLY FHM - MEDICAL CARE 011-10A-0960-01)										
All Other	9,365,708	7,407,490	6,001,113	5,588,774	7,932,557	19,599,226	26,310,905	27,668,900	25,901,244	26,036,930
Program Total	9,365,708	7,407,490	6,001,113	5,588,774	7,932,557	19,599,226	26,310,905	27,668,900	25,901,244	26,036,930
Annual % Increase	-13.06%	-20.91%	-18.99%	-6.87%	41.94%	147.07%	34.24%	5.16%	-6.39%	0.52%
024-10A-0228-01 PURCHASED SOCIAL SERVICES (FORMERLY FHM - PURCHASED SOCIAL SERVICES 011-10A-0961-01)										
All Other	4,555,435	4,605,435	4,401,375	4,174,301	3,942,236	1,971,118	1,971,118	1,971,118	1,971,118	1,971,118
Program Total	4,555,435	4,605,435	4,401,375	4,174,301	3,942,236	1,971,118	1,971,118	1,971,118	1,971,118	1,971,118
Annual % Increase	14.36%	0.00%	-4.43%	-5.16%	-5.56%	-50.00%	0.00%	0.00%	0.00%	0.00%
011-10A-0962-01 FHM - BONE MARROW SCREENING										
All Other	93,712	93,712	89,560	84,940	0	0	0	0	0	0
Program Total	93,712	93,712	89,560	84,940	0	0	0	0	0	0
Annual % Increase	14.27%	0.00%	-4.43%	-5.16%	-100.00%	0.00%	-100.00%	0.00%	-100.00%	0.00%
024-10A-0202-01 LOW-COST DRUGS TO MAINE'S ELDERLY (FORMERLY FHM - DRUGS OF THE ELDERLY AND DISABLED 011-10A-Z015-01)										
All Other	11,674,840	13,912,727	13,031,892	12,352,950	11,878,350	10,244,920	6,897,869	6,897,869	6,217,798	6,082,095
Program Total	11,674,840	13,912,727	13,031,892	12,352,950	11,878,350	10,244,920	6,897,869	6,897,869	6,217,798	6,082,095
Annual % Increase	39.82%	19.17%	-6.33%	-5.21%	-3.84%	-13.75%	-32.67%	0.00%	-9.86%	-2.18%
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)										
Pos. - Leg.	**(16.000)**	**(16.000)**	**(18.000)**	**(13.000)**	**(8.000)**	**(8.000)**	**(8.000)**	**(8.000)**	**(7.000)**	**(7.000)**
Pers. Serv.	**1,052,060**	**1,235,907**	**1,551,554**	**1,289,310**	**775,657**	**914,442**	**893,649**	**930,552**	**1,234,021**	**1,427,071**
All Other	**52,403,278**	**53,787,164**	**49,388,721**	**46,594,021**	**44,495,087**	**46,437,534**	**49,811,264**	**51,169,259**	**48,949,443**	**48,904,243**
Dept. Total	**53,455,338**	**55,023,071**	**50,940,275**	**47,883,331**	**45,270,744**	**47,351,976**	**50,704,913**	**52,099,811**	**50,183,464**	**50,331,314**
Annual % Increase	**15.64%**	**2.93%**	**-7.42%**	**-6.00%**	**-5.46%**	**4.60%**	**7.08%**	**2.75%**	**-3.68%**	**0.29%**
JUDICIAL DEPARTMENT										
011-40A-0963-01 FHM - JUDICIAL DEPARTMENT										
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	94,808	107,960	117,803	116,782	0	0	0	0	0	0
All Other	2,726	2,726	2,605	2,471	0	0	0	0	0	0
Program Total	97,534	110,686	120,408	119,253	0	0	0	0	0	0
Annual % Increase	-5.83%	13.48%	8.78%	-0.96%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
JUDICIAL DEPARTMENT										
Pos. - Leg.	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**94,808**	**107,960**	**117,803**	**116,782**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**2,726**	**2,726**	**2,605**	**2,471**	**0**	**0**	**0**	**0**	**0**	**0**
Dept. Total	**97,534**	**110,686**	**120,408**	**119,253**	**0**	**0**	**0**	**0**	**0**	**0**

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	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15 **	2015-16	2016-17
Annual % Increase	**-5.83%**	**13.48%**	**8.78%**	**-0.96%**	**-100.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
DEPARTMENT OF PUBLIC SAFETY										
011-16A-0964-01 FHM - FIRE MARSHAL										
Pos. - Leg.	(3.000)	(3.000)	(3.000)	(3.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	201,270	250,539	237,637	242,543	0	0	0	0	0	0
All Other	12,120	12,367	1,155,253	13,726	0	0	0	0	0	0
Program Total	213,390	262,906	1,392,890	256,269	0	0	0	0	0	0
Annual % Increase	2.28%	23.20%	429.81%	-81.60%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
011-16A-Z085-01 FHM - DRUG ENFORCEMENT AGENCY PILOT PROJECT										
All Other	0	150,000	0	0	0	0	0	0	0	0
Program Total	0	150,000	0	0	0	0	0	0	0	0
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DEPARTMENT OF PUBLIC SAFETY										
Pos. - Leg.	**(3.000)**	**(3.000)**	**(3.000)**	**(3.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**201,270**	**250,539**	**237,637**	**242,543**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**12,120**	**162,367**	**1,155,253**	**13,726**	**0**	**0**	**0**	**0**	**0**	**0**
Dept. Total	**213,390**	**412,906**	**1,392,890**	**256,269**	**0**	**0**	**0**	**0**	**0**	**0**
Annual % Increase	**2.28%**	**93.50%**	**237.34%**	**-81.60%**	**-100.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
GRAND TOTALS - ALL DEPARTMENTS										
Pos. - Leg.	**(22.500)**	**(22.500)**	**(24.500)**	**(19.500)**	**(9.000)**	**(9.000)**	**(9.000)**	**(9.000)**	**(8.000)**	**(8.000)**
Pers. Serv.	**1,598,387**	**1,858,168**	**2,143,618**	**1,894,833**	**867,387**	**1,016,425**	**986,958**	**1,029,855**	**1,350,621**	**1,545,611**
All Other	**59,485,528**	**66,140,457**	**62,272,204**	**57,348,695**	**49,338,621**	**51,299,411**	**53,538,968**	**54,936,113**	**52,686,810**	**52,639,696**
Grand Total	**61,083,915**	**67,998,625**	**64,415,822**	**59,243,528**	**50,206,008**	**52,315,836**	**54,525,926**	**55,965,968**	**54,037,431**	**54,185,307**
Annual % Increase	**15.57%**	**11.32%**	**-5.27%**	**-8.03%**	**-15.25%**	**4.20%**	**4.22%**	**2.64%**	**-3.45%**	**0.27%**

Notes:

* FHM programs and allocations have been modified to reflect the creation of a unique Fund for a Healthy Maine fund beginning in 2013-14 .

* PL 2015, c. 16 (LD 236) adjusts fiscal year 2014-15 funding in the Medical Care - Payments to Providers program by $2,446,083 and provides $29,805 in fiscal year 2014-15 for Maine's portion of a multistate cost-sharing agreement related to the Tobacco Master Settlement Agreement diligent enforcement requirement.

Prepared by the Office of Fiscal and Program Review

APPENDIX C

Department of Health and Human Services handout on the 2013-2017 State Health Improvement Plan

Maine DHHS Fund for a Healthy Maine Summary

State's Current Public Health and Preventive Health Priorities and Goals

Maine's 2013 – 2017 State Health Improvement Plan is formulated around six priorities. The first four priorities are categorical, or subject-specific, priorities and the remaining two priorities are focused on public health services. The State Health Improvement Plan does not include priorities and goals related to healthcare improvement that are also important to the Department.

Categorical Priorities	Goal
Immunizations	Increase immunization rates in Maine by an average of 10% by June 2017.
Obesity	Reduce adult obesity in Maine by 5% and youth obesity by 10% by June 2017.
Substance Abuse and Mental Health	Reduce substance abuse and improve mental health in Maine by 5% by June 2017
Tobacco Use	Reduce adult and adolescent tobacco use in Maine by 5% by June 2017

Infrastructure Priorities	Goal *no specific quantitative targets were set for infrastructure objectives
Inform, Educate and Empower the Public (Essential Public Health Service* # 3)	Increase Maine's capacity to inform, educate and empower Maine people about health issues by June 2017.
Mobilize Community Partnerships (Essential Public Health Service # 4)	Increase Maine's capacity to mobilize community partnerships and action to identify and solve health problems by June 2017.

Programs Funded by FHM

Appropriation: FHM Community School Grants and Statewide Coordination (014326)

- Community Health Coalitions Program Description: Health promotion, education, and prevention services delivered through community coalition based structures to address tobacco, physical activity, and nutrition in Maine communities and schools.
- School Based Health Centers Program Description: Eight agencies operate sixteen clinic locations to provide medical care, mental health care, and prevention counseling, serving middle and high school students.
- School Based Health Centers Evaluation and Quality Assurance Program Description: data collection and quality improvement support related to the School Based Health Centers.

Appropriation: FHM Tobacco Prevention and Control (014330)

- Partnership for a Tobacco-free Maine Program Description: Tobacco prevention and control program in the Maine CDC with the goals of preventing youth from starting to use tobacco, assisting users to quit, and reducing the effects of tobacco use.

Alignment with State Health Priorities and Goals

Department Strategic Priority	Health Priority	Goal	Related FHM Funded Program(s)	GAP
Improve individual and public health	Immunizations	Increase youth and adult immunizations		
	Obesity	Reduce youth and adult obesity	Community Health Coalitions, School Based Health Centers	Population health and health care/health systems intersection
	Substance Abuse and Mental Health	Reduce substance abuse and improve mental health	Community Health Coalitions, School Based Health Centers	Integration of behavioral health and primary care
	Tobacco Use	Reduce tobacco use and exposure to tobacco smoke	Community Health Coalitions, School Based Health Centers, Partnership for a Tobacco Free Maine	Connection to primary care; need for district-specific metrics
Ensure Efficient Use of Resources to Achieve Quality Outcomes	Value Based Purchasing, Preventive Care	Increase access to Primary Care and reduce overutilization of the Emergency Department/Preventable Admissions		Population health and health care/health systems intersection
	Community Partnerships	Increase the community's active involvement in public health	Community Health Coalitions	Lack of measurable outcomes Population health and health care/health systems intersection

APPENDIX D

Friends for a Fund for a Healthy Maine overview of the Fund for a Healthy Maine program

FUND FOR A

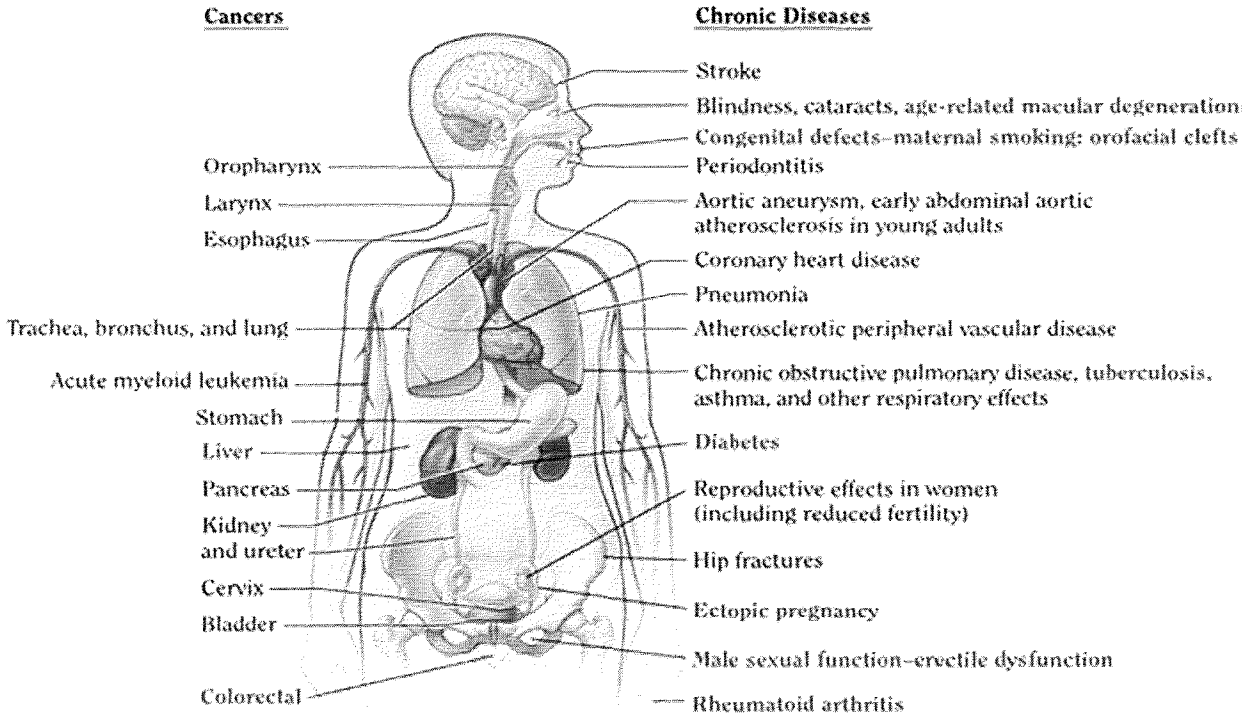
HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

Presented by the Friends of the Fund for a Healthy Maine ~ September 2015

- **Tobacco use is a major preventable cause of premature death and disease worldwide.**

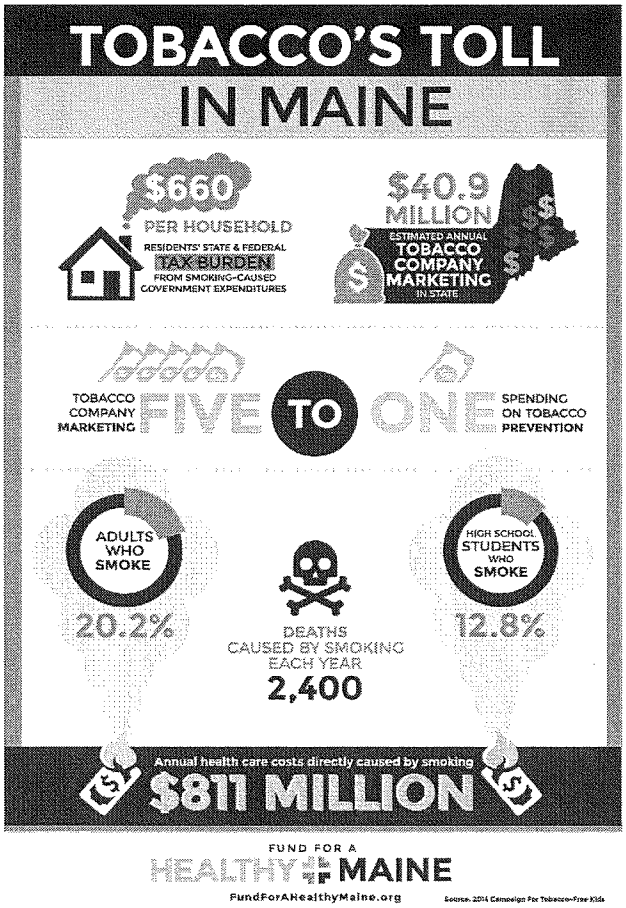
- **Tobacco kills more people in Maine than alcohol, AIDS, car crashes, illegal drugs, murder and suicide COMBINED.**



Conditions in red are new SGR findings

FUND FOR A HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.



Kids now under 18 and alive in Maine who will ultimately die prematurely from smoking = 27,000

Annual health care costs in Maine directly caused by smoking = $811 million

Portion covered by Mainecare = $261.6 million

Smoking-caused productivity losses in ME = $647 million

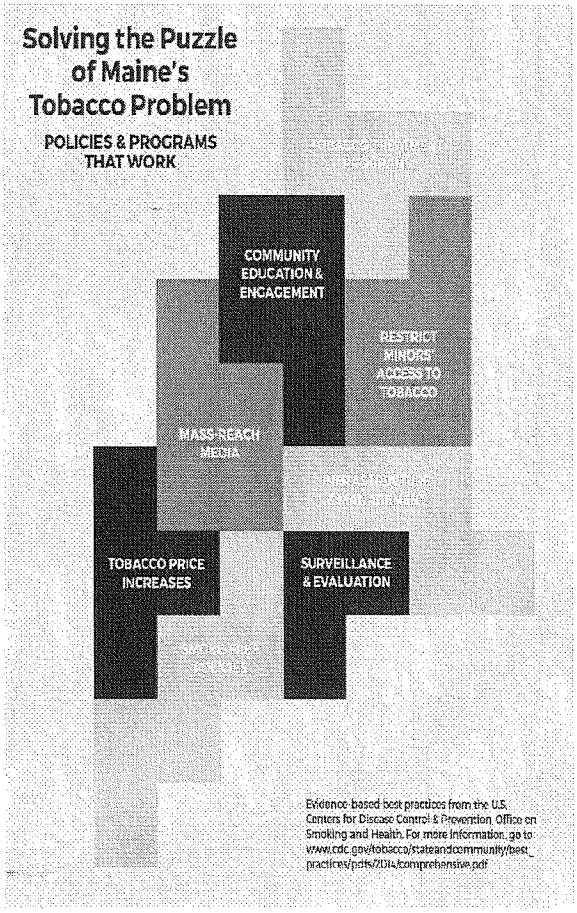
For each death, it is estimated that 30 more suffer from tobacco-related illness

https://www.tobaccofreekids.org/facts_issues/toll_us/maine

Tobacco IS a Winnable Battle

- Sustained funding of comprehensive programs
- Excise tax increases
- 100% smoke-free policies
- Aggressive media campaigns
- Cessation services access
- Comprehensive advertising restrictions

CDC Winnable Battles
http://www.cdc.gov/winnablebattles/



Fund for a Healthy Maine Mission

Creating Opportunity for Greater Health and Lowering Costs for Everyone

Goals

1. Prevent chronic disease
2. Improve health status
3. Reduce future health costs

FUND FOR A HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

75% of Health Care Costs are a Result of Chronic Disease.

We have the tools we need to significantly reduce this number.

FUND FOR A HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

Original Allocations

- **Smoking prevention, cessation and control activities**, including, but not limited to, reducing smoking among the children of the State [**In 2012 Obesity Prevention was added as an allowable use]**;
- **Prenatal and young children's care**, including home visits and support for parents of children from birth to 6 years of age;
- **Child care for children up to 15 years of age**, including after-school care; Health care for children and adults, maximizing to the extent possible federal matching funds;
- **Prescription drugs for adults who are elderly or disabled**, maximizing to the extent possible federal matching funds;
- **Dental and oral health care to low-income persons** who lack adequate dental coverage;
- **Teen Pregnancy Prevention;**
- **Substance abuse prevention and treatment**; and
- **Comprehensive school health programs**, including school-based health centers.

FUND FOR A HEALTHY MAINE

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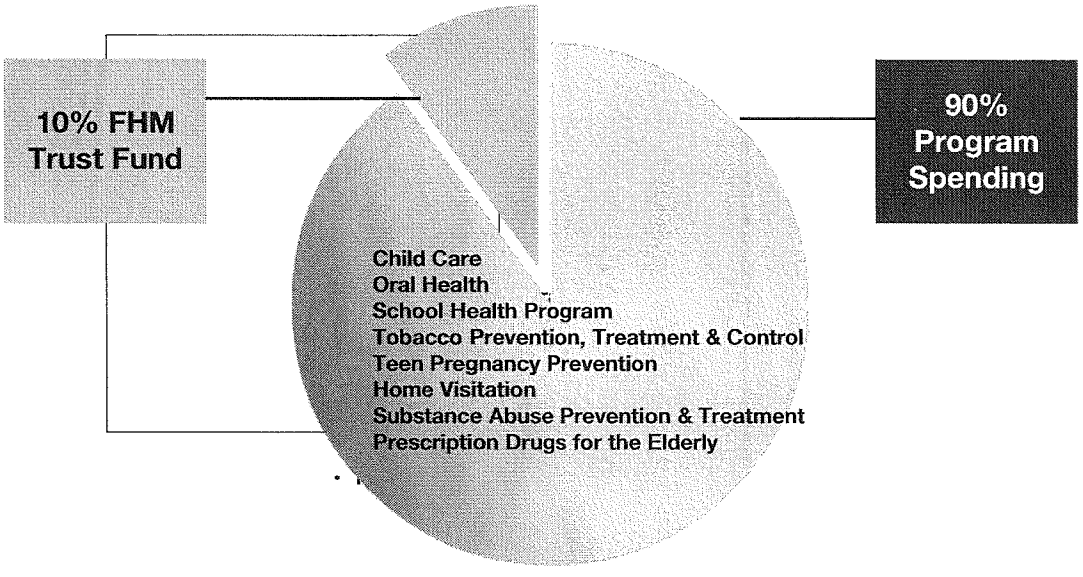
Original Allocation Vision



FUND FOR A HEALTHY MAINE

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FHM Timeline

1998- Landmark Master Tobacco Settlement Case Win in Federal Court. Maine participated in the national tobacco settlement because many Maine people suffered disease and death as a result of tobacco use encouraged by the deceptive practices of the tobacco industry.

1999- The Fund for a Healthy Maine (FHM) was created by the Maine Legislature to receive and disburse Maine's annual tobacco settlement payments.

2000- Allocations began to 8 categories of the FHM.

2009- OPEGA review of the FHM.

2011- Legislative Study Commission of the FHM.

FUND FOR A HEALTHY MAINE

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Legislative Study Commission Recommendations (8)

1. **Change the Fund for a Healthy Maine to a separate fund.** Amend the Fund for a Healthy Maine law to change the Fund for a Healthy Maine from a group of programs within Other Special Revenue Funds to a separate fund. Maintain current law on revenues paid into the fund.
   Legislation passed 125th, LD 1884 - never implemented

2. **Include health promotion and prevention and overweight and obesity to the list of health purposes for the Fund for a Healthy Maine.** Amend the Fund for a Healthy Maine law to broaden "health-related purposes" to "prevention and health promotion purposes." Also amend the list of prevention and health promotion purposes to include overweight and obesity prevention, education and treatment activities.
   Legislation Passed 125th, LD 1855 was implemented

3. **Require separate accounts and annual reporting about the use of Fund for a Healthy Maine funds.** Amend the Fund for a Healthy Maine law to require contractors, vendors and state agencies receiving funding from the Fund for a Healthy Maine to maintain money received from the Fund for a Healthy Maine in separate accounts and to provide a description of how Fund for a Healthy Maine funds for the prior state fiscal year were targeted to the prevention and health promotion purposes specified in the law. Require the Commissioner of Administrative and Financial Services to compile reports and forward information to the Legislature annually.
   Legislation Passed 125th, LD 1884 - never implemented

4. **Require Health and Human Services Committee review of Fund for a Healthy Maine legislation.** Amend the Fund for a Healthy Maine law to require review by the joint standing committee having jurisdiction over health and human services all matters of legislative proposals that affect the Fund for a Healthy Maine that have majority support in the committee to which the legislation was referred. This mirrors the provision currently in Joint Rule 317. This recommendation was adopted by a majority vote of 9 to 3. The minority supported continuing to impose review requirements under Joint Rule317.
   Legislation Passed 125th, LD 1884, was implemented

Legislative Study Commission Recommendations (8)

5. Require study commission review of Fund for a Healthy Maine allocations every four years. Amend the Fund for a Healthy Maine statute to require the Legislature to establish a study commission to review allocations of the Fund for a Healthy Maine beginning in 2015 and every four years thereafter. The composition and duties of the commission would mirror the current commission under Resolve 2011, chapter 112. ***Not Implemented***

6. Recommendations regarding separate program accounts. Direct the Commissioner of Administrative and Financial Services to review program structure for the programs of the Fund for a Healthy Maine and to recommend a new program structure, including a program for overweight and obesity prevention, education and treatment, beginning in state fiscal year 2014-2015. Funding for the new overweight and obesity program is from funding currently provided for this purpose under existing programs.
Legislation Passed 125th, LD 1855 - never implemented

7. Issue a statement of support for funding continued enforcement by the Office of the Attorney General. Include in the recommendations of the Commission a statement of support for continued funding for the Office of the Attorney General from the Fund for a Healthy Maine to enable the office to continue diligent enforcement of the tobacco master settlement agreement in accordance with the requirements of Title 22, chapter 263, subchapters 3 and 4. ***Legislation Not Required - Implemented***

8. Issue a statement of support for investments in public health and prevention and for the original intent of the funding. Include in the recommendations of the Commission a statement that the Commission recognizes the importance of investments in public health and prevention and believes that the original intent of the funding should be maintained and efforts should be made to eliminate health disparities. The statement will also include the following: "Access to adequate health coverage and support for building relationships with health care providers and the health care system are critical to the individual's ability to access important prevention, education and treatment resources related to smoking and tobacco, overweight and obesity, prenatal and young children's care, child care, health care, prescription drugs, dental and oral health care, substance abuse, school health and nutrition programs and counseling on ways to improve individual health behaviors." ***Legislation Not Required - Not Implemented***

Obesity Successes

- 56.2% of adults are meeting physical activity recommendations, a 12% increase since 2011.
- There was a statistically significant increase from 2009 to 2013 in the percentage of students in grades 5 (18% increase) and 9-12 (5% increase) who reported daily intake of 5 or more fruits and vegetables.
- Students who report drinking zero surgary beverages per day has increased by 5% since 2011.
- From 2011 to 2013, the prevalence of obesity and overweight for students in grades 5 and 7-12 remains steady with no statistically significant changes. While decreasing the prevalence of obesity is the ultimate goal, a positive first step is having rates remain steady.

Community & School Grants/Tobacco

HMPs fill the gaps where private health care falls short.
School health, workplace wellness, youth smoking and alcohol and substance abuse, obesity, and senior wellness are some areas where HMPs deliver programmatic prevention and control strategies based on community needs.

HMP programs affect 100% of your constituents.
Babies, older youth, adults and the elderly benefit from HMP programs.

HMPs have the goal of long-term prevention versus short-term treatment. Medicine prescribed by a doctor helps one person, while the comprehensive public health prevention programs of HMPs help thousands avoid unhealthy choices that lead to illness or chronic disease.

HMPs are highly localized to Maine communities. The coalition-based approach to the work of HMPs helps identify specific community and region needs. The approach also ensures that HMP funding is used efficiently and put to use where it is most needed.

HMPs assess and address emerging health threats. Recent examples include the response to the H1N1 and the rapid growth of electronic cigarettes.

FUND FOR A HEALTHY MAINE
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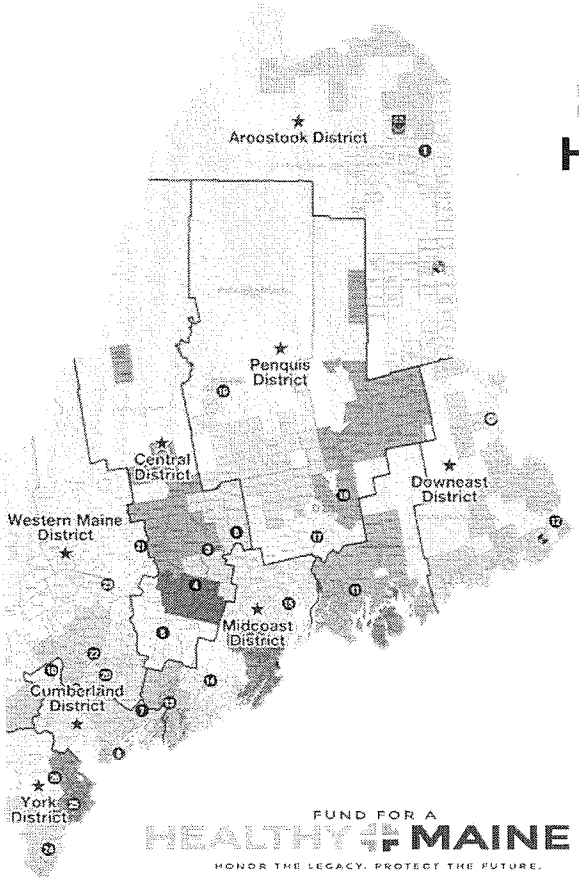

Creation of a Public Health Delivery System & Infrastructure

HMP's rely on monies from the Fund to continue to support community-based outreach – otherwise they would not exist.

Total investment in HMPs is $90 million total over 14 years.

HMPs have leveraged over 19 million dollars in private and federal funds.

HMPs fill the gaps where private healthcare falls short. School health, workplace wellness, youth smoking and alcohol and substance abuse, obesity, and senior wellness are some areas where HMPs deliver programmatic prevention and control strategies based on community needs.

Tobacco Success

- **67% drop in youth smoking** since Maine created its tobacco program in 1997 along with a tobacco tax increase.
- The FHM took over the program funding and is the only state money dedicated to decreasing the **#1 killer in Maine**.
- **Cigarette use declined from 18% in 2009 to 13% in 2013.**
- The Maine Tobacco Helpline has **helped over 100,000 clients** since its inception.
- **Decreased the high school smoking rate from 39% to 18%.**

FUND FOR A HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

School Based Health Center Success

- The Fund helps **16 SBHC's provide access to care for close to 12,000 students,** allowing parents to stay at work and decreasing absenteeism and drop-out rates in students.
- More than one third **(35%) of students who smoke and were seen at a SBHC** reported that they reduced their smoking or quit smoking as a result of their visit.
- More than **half of SBHC encounters were with a behavioral health specialist** and **57% of medical visits were for preventative screenings** such as immunization or well-child visits.
- **45% of students in a school with a SBHC were enrolled with the center.**

FUND FOR A HEALTHY MAINE

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Substance Abuse Success

- **Decreased** the alcohol use rate among Maine's 6th to 12th grade students from **71% to 48%.**
- The proportion of high school students in Maine who report consuming alcohol in the past month has decreased notably since 2009- **dropping from 32% in 2009 to 26% in 2013.**
- Binge drinking in high school age youth has **declined from 19% in 2009 to 15% in 2013.**
- Alcohol and/or drug related crashes among 16-20 year **olds decreased from 151 crashes in 2009 to 82 crashes in 2013, representing a 46% reduction.**

FUND FOR A
HEALTHY MAINE
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Oral Health Success

- 25% of Maine dentists participate in the Donated Dental Services Program, providing free services to qualified disabled and elderly individuals- average value of these services was over $3,300 in SFY 14, and the total was close to $376,000.
- 37 loans to dental students who already have or will return to Maine (with return service obligations) and 23 loan repayment awards to dentists practicing in underserved areas. The overall retention of dentists – that is, of dentists who have stayed in Maine to practice after completing their obligations – is about 72%.
- FHM supports 5 community based agencies in providing over 4,600 dental services to about 2360 patients in 10 locations in SFY14. The Subsidy Program, intended to help offset costs of providing reduced fee services to low income patients, has been reduced considerably since SFY 11, when 13 agencies with dental clinics in 19 locations participated and provided just under 37,000 dental services to 19,259 people, for a total of $714,033.
- Support preventive programs in about 180 elementary schools, mostly in rural areas, where children are more likely to encounter challenges in finding regular access to dental care. These programs offer classroom-based education, and about half also provide dental sealants and fluoride for second-graders. Between the 2013 and 2014 school years, an average of 94 schools provided sealants to over 1600 children, who received an average of 3.2 sealants each.

FUND FOR A
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Teen Pregnancy Prevention Success (DEFUNDED)

- Maine's teen **pregnancy rate decreased by 48%** between 1988 and 2005, one of the most dramatic decreases in the nation.
- **Maine's rates of teen pregnancy and teen birth are among the lowest in the nation,** down from 70 per thousand girls in 1992 to 37 per thousand in 2010.
- The percentage of high school students who have ever had sexual intercourse has **declined from 52% in 1997 to 45% in 2007**.
- Among high school students who are sexually active, the percentage who **used a condom during their last sexual intercourse has increased significantly from 51% in 1997 to 59% in 2007**. The percentage who used birth control pills has increased from 30% in 1997 to 41% in 2007.

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Child Care Success

- **About 3,000 children, ages birth – 12, currently receive child care, Head Start, or after-school programs.**
- Nearly **2,500 children, ages 12 - 15, participate** in a range of recreational, cultural, academic, and arts programs after school and in the summer.

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Home Visitation Success (DEFUNDED)

- **92% of Maine Families participants' children were up to date with immunizations** as a result of home visitors providing education and support to address barriers to timely immunizations.
- As a result of routine screening by professional home visitors, **more than 177 children of Maine Families participants were identified with possible developmental delays** and provided supports to help address those delays early before more costly remediation is needed in school.
- Among the **15% of babies who were exposed to second-hand smoke, over half who were exposed at 3 months of age were no longer exposed by 9 months of age.**
- **99.4% of children of Maine Families participants were connected to a primary care provider** compared to about two-thirds of children who have a medical home statewide.

FUND FOR A HEALTHY MAINE

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MAINE LANDSCAPE

- Maine spends approximately **$11 billion on healthcare** costs each year.
- The Fund for a Healthy Maine, Maine's only source of State funds for prevention, **accounts for only .48%** of Maine's total health care expenditure.
- Every $1 of these vital resources **saves taxpayers** from $5 to $29 depending on the program *(Trust for America's Health).*
- ME does not have a system of health departments, so FHM infrastructure is critical.
- The Fund for a Healthy Maine has **saved Maine $4 billion** over the past ten years in long- term health care costs.
- **91% of Maine voters feel the tobacco settlement funds should be used to promote good health for all Mainers.**

FUND FOR A HEALTHY MAINE

HONOR THE LEGACY. PROTECT THE FUTURE.

Prevention is an Investment that Pays

Every $1 taken from FHM prevention programs will add at least $7.50 to Maine's future health costs. Savings estimates go higher, but one thing is clear: the FHM is an investment in our future health and financial well-being *(Trust for America's Health).*

Every **$1 taken from the FHM today will be $1 that is <u>not</u> available** to fund prevention programs for our most at-risk citizens.

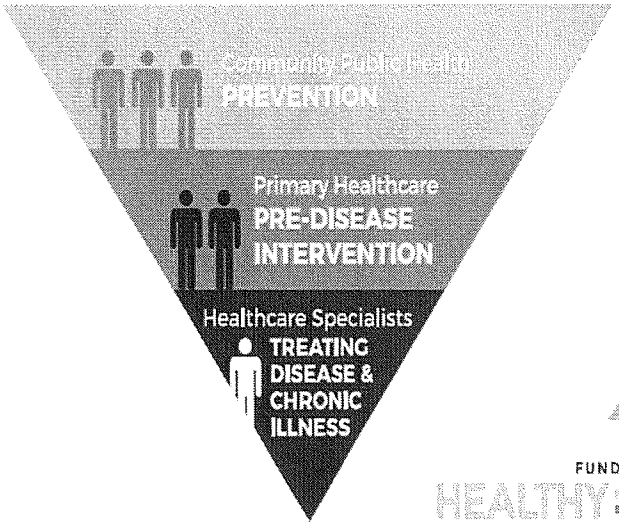
The FHM is a nationally recognized success story. Maine's use of tobacco settlement dollars and specifically Maine's tobacco prevention and treatment program continue to draw both national and international recognition for their comprehensive approaches to preventing costly healthcare.

FUND FOR A HEALTHY MAINE

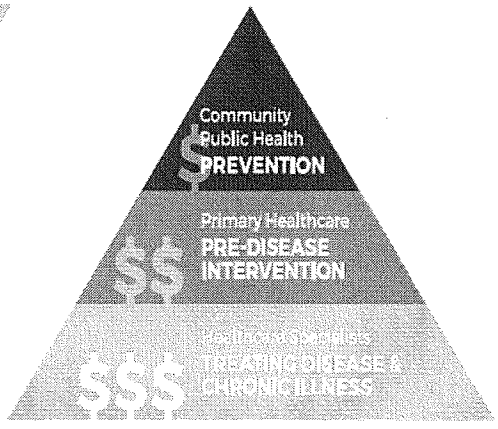
HONOR THE LEGACY. PROTECT THE FUTURE.

The Path to Healthy People and Strong Communities

REDUCING CHRONIC ILLNESS REQUIRES BOTH PREVENTION AND EARLY INTERVENTION



PREVENTION IS OUR SMARTEST INVESTMENT IN SAVING LIVES AND REDUCING HIGH HEALTH CARE COSTS



FUND FOR A HEALTHY MAINE

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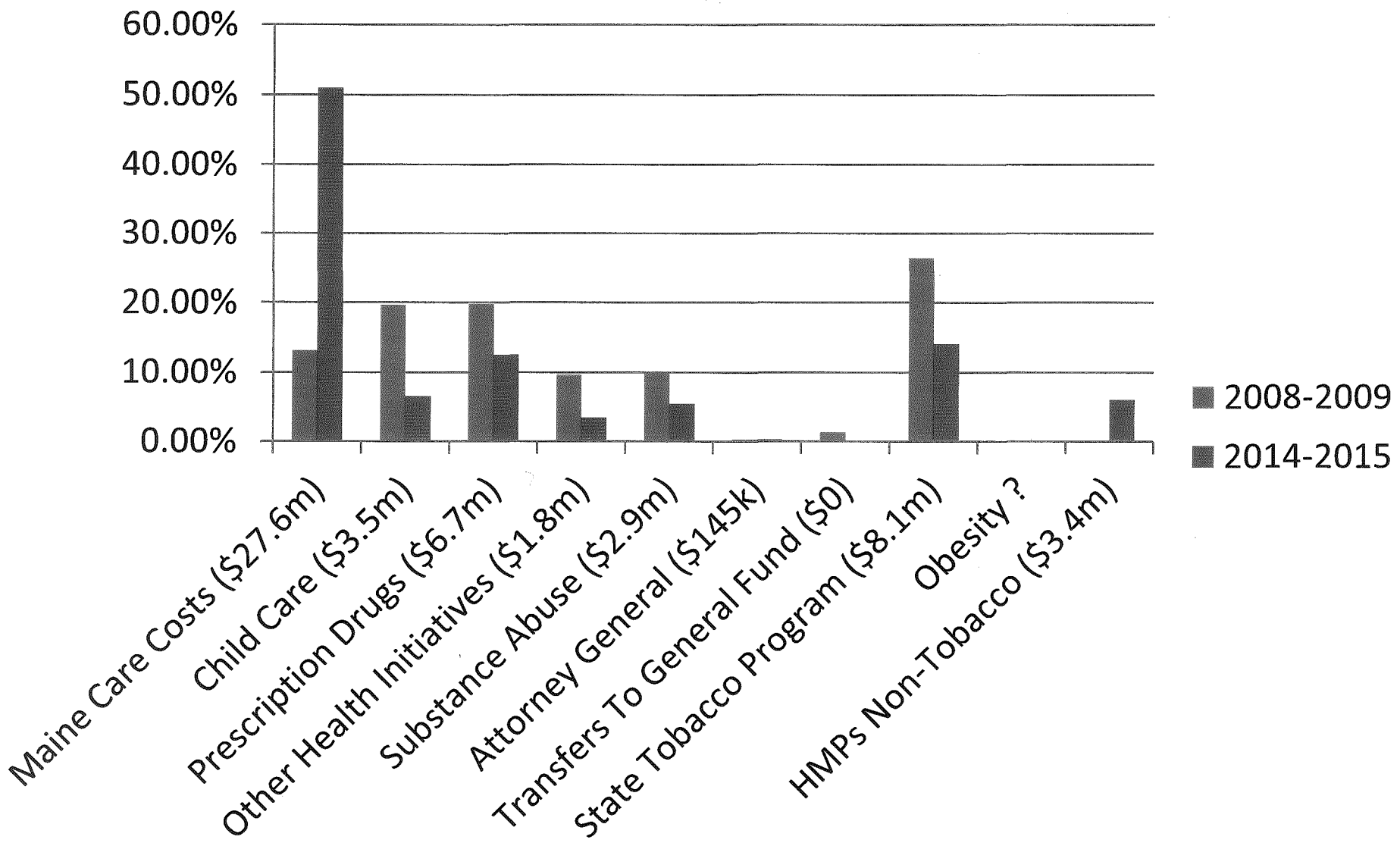
FundForAHealthyMaine.org

FHM Allocation Changes



APPENDIX E

Department of Administrative and Financial Services report pursuant to Public Law 2011, chapter 701, section 2

STATE OF MAINE
DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES
State House Station #58
Augusta, Maine 04333

DATE: October 1, 2015

TO: Senator Erik L. Brakey, Chair
Representative Andrew Gattine, Chair
Members, Joint Standing Committee on Health and Human Services

FROM: Richard Rosen, Commissioner

SUBJECT: Fund for a Healthy Maine

Please see the attached report containing expenditure detail for Fiscal Year 2015 that has been received from state agencies as required by Public Law 2011, chapter 701, section 2:

"A state agency that receives allocations from the fund and a contractor or vendor that receives funding allocated from the fund shall maintain that money in a separate account and shall report by September 1st of each year to the Commissioner of Administrative and Financial Services providing a description of how those funds for the prior state fiscal year were targeted to the prevention and health-related purposes listed in subsection 6. The Commissioner of Administrative and Financial Services shall by October 1st of each year compile the reports provided under this subsection and forward the information in a report to the Legislature."

As of this date, the Department of Administrative and Financial Services has not received any additional reporting describing Fiscal Year 2015 expenditures from contractors or vendors.

Cc: Office of Fiscal and Program Review

Fund for a Healthy Maine Expenditures by Agency - Fiscal Year 2015

Health and Human Services

Expenditure Category	Definition	OMS	CDC	OCFS	SAMHS	Total
6A	Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State		8,475,672			8,475,672
6A1	Prevention, education and treatment activities concerning unhealthy weight and obesity		2,710,379			2,710,379
6B	Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age					-
6C	Child care for children up to 15 years of age, including after-school care			3,312,234		3,312,234
6D	Health care for children and adults, maximizing to the extent possible federal matching funds	6,612,022	674,759			7,286,781
6E	Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds	27,846,495				27,846,495
6F	Dental and oral health care to low-income persons who lack adequate dental coverage		315,499			315,499
6G	Substance abuse prevention and treatment	1,166,851			1,785,130	2,951,981
6H	Comprehensive school health and nutrition programs, including school-based health centers		580,751			580,751
	Total by Office	35,625,368	12,757,060	3,312,234	1,785,130	53,479,792

Department of Education

Hungry students have a much harder time learning. The Child Nutrition program assists schools in providing a healthy breakfast and lunch to students in order to give them the sustenance they need to be able to learn. Fund for a Healthy Maine dollars are used to provide breakfast for those students who receive meals at a reduced cost. Public schools are reimbursed 30 cents per reduced meal. Breakfast is highly correlated with improved learning and higher test scores.

Office of the Attorney General

The Office of the Attorney General's Tobacco Enforcement section within the Consumer Protection Division works toward prevention and health-related purposes as those goals stem from tobacco use in the State in a number of ways. As a signatory state to the 1998 Tobacco Master Settlement Agreement, Maine is an active participant in multi-state efforts to promote public health awareness, education and legislative advances around myriad tobacco issues, including, but not limited to: marketing to youth; introduction and regulation of new tobacco products on the market; and smoking in movies and other mass-marketed depictions. The OAG also oversees the enforcement of the State's tobacco laws as they pertain to retailers, and to tobacco use in public and employment settings.

Finance Authority of Maine

The Finance Authority of Maine (FAME) receives via the biennial budget two FFHM allocations: one is for the FAME-administered Maine Dental Loan and Loan Repayment Programs ($237,740 in each year of the biennium), while the other is "pass-through money" that supports the University of New-England-administered Maine Area Health Education Centers ($110,000 in each year of the biennium). As required by statute, these allocations are indeed maintained by FAME in a separate account.

The Maine Dental Education Loan and Loan Repayment Programs provide need-based, forgivable loans to Maine residents pursuing post-graduate education in dentistry and loan repayment for dentists providing services to underserved populations in Maine. The FFHM allocations allow for the selection of new participants in the program and provide continued funding for students needing loans and loan repayment as dentists practicing in underserved areas in Maine. Through the funding, FAME is able to meet its commitment to existing program participants, as well as to add new participants. A commitment in this program is four years for both students receiving loans and for dentists receiving loan repayments. FAME has been able to leverage money in this program twice in the loan repayments program: once through a Health Resources and Services Administration (HRSA) grant, and another time with Delta Dental money. Thus, the program has been efficient and innovative.

For FY 15, the Maine Dental Loan Program spent $260,000 to assist 13 students. These students received $20,000 each for their loans. The Maine Dental Loan Repayment Program spent $130,000 to assist 10 loan recipients. These loan repayment participants received payments ranging from $10,000 to $30,000, depending on the terms of their particular agreements.

The Maine Area Health Education Centers (AHEC) funding is "pass-through" money that FAME transfers to the University of New England. This money helps to fund the rural health workforce development programs in the Area Health Education Centers, which are located in Bangor, Farmington, and Presque Isle. These funds are matched 1:1 by HRSA.

The AHEC network works to alleviate shortages of health professionals in Maine's rural and underserved areas by actively engaging with academic and community partners to:

- Encourage Maine youth and mid-career professionals to explore health careers and create a "pipeline" to target those Maine residents, particularly those from rural areas with the most likelihood of staying within Maine to live and work;
- Provide rural, community-based clinical training experiences for medical and other health professions students. Evidence shows that where students' initial placements occur creates a likelihood that they will return to practice in those communities;
- Support practicing health professionals with continuing education and distance learning opportunities to train and retain Maine health professionals within the state of Maine.

Please find the FY 15 budget included in the following table by the Area Health Education Centers to FAME. As you can see, it includes the FFHM budgeted allocation for $110,000, as well as some carry-over funds of $459.03.

Maine Area Health Education Centers Network
FAME Budget FY15
July 1, 2014 – June 30, 2015

Activities	Budget Amount
Western Maine AHEC (Franklin Memorial Hospital) • Support retention and recruitment activities for health care personnel through program curriculum development, materials, training supplements, speakers, and conference support • Support youth related programs such as Scrub Club and Public Health Pipeline to increase interest in health careers • Hold health care career fair for college students, high school students and mid-career workers to expand interest in health careers	$27,000.00
Northern Maine AHEC (Northern Maine Community College) • Provide support for non-credit and short term health care training programs with program educational supplies, IT support for distance education opportunities, and training materials and equipment • Support travel related to AHEC program activities and staff development • Provide support for pipeline activities such as Survivor Aroostook and DOC4ADay to expose students to health careers	$27,000.00
Eastern Maine AHEC (Penobscot Community Health Care) • Support pipeline activities for high school students including DOC4ADay, Dentist4ADay, and Medical Outreach Maine in conjunction with Tufts/MMC students, UMaine Orono students and Waldo County public schools • Develop and implement new retention programs such as "Finance 101" and "Geriatric Issues" • Support placement of health profession students in clinical rotations including students in PA, Nurse Practitioners, Pharmacists, physicians, dental and other health profession programs	$25,000.00

Tribal Outreach Activities (Maine Indian Education) • Support the 4th Annual Career Expo for tribal students in Washington County to expose all Maine tribal students to a variety of careers including health careers	$7,000.00
Pipeline, Primary Care and Interprofessional Education Activities (Maine Medical Center) • Support pipeline activities such a DOC4ADay and activities to interest medical students in primary care such as conferences, speakers and community involvement activities • Support development of an Interprofessional Education clinical rotation placement program for UNE health profession students (DO, Pharmacy, Social Work)	$17,800.00
AHEC Program Office (University of New England) • Support implementation of interprofessional programs and community involvement projects during clinical placements through mini-grants and training opportunities • Increase interest in family medicine and primary care among health profession students through outreach, conferences and speakers/training support • Support pipeline activities such as summer enrichment or other pipeline activities	$6,659.03
Total	**$110,459.03**

Department of Administrative & Financial Services
Fund for a Healthy Maine
014 18F 0921 01
Sources & Uses
For Fiscal Year 2015
As of June 30, 2015

		FY 2015 Budgeted Sources/Uses	Net FY 2014 Encumbrances Forward	FY 2015 Actual Year To Date Sources/Uses	FY 2014 Balances Forward *(see footnote 1)*	Actual Less Budget	Cash Outlays	Cash Balance	Net Encumbrances	Unobligated Balance
Sources										
Revenue From Settlement	2526	$ 48,832,108.00		$ 49,475,682.05		$ 643,574.05				
Revenue From Slot Machines	1322	4,288,409.00		4,107,613.86		(180,795.14)				
Interest Income	2105	7,826.00		8,956.27		1,130.27				
Prior Year Adjustments	2115, 2952, 2956	0.00		430,389.55		430,389.55				
Contributions from OSR	2719	0.00		-		0.00				
Transfers from Unapprop Surplus	2934	0.00		-		0.00				
Balance Forward		7,284,324.10		7,284,324.10		0.00				
General Fund Advance	2945	0.00		-		0.00				
Total Available		$ 60,412,667.10		$ 61,306,965.83		$ 894,298.73				
uses										
Tobacco Prevention & Control	01410A095302	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Community School Grants	01410A095307	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Public Health Infrastructure	01410A095308	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Purchased Social Services	01410A096101	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Drugs for the Elderly	01410AZ01501	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Immunization	01410AZ04801	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Substance Abuse	01414G094801	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FHM - School Breakfast	02405AZ06801	213,720.00	0.00	201,972.90	0.00	(11,747.10)	201,972.90	0.00	0.00	0.00
FHM - Oral Health	02410A014325	300,000.00	0.00	298,500.00	0.00	(1,500.00)	279,036.00	19,464.00	19,464.00	0.00
FHM - Community/School Grants & Statewid	02410A014326	5,018,896.00	399,234.50	4,753,017.92	399,234.50	(265,878.08)	4,816,106.11	336,146.31	336,146.31	0.00
FHM - Public Health Infrastructure	02410A014327	1,355,923.00	104,148.00	1,149,165.29	104,148.00	(206,757.71)	1,185,403.63	67,909.66	67,909.66	0.00
FHM - Donated Dental	02410A014328	36,463.00	0.00	36,463.00	0.00	0.00	36,463.00	0.00	0.00	0.00
FHM - Immunization	02410A014329	1,078,884.00	27,452.10	647,306.71	27,452.10	(431,577.29)	674,758.81	0.00	0.00	0.00
FHM - Tobacco Prevention, Control & Treatm	02410A014330	6,417,178.00	1,241,111.27	5,327,636.78	1,241,111.27	(1,089,541.22)	5,765,293.02	803,455.03	803,455.03	0.00
FHM - Medical Care	02410A014701	27,668,900.00	0.00	27,668,899.28	0.00	(0.72)	27,668,899.28	0.00	0.00	0.00
FHM - Drugs for the Elderly & Disabled	02410A020201	2,275,081.00	154,568.41	2,691,751.07	154,568.41	416,670.07	2,682,003.61	164,315.87	164,315.87	0.00
FHM - Purchased Social Services	02410A022801	1,971,118.00	0.00	1,970,810.17	0.00	(307.83)	1,970,810.17	0.00	0.00	0.00
FHM - Head Start	02410A054504	1,354,580.00	35,795.90	1,341,288.25	35,795.90	(13,291.75)	1,341,424.25	35,659.90	35,659.90	(0.00)
FHM - Substance Abuse	02414G067901	1,848,306.00	54,078.75	1,813,898.96	54,078.75	(34,407.04)	1,785,129.77	82,847.94	82,847.94	0.00
FHM - Office of Substance Abuse Medicaid M	02414G084401	1,306,059.00	0.00	1,166,850.50	0.00	(139,208.50)	1,166,850.50	0.00	0.00	0.00
FHM - Attorney General	02426A094701	152,532.00	0.00	145,532.27	0.00	(6,999.73)	145,532.27	0.00	0.00	0.00
FHM - Health Education Centers	02494F095002	110,000.00	0.00	110,000.00	0.00	0.00	110,000.00	0.00	0.00	0.00
FHM - Dental Education	02494F095101	237,740.00	0.00	237,740.00	0.00	0.00	237,740.00	0.00	0.00	0.00
FHM - Drugs for the Elderly & Disabled - SLC	02410A020201	4,489,682.00	0.00	4,107,613.86	0.00	(382,068.14)	4,107,613.86	0.00	0.00	0.00
TOTAL		55,835,062.00	2,016,388.93	53,668,446.96	2,016,388.93	(2,166,615.04)	54,175,037.18	1,509,798.71	1,509,798.71	0.00
UNDISTRIBUTED NET BALANCE		$ 4,577,605.10	$ (2,016,388.93)	$ 7,638,518.87	$ (2,016,388.93)	$ 3,060,913.77				

Footnotes

1 All other balances are to satisfy encumbrances carried forward. This is also recognized in the encumbrances column as a liability.
The balances forward shown have also been reduced by the amounts returned to the Fund as a result of lapsed prior year encmbrances.

APPENDIX F

Suggested legislation

Title: An Act to Require an Annual Report on the Fund for a Healthy Maine

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1511, sub-§16 is enacted to read:

16. Annual report by Commissioner. Beginning January 2017, the Commissioner shall report annually no later than January 1st of each year 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 include the following information from the previous state fiscal year:

A. Detailed spending from the fund showing annual expenditures in all programs;

B. Progress the department is making toward health priorities identified by the department as improving health status in the State using expenditures from the fund;

C. Information relating to any audit conducted by the department, the Department of Administrative and Financial Services or the Office of the State Auditor of any programs funded by the fund including summary information, frequency of any audit, the level of detail of any audit, and how often correction action plans were developed and applied; and

D. Any data submitted to the Department of Administrative and Financial Services pursuant to subsection 13.

SUMMARY

This bill requires the Commissioner of Health and Human Services to submit an annual report to the joint standing committee having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services by January 1st of each year. The report must include: detailed spending from the Fund for a Healthy Maine; progress the department is making toward health priorities using Fund for a Healthy Maine funding identified as improving health status in the State; information relating to any audit from the Department of Health and Human Services, the Department of Administrative and Financial Services and the Office of the State Auditor; and any data submitted to the Department of Administrative and Financial Services pursuant to Title 22, section 1511, subsection 13.

APPENDIX G

Committee letters to the Government Oversight Committee, the Department of Administrative and Financial Services and Department of Health and Human Services

SENATE

ERIC L. BRAKEY, DISTRICT 20, CHAIR
EARLE L. MCCORMICK, DISTRICT 14
ANNE M. HASKELL, DISTRICT 28

ANNA BROOME, LEGISLATIVE ANALYST
MICHAEL O'BRIEN, LEGISLATIVE ANALYST
ANNIE BUCKMAN, COMMITTEE CLERK

HOUSE

DREW GATTINE, WESTBROOK, CHAIR
PETER C. STUCKEY, PORTLAND,
MATTHEW J. PETERSON, RUMFORD
SCOTT M. HAMANN, SOUTH PORTLAND
CHRISTINE S. BURSTEIN, LINCOLNVILLE
PATRICIA HYMANSON, YORK
DEBORAH J. SANDERSON, CHELSEA
RICHARD S. MALABY, HANCOCK
FRANCES M. HEAD, BETHEL
KAREN VACHON, SCARBOROUGH

STATE OF MAINE
ONE HUNDRED AND TWENTY-SEVENTH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

TO: Roger Katz, Senate Chair
Charles Kruger, House Chair
Joint Standing Committee on Government Oversight

FROM: Eric L. Brakey, Senate Chair EB
Drew Gattine, House Chair DG
Joint Standing Committee on Health and Human Services

DATE: December 15, 2015

RE: Support of study of Department of Health and Human Services audit functions

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We are writing to express our support for the task on OPEGA's work plan related to the Department of Health and Human Services audit functions.

Our Committee recently completed a study of the allocations of the Fund for a Healthy Maine. Throughout the study, we had several conversations about auditing related to FHM contracts, and several questions remain. Although vendors receiving FHM funding told us that they routinely file financial reports required by their contract, it is unclear whether the Department of Health and Human Services is regularly conducting audits as part of routine contract management. If audits are being regularly conducted, our Committee would like the results to be more readily available. Our Committee needs this information to make informed decisions about whether FHM funding should be adjusted.

We understand that the task on OPEGA's work plan concerns the effectiveness of the Department of Health and Human Services' audit functions in identifying and addressing fraud, waste and abuse in programs they administer. Although this task is not entirely related to our above-mentioned concerns, we would like to go on record as supporting the task on OPEGA's work plan and alert your Committee to our recent discussions related to FHM-related auditing.

Please let us know if you have any questions. Thank you.

SENATE

ERIC L. BRAKEY, DISTRICT 20, CHAIR
EARLE L. MCCORMICK, DISTRICT 14
ANNE M. HASKELL, DISTRICT 28

ANNA BROOME, LEGISLATIVE ANALYST
MICHAEL O'BRIEN, LEGISLATIVE ANALYST
ANNIE BUCKMAN, COMMITTEE CLERK

HOUSE

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FRANCES M. HEAD, BETHEL
KAREN VACHON, SCARBOROUGH

STATE OF MAINE
ONE HUNDRED AND TWENTY-SEVENTH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

December 15, 2015

Richard W. Rosen, Commissioner
Department of Administrative and Financial Services
78 State House Station
Augusta, ME 04333-0078

Dear Commissioner Rosen,

Thank you for your recent participation in our study of allocations of the Fund for a Healthy Maine, including your presentation on the first annual report submitted pursuant to section 2 of Public Law 2011, chapter 701 – "An Act To Revise the Laws Regarding the Fund for a Healthy Maine." We are writing to request an update on your progress implementing the following two statutory provisions, which were enacted by the Legislature following the report from the 2011 Commission to Study the Allocations of the Fund for a Healthy Maine.

1. Public Law 2011, chapter 701, section 2. In addition to state agencies receiving allocations from the Fund for a Healthy Maine, the report submitted pursuant to this section requires contractors and vendors that receive funding from the Fund for a Healthy Maine to describe how the funds for the previous fiscal year were targeted to the prevention and health-related purposes listed in the Fund for a Healthy Maine statute (Title 22, section 1511, subsection 6). The 2015 report that we received from your Department did not include this valuable information. We respectfully request that this information be made available to us now and included in all future annual reports.

2. Public Law 2011, chapter 617, section 2. This statute requires the Department of Administrative and Financial Services to create a separate budget entry or new account for prevention, education and treatment activities concerning unhealthy weight and obesity. The intent of this legislation was to separate anti-obesity efforts from tobacco cessation efforts in the accounting system and thereby increase the transparency of these public health activities. To our knowledge, this has not yet occurred.

Please let us know if you have any questions. We thank you for your cooperation and look forward to hearing from you soon.

Sincerely,

Sen. Eric L. Brakey
Senate Chair

Rep. Drew Gattine
House Chair

SENATE

ERIC L. BRAKEY, DISTRICT 20, CHAIR
EARLE L. MCCORMICK, DISTRICT 14
ANNE M. HASKELL, DISTRICT 28

ANNA BROOME, LEGISLATIVE ANALYST
MICHAEL O'BRIEN, LEGISLATIVE ANALYST
ANNIE BUCKMAN, COMMITTEE CLERK

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FRANCES M. HEAD, BETHEL
KAREN VACHON, SCARBOROUGH

STATE OF MAINE
ONE HUNDRED AND TWENTY-SEVENTH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

December 15, 2015

Mary Mayhew, Commissioner
Department of Health and Human Services
221 State Street
Augusta, ME 04333-0040

Dear Commissioner Mayhew,

As you know, our Committee met this interim to study the allocations of the Fund for a Healthy Maine. During this process, we were briefed by the Healthy Maine Partnerships and learned that considerable uncertainty exists among the Partnerships and the public health community on the content and funding levels of the new contracts, beginning July 1, 2017.

We voted unanimously to request regular updates from the Department of Health and Human Services on the progress and content of the Request for Proposals that will be issued in the near future for Healthy Maine Partnership contracts (replacing those that will end on June 30, 2016). We respectfully request that these updates begin when the Legislature reconvenes in January 2016 for the Second Regular Session.

We thank you in advance for your cooperation. Please let us know if you have any questions.

Sincerely,

Eric L. Brakey

Sen. Eric L. Brakey
Senate Chair

Rep. Drew Gattine
House Chair

§1036. Allocation of funds

1. Distribution for administrative expenses of board. A slot machine operator licensed under section 1011, subsection 2 or a casino operator that is a commercial track that was licensed to operate slot machines under section 1011, subsection 2 on January 1, 2011 shall collect and distribute 1% of gross slot machine income to the Treasurer of State for deposit in the General Fund for the administrative expenses of the board.
[PL 2011, c. 417, §7 (AMD).]

2. Distribution of net slot machine income from casino with commercial track. A slot machine operator licensed under section 1011, subsection 2 or a casino operator that is a commercial track that was licensed to operate slot machines under section 1011, subsection 2 on January 1, 2011 shall collect and distribute 39% of the net slot machine income from slot machines operated by the slot machine operator to the board for distribution by the board as follows:

A. Three percent of the net slot machine income must be deposited to the General Fund for administrative expenses of the board in accordance with rules adopted by the board, except that of the amount calculated pursuant to this paragraph, the following amounts must be transferred annually to the Gambling Addiction Prevention and Treatment Fund established by Title 5, section 20006-B:

(1) For the fiscal year beginning July 1, 2011, $50,000;

(2) For the fiscal year beginning July 1, 2012, $50,000; and

(3) For the fiscal year beginning July 1, 2013 and for each fiscal year thereafter, $100,000;
[PL 2009, c. 622, §2 (AMD).]

B. Ten percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the fund established in section 298 to supplement harness racing purses; [PL 2005, c. 663, §12 (AMD).]

C. Three percent of the net slot machine income must be credited by the board to the Sire Stakes Fund created in section 281; [PL 2005, c. 663, §12 (AMD).]

D. Three percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Agricultural Fair Support Fund established in Title 7, section 91; [PL 2007, c. 466, Pt. A, §29 (RPR).]

E. Ten percent of the net slot machine income must be forwarded by the board to the State Controller and except as otherwise provided in this paragraph credited to the Fund for a Healthy Maine established by Title 22, section 1511 and segregated into a separate account under Title 22, section 1511, subsection 11, with the use of funds in the account restricted to the purposes described in Title 22, section 1511, subsection 6, paragraph E. For the fiscal years ending June 30, 2010, June 30, 2011 and June 30, 2012, the amount credited annually by the State Controller to the Fund for a Healthy Maine under this paragraph may not exceed $4,500,000 annually and any funds in excess of $4,500,000 annually during these fiscal years must be credited as General Fund undedicated revenue, and, for the fiscal year ending June 30, 2013, the amount credited by the State Controller to the Fund for a Healthy Maine under this paragraph is $0; [PL 2011, c. 657, Pt. E, §1 (AMD).]

F. Two percent of the net slot machine income must be forwarded by the board to the University of Maine System Scholarship Fund created in Title 20-A, section 10909 and to the Board of Trustees of the Maine Maritime Academy to be applied by the board of trustees to fund its scholarship program. The slot machine income under this paragraph must be distributed as follows:

(1) The University of Maine System share is the total amount of the distribution multiplied by the ratio of enrolled students in the system to the total number of enrolled students both in the system and at the Maine Maritime Academy; and

(2) The Maine Maritime Academy share is the total amount of the distribution multiplied by the ratio of enrolled students at the academy to the total number of enrolled students both in the system and at the academy; [PL 2013, c. 118, §1 (AMD).]

G. One percent of the net slot machine income must be forwarded by the board to the board of trustees of the Maine Community College System to be applied by the board of trustees to fund its scholarships program under Title 20-A, section 12716, subsection 1; [PL 2005, c. 663, §12 (AMD).]

H. Four percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Fund to Encourage Racing at Maine's Commercial Tracks, established in section 299; [PL 2015, c. 493, §4 (AMD).]

I. Two percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Fund to Stabilize Off-track Betting Facilities established by section 300, as long as a facility has conducted off-track wagering operations for a minimum of 250 days during the preceding 12-month period in which the first payment to the fund is required. After 48 months of receiving an allocation of the net slot machine income from a licensed operator, the percent of net slot machine income forwarded to the Fund to Stabilize Off-track Betting Facilities is reduced to 1% with the remaining 1% to be forwarded to the State in accordance with subsection 1; and [PL 2005, c. 663, §12 (AMD).]

J. One percent of the net slot machine income must be forwarded directly to the municipality in which the slot machines are located. [PL 2005, c. 663, §12 (AMD).]
[PL 2015, c. 493, §4 (AMD).]

2-A. Distribution from casino of slot machine income. A casino operator shall collect and distribute 46% of the net slot machine income from slot machines operated by the casino operator to the board for distribution by the board as follows:

A. Twenty-five percent of the net slot machine income must be forwarded directly by the board to the Treasurer of State, who shall credit the money to the Department of Education, to be used for essential programs and services for kindergarten to grade 12 under Title 20-A, chapter 606-B; [PL 2017, c. 284, Pt. C, §1 (AMD).]

B. Four percent of the net slot machine income must be forwarded by the board to the University of Maine System Scholarship Fund created in Title 20-A, section 10909 and to the Board of Trustees of the Maine Maritime Academy to be applied by the board of trustees to fund its scholarship program. The slot machine income under this paragraph must be distributed as follows:

(1) The University of Maine System share is the total amount of the distribution multiplied by the ratio of enrolled students in the system to the total number of enrolled students both in the system and at the Maine Maritime Academy; and

(2) The Maine Maritime Academy share is the total amount of the distribution multiplied by the ratio of enrolled students at the academy to the total number of enrolled students both in the system and at the academy; [PL 2013, c. 118, §2 (AMD).]

C. Three percent of the net slot machine income must be forwarded by the board to the Board of Trustees of the Maine Community College System to be applied by the board of trustees to fund its scholarships program under Title 20-A, section 12716, subsection 1; [IB 2009, c. 2, §45 (NEW).]

D. Four percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall distribute the funds to the tribal governments of the Penobscot Nation and the Passamaquoddy Tribe; [IB 2009, c. 2, §45 (NEW).]

E. Three percent of the net slot machine income must be deposited to the General Fund for administrative expenses of the board, including gambling addiction counseling services, in accordance with rules adopted by the board; [IB 2009, c. 2, §45 (NEW).]

F. Two percent of the net slot machine income must be forwarded directly to the municipality in which the casino is located; [IB 2009, c. 2, §45 (NEW).]

G. One percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Agricultural Fair Support Fund established in Title 7, section 91; [IB 2009, c. 2, §45 (NEW).]

H. One percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the fund established in section 298 to supplement harness racing purses; [IB 2009, c. 2, §45 (NEW).]

I. One percent of the net slot machine income must be credited by the board to the Sire Stakes Fund created in section 281; [IB 2009, c. 2, §45 (NEW).]

J. One percent of the net slot machine income must be forwarded directly to the county in which the casino is located to pay for mitigation of costs resulting from gaming operations; [PL 2011, c. 625, §3 (AMD).]

K. [PL 2011, c. 625, §3 (AMD); PL 2011, c. 657, Pt. W, §5 (REV); MRSA T. 8 §1036, sub2A, ¶K (RP).]

L. Beginning July 1, 2013, 1/2 of 1% of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Maine Milk Pool, Other Special Revenue Funds account within the Department of Agriculture, Conservation and Forestry to help fund dairy farm stabilization pursuant to Title 7, sections 3153-B and 3153-D; and [PL 2011, c. 625, §4 (NEW); PL 2011, c. 657, Pt. W, §5 (REV).]

M. Beginning July 1, 2013, 1/2 of 1% of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Dairy Improvement Fund established under Title 10, section 1023-P. [PL 2011, c. 625, §4 (NEW).]

If a recipient of net slot machine income in paragraph D, H or I owns or receives funds from a slot machine facility or casino, other than the casino in Oxford County or the slot machine facility in Bangor, then the recipient may not receive funds under this subsection, and those funds must be retained by the Oxford County casino operator.
[PL 2017, c. 284, Pt. C, §1 (AMD).]

2-B. Distribution from casino of table game income. A casino operator licensed in accordance with section 1011, subsection 2-A, paragraph A shall collect and distribute 16% of the net table game income from table games operated by the casino operator to the board for distribution by the board as follows:

A. Ten percent of the net table game income must be forwarded directly by the board to the Treasurer of State, who shall credit the money to the Department of Education, to be used for essential programs and services for kindergarten to grade 12 under Title 20-A, chapter 606-B; [PL 2017, c. 284, Pt. C, §2 (AMD).]

B. Three percent of the net table game income must be deposited to the Gambling Control Board administrative expenses Other Special Revenue Funds account, which is a nonlapsing dedicated account; [PL 2011, c. 417, §9 (AMD).]

C. Two percent of the net table game income must be forwarded directly to the municipality in which the table games are located; and [IB 2009, c. 2, §46 (NEW).]

D. One percent of the net table game income must be forwarded directly to the county in which the table games are located to pay for mitigation of costs resulting from gaming operations. [IB 2009, c. 2, §46 (NEW).]

[PL 2017, c. 284, Pt. C, §2 (AMD).]

2-C. Distribution of table game income from casino with a commercial track. A casino operator that is a commercial track and was licensed to operate slot machines on January 1, 2011 shall collect and distribute 16% of the net table game income from table games operated by the casino operator to the board for distribution by the board as follows:

A. Nine percent of the net table game income must be deposited to the General Fund for administrative expenses of the board, including gambling addiction counseling services, in accordance with rules adopted by the board; [PL 2011, c. 417, §10 (NEW).]

B. Three percent of the net table game income must be deposited to the Gambling Control Board administrative expenses Other Special Revenue Funds account, which is a nonlapsing dedicated account; [PL 2011, c. 417, §10 (NEW).]

C. Two percent of the net table game income must be forwarded directly to the municipality in which the table games are located; and [PL 2011, c. 417, §10 (NEW).]

D. Two percent of net table game income must be deposited into the Coordinated Veterans Assistance Fund established in Title 37-B, section 514. [PL 2013, c. 128, §1 (AMD).]

[PL 2013, c. 128, §1 (AMD).]

3. Failure to deposit funds. A slot machine operator or casino operator who knowingly or intentionally fails to comply with this section commits a Class C crime. In addition to any other sanction available by law, the license of the operator may be revoked by the board and the slot machines or table games operated by that slot machine operator or casino operator may be disabled, and the slot machines or table games, slot machines' or table games' proceeds and associated equipment may be confiscated by the board and are subject to forfeiture under Title 17-A, section 959 or 960.

[IB 2009, c. 2, §47 (AMD).]

4. Late payments. The board may adopt rules establishing the dates on which payments required by this section are due. All payments not remitted when due must be paid together with interest on the unpaid balance at a rate of 1.5% per month.

[PL 2003, c. 687, Pt. A, §5 (NEW); PL 2003, c. 687, Pt. B, §11 (AFF).]

5. Annual report on use of funds.

[PL 2011, c. 358, §5 (RP).]

SECTION HISTORY

PL 2003, c. 687, §A5 (NEW). PL 2003, c. 687, §B11 (AFF). PL 2005, c. 109, §1 (AMD). PL 2005, c. 563, §10 (AMD). PL 2005, c. 663, §§11,12 (AMD). PL 2007, c. 466, Pt. A, §29 (AMD). PL 2009, c. 462, Pt. H, §1 (AMD). PL 2009, c. 571, Pt. FFF, §1 (AMD). PL 2009, c. 622, §2 (AMD). IB 2009, c. 2, §§45-47 (AMD). PL 2011, c. 358, §§4, 5 (AMD). PL 2011, c. 380, Pt. II, §1 (AMD). PL 2011, c. 417, §§7-10 (AMD). PL 2011, c. 477, Pt. DD, §1 (AMD). PL 2011, c. 625, §§3, 4 (AMD). PL 2011, c. 657, Pt. E, §1 (AMD). PL 2011, c. 657, Pt. W, §5 (REV). PL 2013, c. 118, §§1, 2 (AMD). PL 2013, c. 128, §1 (AMD). PL 2015, c. 493, §4 (AMD). PL 2017, c. 284, Pt. C, §§1, 2 (AMD).

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FUND FOR A HEALTHY MAINE (FHM) – ORIENTATION

HHS COMMITTEE

PRESENTED BY LUKE LAZURE, SENIOR ANALYST
OFFICE OF FISCAL AND PROGRAM REVIEW

JANUARY 31, 2023

FHM DOCUMENTS FOR REVIEW

- **PART A -** How to Read FHM Documents
  - FHM Statute
  - FHM Status – SFY 20 & 21 and SFY 21 - 23
  - FHM – 10-year Allocations through SFY 2023

- **PART B –** Current FHM Document Review
  - FHM Status – SFY 22 & 23 and SFY 23 - 25
  - FHM – 10-year Allocations through SFY 2025

FHM STATUTE

- PL 1999, c. 401, Pt. V, §1 originally created the Fund for a Healthy Maine
- Created after the Master Settlement Agreement (MSA) was finalized
- Funds have always been identified separately
  - Originally, they were included in the Other Special Revenue Funds (014), though identified for tracking purposes in separate units
  - PL 2011, c. 701, §2 – created a NEW fund (024) where all FHM revenue and expenditures are now tracked
- Legislature allocates the FHM funds and the department expends the funds as outlined by the allocations
- Any unspent funds at the end of the year lapse back in the FHM for future use
- If you are wondering "How did we get here?" This is the Statute for you

FHM STATUTE

PART I

Title 22: HEALTH AND WELFARE

Subtitle 2: HEALTH

Part 3: PUBLIC HEALTH HEADING: PL 1989, C. 487, §11 (RPR)

Chapter 260-A: SETTLEMENT FUNDS HEADING: PL 1999, C. 401, PT. V, §1 (NEW)

§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 for the purposes specified in this chapter as a separate and distinct fund for accounting and budgetary reporting purposes.

[PL 2011, c. 701, §1 (AMD).]

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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

B. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and [PL 1999, c. 401, Pt. V, §1 (NEW).]

C. Interest earned or other investment income on balances in the fund. [PL 1999, c. 401, Pt. V, §1 (NEW).]

[PL 1999, c. 401, Pt. V, §1 (NEW).]

- §2 A. - Master Settlement Agreement (MSA)
- §2 B. - 10% of the Hollywood Casino slots revenue
- §2 C. – Interest earned on FHM funds

FHM STATUTE

PART II

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.

[PL 2001, c. 559, Pt. AA, §3 (NEW); PL 2001, c. 559, Pt. AA, §5 (AFF).]

- Any unencumbered balance lapses back to FHM
  - You will see these lapsing funds on the Status document we will discuss later
- No FHM funding is available without specific legislative approval
  - This approval is the allocating of funds done in the budget or a bill and you can see past allocations on the FHM 10-year Allocations document we will discuss later

4. Restrictions. This section does not require the provision of services for the purposes specified in subsection 6. 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.

[PL 1999, c. 401, Pt. V, §1 (NEW).]

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.

[PL 1999, c. 401, Pt. V, §1 (NEW).]

- §4 – Allocations must "supplement, not supplant, appropriations from the General Fund"
  - This does not bind the ability of the legislature to supplant other funding by "notwithstanding" this language in a piece of legislation. Essentially, previously enacted statutes do not bind future legislatures, they provide a roadmap of a previous legislatures intent *(Note: If nothwithstanding language is not included, the bill is still valid. Allocating funding is enough, but the notwithstanding language clarifies the current legislatures intent.)*

- §5 – FHM funds cannot be transferred to the General Fund without legislative approval

FHM STATUTE

PART III

6. Health promotion 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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

A-1. Prevention, education and treatment activities concerning unhealthy weight and obesity; [PL 2011, c. 617, §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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

C. Child care for children up to 15 years of age, including after-school care; [PL 1999, c. 401, Pt. V, §1 (NEW).]

D. Health care for children and adults, maximizing to the extent possible federal matching funds; [PL 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; [PL 1999, c. 401, Pt. V, §1 (NEW).]

F. Dental and oral health care to low-income persons who lack adequate dental coverage; [PL 1999, c. 401, Pt. V, §1 (NEW).]

G. Substance use disorder prevention and treatment; and [PL 2017, c. 407, Pt. A, §71 (AMD).]

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

[PL 2017, c. 407, Pt. A, §71 (AMD).]

- The current legislature can decide to spend funds in a way that does not specifically meet one of these purposes:
  - They could use "notwithstanding" language in a piece of legislation *(Note: If nothwithstanding language is not included, the bill is still valid. Allocating funding is enough, but the notwithstanding language clarifies the current legislatures intent.)*

  or
  - They could add a purpose to this subsection

FHM STATUTE

PART IIII

14. Legislative committee review of legislation. Whenever a 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 to the committee of jurisdiction and to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.

[PL 2011, c. 701, §2 (NEW).]

- Any piece of legislation that includes new or increased funding for the Fund for a Healthy Maine and has the support of a majority of the committee, must be reviewed by the committee with jurisdiction over health and human services matters (i.e. YOU)
- The HHS committee will review the bill and potential impact on the FHM and report back to the committee with jurisdiction over the original bill
- This report back from HHS is NOT binding, but provides the committee additional information to make their final decision.

FHM 10-YEAR ALLOCATIONS

- Outlines total allocations for a 10 year span
  - Current file covers SFY 2013-14 through SFY 2022-23
- Broken down by each Department and Program
- Includes legislative position count, personal services, all other, capital and a program total
- Also notes year-to-year % increase (decrease)
- If you are wondering "How much FHM funding have we provided to program X in the past?" this is the document that answers that question

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Adjusted for Departmental Reorganizations*

Allocations through 129th Legislature and the Governor's EFY 2021 and 2022-2023 Biennial Budget Proposals

FY 2013-14 to FY 2022-23

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
DEPARTMENT OF THE ATTORNEY GENERAL										
024-26A-0947-01 FHM - ATTORNEY GENERAL (FORMERLY 011-26A-0947)										
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)
Pers. Serv.	93,309	99,303	116,600	$118,540	121,765	$127,517	140,826	$147,220	109,765	$115,063
All Other	21,224	51,029	21,542	19,628	19,628	19,628	20,860	20,860	21,164	21,164
Program Total	114,533	150,332	138,142	138,168	141,393	147,145	161,686	168,080	130,929	136,227
Annual % Increase	-9.43%	31.26%	-8.11%	0.02%	2.33%	4.07%	9.88%	3.95%	0.00%	4.05%
DEPARTMENT OF THE ATTORNEY GENERAL										
Pos. - Leg.	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**
Pers. Serv.	**93,309**	**99,303**	**116,600**	**118,540**	**121,765**	**127,517**	**140,826**	**147,220**	**109,765**	**115,063**
All Other	**21,224**	**51,029**	**21,542**	**19,628**	**19,628**	**19,628**	**20,860**	**20,860**	**21,164**	**21,164**
Dept. Total	**114,533**	**150,332**	**138,142**	**138,168**	**141,393**	**147,145**	**161,686**	**168,080**	**130,929**	**136,227**
Annual % Increase	**-9.43%**	**31.26%**	**-8.11%**	**0.02%**	**2.33%**	**4.07%**	**9.88%**	**3.95%**	**0.00%**	**4.05%**
DEPARTMENT OF EDUCATION										
024-05A-Z068-01 FHM - SCHOOL BREAKFAST PROGRAM (FORMERLY 011-05A-Z068-01)										
All Other	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720
Program Total	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DEPARTMENT OF EDUCATION										
Pos. - Leg.	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Dept. Total	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Annual % Increase	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
FINANCE AUTHORITY OF MAINE										
024-94F-0950-02 FHM - HEALTH EDUCATION CENTERS (FORMERLY 011-94F-0950-02)										
All Other	105,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000
Program Total	105,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000
Annual % Increase	4.63%	4.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-94F-0951-01 FHM - DENTAL EDUCATION (FORMERLY 011-94F-0951-01)										
All Other	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740
Program Total	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-94F-Z229-01 MAINE HARVESTED FOOD PRODUCTS FOR RESIDENTS WITH FOOD INSECURITY										
All Other	0	0	0	3,000,000	0	0	0	0	0	0
Program Total	0	0	0	3,000,000	0	0	0	0	0	0
Annual % Increase	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
FINANCE AUTHORITY OF MAINE										
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pos. - Other	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0	0
All Other	342,740	347,740	347,740	3,347,740	347,740	347,740	347,740	347,740	347,740	347,740
Dept. Total	342,740	347,740	347,740	3,347,740	347,740	347,740	347,740	347,740	347,740	347,740
Annual % Increase	1.37%	1.46%	0.00%	862.71%	-89.61%	0.00%	0.00%	0.00%	0.00%	0.00%
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)										
024-10A-0143-25 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: ORAL HEALTH) (FORMERLY FHM - BUREAU OF HEALTH - ORAL HEALTH 011-10A-0953-01)										
All Other	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Program Total	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-30 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: TOBACCO PREVENTION AND CONTROL) (FORMERLY FHM - BUREAU OF HEALTH - TOBACCO PREVENTION AND CONTROL 011-10A-0953-02)										
Pos. - Leg.	(7.000)	(7.000)	(6.000)	(6.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)
Pers. Serv.	574,885	595,191	485,716	500,277	421,714	433,766	429,777	455,616	461,328	471,236
All Other	5,821,987	5,821,987	5,821,987	5,821,987	3,824,805	3,825,247	8,825,247	8,825,247	3,825,247	3,825,247
Program Total	6,396,872	6,417,178	6,307,703	6,322,264	4,246,519	4,259,013	9,255,024	9,280,863	4,286,575	4,296,483
Annual % Increase	0.10%	0.32%	-1.71%	0.23%	-32.83%	0.29%	117.30%	0.28%	0.00%	0.23%
024-10A-0143-31 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: FHM - SUBSTANCE ABUSE PREVENTION)										
All Other	0	0	0	0	777,504	777,504	777,504	777,504	777,504	777,504
Program Total	0	0	0	0	777,504	777,504	777,504	777,504	777,504	777,504
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-26 MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: COMMUNITY/ SCHOOL GRANTS & STATEWIDE COORDINATION) (FORMERLY FHM - BUREAU OF HEALTH - COMMUNITY/SCHOOL GRANTS 011-10A-0953-07)										
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	227,374	237,752	204,118	212,539	256,270	262,731	272,447	286,307	295,591	298,900
All Other	4,781,144	4,781,144	4,781,144	4,781,144	1,750,939	2,351,108	2,511,108	2,511,108	2,511,108	2,511,108
Program Total	5,008,518	5,018,896	4,985,262	4,993,683	2,007,209	2,613,839	2,783,555	2,797,415	2,806,699	2,810,008
Annual % Increase	-0.07%	0.21%	-0.67%	0.17%	-59.81%	30.22%	6.49%	0.50%	0.00%	0.12%

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		2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
024-10A-0143-27	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: PUBLIC HEALTH INFRASTRUCTURE) (FORMERLY FHM - PUBLIC HEALTH INFRASTRUCTURE 011-10A-0953-08)										
Pos. - Leg.		(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(7.000)	(7.000)	(7.000)	(7.000)
Pers. Serv.		91,390	97,609	544,187	714,255	524,984	545,296	1,270,949	1,356,042	606,688	623,348
All Other		1,258,314	1,258,314	1,990,109	1,944,926	1,638,542	1,594,225	2,057,483	2,237,980	3,237,980	3,237,980
Cap. Exp.		0	0		0	0	0	0	0	0	0
Program Total		1,349,704	1,355,923	2,534,296	2,659,181	2,163,526	2,139,521	3,328,432	3,594,022	3,844,668	3,861,328
Annual % Increase		-1.07%	0.46%	86.91%	4.93%	-18.64%	-1.11%	55.57%	7.98%	0.00%	0.43%
024-10A-0143-28	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: DONATED DENTAL) (FORMERLY FHM - DONATED DENTAL 011-10A-0958-01)										
All Other		36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463
Program Total		36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-29	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: IMMUNIZATION) (FORMERLY FHM - IMMUNIZATION 011-10A-Z048-01)										
All Other		1,078,884	1,078,884	0	0	0	0	0	0	0	0
Program Total		1,078,884	1,078,884	0	0	0	0	0	0	0	0
Annual % Increase		0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0545-04	HEAD START (FORMERLY FHM - HEAD START 011-10A-0959-01)										
All Other		1,354,580	1,354,580	1,929,580	1,929,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580
Program Total		1,354,580	1,354,580	1,929,580	1,929,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580
Annual % Increase		0.00%	0.00%	42.45%	0.00%	-29.80%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0147-01	MEDICAL CARE - PAYMENTS TO PROVIDERS (FORMERLY FHM - MEDICAL CARE 011-10A-0960-01)										
All Other		26,310,905	27,668,900	25,901,244	26,036,930	31,036,930	31,036,930	31,036,930	27,118,732	30,934,045	30,865,455
Program Total		26,310,905	27,668,900	25,901,244	26,036,930	31,036,930	31,036,930	31,036,930	27,118,732	30,934,045	30,865,455
Annual % Increase		34.24%	5.16%	-6.39%	0.52%	19.20%	0.00%	0.00%	-12.62%	0.00%	-0.22%
024-10A-0228-01	PURCHASED SOCIAL SERVICES (FORMERLY FHM - PURCHASED SOCIAL SERVICES 011-10A-0961-01)										
All Other		1,971,118	1,971,118	1,971,118	1,971,118	1,971,118	1,971,118	4,471,118	4,471,118	1,971,118	1,971,118
Program Total		1,971,118	1,971,118	1,971,118	1,971,118	1,971,118	1,971,118	4,471,118	4,471,118	1,971,118	1,971,118
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	126.83%	0.00%	0.00%	0.00%
024-10A-0202-01	LOW-COST DRUGS TO MAINE'S ELDERLY (FORMERLY FHM - DRUGS OF THE ELDERLY AND DISABLED 011-10A-Z015-01)										
All Other		6,897,869	6,897,869	6,217,798	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095
Program Total		6,897,869	6,897,869	6,217,798	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095
Annual % Increase		-32.67%	0.00%	-9.86%	-2.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
024-10A-Z202-41 OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED (FORMERLY OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED 024-14G-0844-01)										
All Other	1,301,714	1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,141,178	1,301,730	1,298,843
Program Total	1,301,714	1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,141,178	1,301,730	1,298,843
Annual % Increase	2.04%	0.33%	0.00%	0.00%	0.00%	0.00%	0.00%	-12.62%	0.00%	-0.22%
024-10A-Z199-01 OFFICE OF SUBSTANCE ABUSE (FORMERLY OFFICE OF SUBSTANCE ABUSE 024-14G-0679-01)										
All Other	1,848,306	1,848,306	1,848,306	1,848,306	1,070,802	1,070,802	1,698,223	2,075,644	1,070,802	1,070,802
Program Total	1,848,306	1,848,306	1,848,306	1,848,306	1,070,802	1,070,802	1,698,223	2,075,644	1,070,802	1,070,802
Annual % Increase	0.00%	0.00%	0.00%	0.00%	-42.07%	0.00%	58.59%	22.22%	0.00%	0.00%
024-10A-Z199-02 OFFICE OF SUBSTANCE ABUSE (FORMERLY OFFICE OF SUBSTANCE ABUSE 024-14G-0679-01)										
All Other	0	0	0	0	0	0	2,000,000	3,500,000	1,000,000	1,000,000
Program Total	0	0	0	0	0	0	2,000,000	3,500,000	1,000,000	1,000,000
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	75.00%	100.00%	0.00%
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)										
Pos. - Leg.	**(8.000)**	**(8.000)**	**(7.000)**	**(7.000)**	**(6.000)**	**(6.000)**	**(12.000)**	**(12.000)**	**(12.000)**	**(12.000)**
Pers. Serv.	**893,649**	**930,552**	**1,234,021**	**1,427,071**	**1,202,968**	**1,241,793**	**1,973,173**	**2,097,965**	**1,363,607**	**1,393,484**
All Other	**52,961,284**	**54,323,624**	**52,103,808**	**52,058,608**	**51,149,837**	**51,706,131**	**62,456,810**	**60,431,649**	**54,402,672**	**54,331,195**
Dept. Total	**53,854,933**	**55,254,176**	**53,337,829**	**53,485,679**	**52,352,805**	**52,947,924**	**64,429,983**	**62,529,614**	**55,766,279**	**55,724,679**
Annual % Increase	**6.69%**	**2.60%**	**-3.47%**	**0.28%**	**-2.12%**	**1.14%**	**21.69%**	**-2.95%**	**0.00%**	**-0.07%**
MAINE STATE HOUSING AUTHORITY										
024-99H-Z267-01 LEAD ABATEMENT FUND										
All Other	0	0	0	0	0	4,000,000	0	0	0	0
Program Total	0	0	0	0	0	4,000,000	0	0	0	0
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%
MAINE STATE HOUSING AUTHORITY										
All Other	**0**	**0**	**0**	**0**	**0**	**4,000,000**	**0**	**0**	**0**	**0**
Dept. Total	**0**	**0**	**0**	**0**	**0**	**4,000,000**	**0**	**0**	**0**	**0**
Annual % Increase	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**-100.00%**	**0.00%**	**0.00%**	**0.00%**
GRAND TOTALS - ALL DEPARTMENTS										
Pos. - Leg.	**(9.000)**	**(9.000)**	**(8.000)**	**(8.000)**	**(7.000)**	**(7.000)**	**(13.000)**	**(13.000)**	**(13.000)**	**(13.000)**
Pers. Serv.	**986,958**	**1,029,855**	**1,350,621**	**1,545,611**	**1,324,733**	**1,369,310**	**2,113,999**	**2,245,185**	**1,473,372**	**1,508,547**
All Other	**53,538,968**	**54,936,113**	**52,686,810**	**55,639,696**	**51,730,925**	**56,287,219**	**63,039,130**	**61,013,969**	**54,985,296**	**54,913,819**
Grand Total	**54,525,926**	**55,965,968**	**54,037,431**	**57,185,307**	**53,055,658**	**57,656,529**	**65,153,129**	**63,259,154**	**56,458,668**	**56,422,366**
Annual % Increase	**4.22%**	**2.64%**	**-3.45%**	**5.83%**	**-7.22%**	**8.67%**	**13.00%**	**-2.91%**	**0.00%**	**-0.06%**

otes:

FHM programs and allocations have been modified to reflect the transfer of all FORMERLY BDS funding to new accounts in the FORMERLY DHS Department.

FHM STATUS DOCUMENT

- Outlines the available funds in the Fund for a Healthy Maine account
- Broken down into 3 parts:
  1. All Revenue (resources)
  2. All Legislatively Approved Allocations (uses)
  3. Total change and ending balance
- The bottom of the page includes notes about the data included in the file
- If you are asking “Do we have the money to do X?” this is the file that balances the checkbook

FHM STATUS SFY 20 AND 21 –
WITH GOV. PROPOSED SUPP BUDGET - **RESOURCES**

This file is for the current biennium and is important while supplemental budget discussions are still on-going.

The revenue identified in the RFC, which comes from the sources noted in Statute – MSA, Slots and Interest

All RFC's during the biennium.

Accounting adjustments for previous years.

Unexpended allocations – legislature allocated $1m and the dept spent $750K, so $250K would lapse back to FHM

DRAFT: 02/11/2021

FUND FOR A HEALTHY MAINE (FHM) STATUS

With Governor's Proposed Emergency FY21 Supplemental Budget (LR 1970) [1]

	FY 20	FY 21
FHM RESOURCES:		
Revenue:		
December 2018 Base Revenue Estimate	$49,851,601	$49,911,520
May 2019 Revenue Forecast	($1,028,991)	($10,197,364)
Dec 2019 Revenue Forecast	$47,565	($119,499)
Mar 2020 Revenue Forecast	$73,576	($218)
Aug 2020 Revenue Forecast	$0	$4,032,665
Dec 2020 Revenue Forecast	$0	$1,124,815
Revenue Variances (Actual minus Budgeted Revenue)	$599,603	$0
Subtotal - Revenue	$49,543,354	$44,751,919
Other Resources and Adjustments		
Adjustments to Prior Year Balances	($560,732)	$0
Lapsed Balances from Unexpended Funds	$5,776,255	$0
Subtotal - Other Resources and Adjustments	$5,215,523	$0
Total FHM Resources	**$54,758,877**	**$44,751,919**

Difference between forecast and actual.

Total cash available for the year.

FHM STATUS SFY 20 AND 21 –
WITH GOV. PROPOSED SUPP BUDGET – ALLOCATIONS AND OTHER USES

Any legislatively approved transfers in or out of the FHM.

Part Q of the Supp. Budget.

FHM ALLOCATIONS AND OTHER USES: [2]	FY 20	FY 21
Transfers		
Transfers through 129th Legislature, 2nd Regular Session	$0	$0
Governor's Proposed Emergency FY21 Supplemental Budget (LR 1970)	$0	($14,500,000)
Subtotal - Transfers	$0	($14,500,000)
Allocations		
2020-2021 Biennial Budget (LD 1001 - PL 2019, c. 343) Baseline	$52,177,942	$52,232,930
2020-2021 Biennial Budget (LD 1001 - PL 2019, c. 343) Adjustments	$11,587,766	$13,344,461
129-1 Other Enacted Bills	$1,387,421	$1,764,842
Governor's Proposed Emergency FY21 Supplemental Budget (LR 1970)	$0	($4,083,079)
Subtotal - Allocations	$65,153,129	$63,259,154
Total Allocations and Other Uses	**$65,153,129**	**$48,759,154**

All legislatively approved allocations – Baseline from the 20-21 Budget, All Initiatives in the 20-21 Budget, all other enacted bills and changes proposed in the 21 Supp. Budget.

Total of ALL allocations and transfers.

FHM STATUS SFY 20 AND 21 –

WITH GOV. PROPOSED SUPP BUDGET – TOTAL CHANGE AND ENDING BALANCE

Total Revenue – Total allocations = Net Change for the Year

Ending Balance from SFY 2019

Beginning Balance – Net Change for SFY 20 = Ending Balance

Beginning Balance – Net Change for SFY 21 = Ending Balance for the Biennium

	FY 20	FY 21
Net Change (Resources minus Allocations and Uses)	($10,394,252)	($4,007,235)
BEGINNING BALANCE	$49,108,880	$38,714,628
NET CHANGE (FROM ABOVE)	($10,394,252)	($4,007,235)
ENDING BALANCE	$38,714,628	$34,707,393

Notes:

[1] Reflects all actions through the end of the 129th Legislature, 2nd Regular Session with FY 20 closing transactions, the Special August 2020 Revenue Forecast and the December 2020 Revenue Forecast and includes the Governor's Proposed Emergency FY21 Supplemental Budget (LR 1970).

[2] For the purposes of this summary, transfers out are treated as an expenditure/use and are positive amounts, while transfers in are negative amounts.

Prepared by the Office of Fiscal and Program Review

This document is prepared by OFPR for each budget and after each RFC Report and at the end of each fiscal year

FHM STATUS SFY 21, 22 AND 23
WITH GOVERNOR'S PROPOSED BIENNIAL BUDGET

This file is SFY 21 and the next biennium and is important for the biennial budget discussions.

Revenue BEGINS with the Dec 2020 estimate from the RFC.

This file is for 3 Years – Current year & Next Biennium

Updated: 02/11/2021

FUND FOR A HEALTHY MAINE (FHM) STATUS

2022-2023 Governor's Proposed Budget [1]

	FY 21	FY 22	FY 23
FHM RESOURCES:			
Revenue:			
December 2020 Base Revenue Estimate	$44,751,919	$42,504,640	$40,909,864
Subtotal - Revenue	$44,751,919	$42,504,640	$40,909,864
Total FHM Resources	**$44,751,919**	**$42,504,640**	**$40,909,864**

Total Cash available

This is the same information that was on the SFY 20 and 21 Status file, with the same ending balance that carries forward as the beginning balance in SFY 22.

	FY 21	FY 22	FY 23
FHM ALLOCATIONS AND OTHER USES: [2]			
Transfers			
Transfers through 129th Legislature	$0	$0	$0
Governor's Proposed EFY 21 Supplemental Budget (LR 1970)	($14,500,000)	$0	$0
Governor's Proposed Biennial Budget Adjustments (LR 1971)	$0	$0	$0
Subtotal - Transfers	($14,500,000)	$0	$0
Allocations			
Allocations through 129th Leg. / Est. 2022-2023 Baseline[5]	$67,342,233	$54,565,578	$54,600,753
Governor's Proposed EFY 21 Supplemental Budget (LR 1970)	($4,083,079)	$0	$0
Governor's Proposed Biennial Budget Adjustments (LR 1971)	$0	$1,893,090	$ 1,821,613
Subtotal - Allocations	$63,259,154	$56,458,668	$56,422,366
Total Allocations and Other Uses	**$48,759,154**	**$56,458,668**	**$56,422,366**
Net Change (Resources minus Allocations and Uses)	**($4,007,235)**	**($13,954,028)**	**($15,512,502)**
BEGINNING BALANCE	**$38,714,628**	**$34,707,393**	**$20,753,365**
NET CHANGE (FROM ABOVE)	**($4,007,235)**	**($13,954,028)**	**($15,512,502)**
ENDING BALANCE	**$34,707,393**	**$20,753,365**	**$5,240,863**

Total of all FHM initiatives in the biennial budget.

Total of Baseline allocations carried forward plus all initiatives in the budget.

Ending Balance for each year of the biennium.

FHM STATUS SFY 21, 22 AND 23 – OUTLINE OF BIENNIAL INITIATIVES FOR FHM

This section outlines all initiatives in the budget that impact FHM (NOTE: depending on the number of initiatives this section may only summarize groups of initiatives, but this year there were only 4 total).

[4] Allocation Changes Proposed in Governor's 2022-2023 Biennial Budget:	Net Cost (Savings) FY 22	FY 23
> Provides one-time funding to establish the Overdose Prevention through Intensive Outreach, Naloxone and Safety program to raise awareness about drug overdose risks and to promote the new Opiate Use Disorder and Substance Use Disorder Treatment Locator.	$ 1,000,000	$ 1,000,000
> Provides funding to support development of a strategy and one-time investments in public health infrastructure to reduce disparities in outcomes for Maine residents in minority groups.	$ 1,000,000	$ 1,000,000
> Adjusts funding as a result of the increase in the Federal Medical Assistance Percentage for federal fiscal years 2021-2023.	$ (107,214)	$ (178,691)
> Provides funding for Department of Administrative and Financial Services, Office of Information Technology (OIT) rate increases, computer replacements and other information technology needs.	$ 304	$ 304
Total Proposed FHM Allocation Initiatives	**$ 1,893,090**	**$ 1,821,613**

The total of the proposed initiatives ties to the line above in the allocation section.

Notes:

Notes about the data above.

[1] Reflects all actions through the end of the 129th Legislature, the December 2020 Revenue Forecast, the Governor's Proposed Emergency FY 21 Supplemental Budget (LD) and the Governor's Proposed 2022-2023 Biennial Budget (LD).

[2] For the purposes of this summary, transfers out are treated as an expenditure/use and are positive amounts, while transfers in are negative amounts.

[3] The estimated 2022-2023 Baseline Budget reflects FY 22 and FY 23 fiscal note estimates for 129th Legislature enacted bills (i.e., excluding one-time FY 21 allocations and deallocations, adding estimated growth for personal services allocations).

Prepared by the Office of Fiscal and Program Review

MPHA
Maine Public Health Association

Success Story or Missed Opportunity?

A Brief History of the Fund for a Healthy Maine

The Tobacco Master Settlement Agreement

In 1998, Maine was one of 46 states that settled a lawsuit with the cigarette manufacturers for illness and death caused by tobacco use. In the Tobacco Master Settlement Agreement (Tobacco MSA), the states agreed to end their lawsuit in exchange for annual payments in perpetuity from tobacco product manufacturers in order to compensate taxpayers for public costs related to tobacco use. To date, payments from tobacco manufacturers have averaged about $6.3 billion per year (1999-2020) across all states. The payment is calculated as a percentage of smoking-related Medicaid expenditures and smoking-related non-Medicaid health care costs in each state. The State of Maine's share, or "allocation percentage," of the settlement revenue has resulted in payments of about $51.8 million per year.

Despite the lawsuit's original intent, the final Tobacco MSA imposed no specific restrictions on how states could spend their payments. According to the US Government Accountability Office (GAO), states used these windfall revenues from the beginning for a host of purposes not directly related to tobacco use: filling budget holes, cutting taxes, other spending, increasing reserves, etc.

A 2007 GAO study shows that while states allocated the largest portion of their payments to "health care" (30.0%), they had not necessarily focused on tobacco-related health care costs. The same study shows the second largest portion of payments going to "budget shortfalls" (22.9%), followed by allocations to "general purposes" (7.1%), "infrastructure" (6.0%), "education" (5.5%), and debt service on the securitization (sale) of the Tobacco MSA annuity (5.4%). In fact, "tobacco control" received the smallest percentage of funding (3.5%) of any category in the GAO study.

Maine took a forward-thinking approach

Maine's governor and legislature recognized and honored the intent of the settlement dollars by creating the Fund for a Healthy Maine. The Fund was designed to receive and allocate Maine's approximately $53.8 million per year to programs to prevent chronic disease, promote good health, reduce adverse experiences, lower health costs, and give Maine children and adults every opportunity to live healthy, productive lives – all without supplanting existing state investments or federal grants in these areas.

When the Maine Legislature created the Fund for a Healthy Maine in 1999 (Public Law 1999, Chapter 401, Part V – the biennial budget bill), it specified for which types of programs the funds were to be used. Subsequent amendments to the purposes of the Fund (underlined below) were made by the Legislature in full consultation with Maine's public health community.

The current statutory framework for the Fund for a Healthy Maine is as follows:

6. Health promotion 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;

A-1. Prevention, education and treatment activities concerning unhealthy weight and obesity;

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.

Maine has long been an outlier among states in the way it has protected Tobacco MSA revenues for the preventive health programs that were originally intended. According to a 2009 review by the Maine Office of Program Evaluation and Government Accountability, "Maine has consistently prioritized preventive health services more than other states receiving [Tobacco MSA] funding."

While Maine's leadership in prioritizing preventive health programming is important to acknowledge, it masks the equally important fact that allocations from the Fund for a Healthy Maine have not adhered to Maine lawmakers' founding vision and intent. The 119th Maine Legislature designed a youth-centered framework to assure that Tobacco MSA funds were used to prevent chronic illness, promote good health, and reduce long-term health costs; however, subsequent legislatures have consistently redirected or rebalanced the focus of these funds in ways that have undermined the Fund's original and statutory objectives.

The Fund was intended to supplement, not supplant, other funding streams

When the Legislature established the Fund for a Healthy Maine in 1999, among the Fund's purposes was "Health care for children and adults, maximizing to the extent possible federal matching funds" (see above statutory framework). This is a clear reference to the state's Medicaid program. Historically, the state's Medicaid program draws down federal matching funds of approximately $2 for every $1 of state appropriated funds.

Given the enormity of Medicaid expenditures – approximately $272 million in 2001 (see p. 170) – lawmakers were mindful that tobacco settlement funds could be swallowed-up in their entirety by this one program, leaving nothing for investments in disease prevention and health promotion initiatives. This is why, from the beginning, the legislature included another section in the Fund for a Healthy Maine law (see subsection 4) that states, "Allocations from the fund must be used to supplement, not supplant, appropriations from the General

Fund." The legislature clearly intended to prevent the Fund for a Healthy Maine from being used to support programming that was already supported by another funding stream, whether the state's General Fund or otherwise.

The trend of using the Fund for non-preventive purposes is worsening

The distinct statutory barrier to supplantation notwithstanding, a substantial and growing proportion of the Fund for a Healthy Maine has been spent in ways that have supplanted General Fund investments in health care.

In 2001, the first year of program expenditures, Fund for a Healthy Maine spending on Medicaid was limited to expanding Medicaid eligibility to new populations: pregnant women, children, and their parents (see Parts PP & OO). Approximately $4.5 million was budgeted from the Fund for a Healthy Maine specifically to cover these costs. Over time, these expenditures grew to include Medicaid costs beyond expansion to vulnerable populations. In just 10 years (2012), the baseline budget for Fund for a Healthy Maine Medicaid expenditures had grown by $3 million to $7.5 million (p. 653).

Since 2013, however, there has been an even greater growth in the use of the Fund for a Healthy Maine for Medicaid. By the 2014-2015 biennium, the baseline for annual Medicaid expenditures from the Fund for a Healthy Maine had grown to $18.2 million – a 400% increase since the Fund's inception.

As of the current biennium (2020-2021), the Medicaid baseline in the Fund for a Healthy Maine has increased to $31.0 million. This nearly seven-fold increase over the Fund's 20-year history, combined with a recent reduction in tobacco settlement revenue, which is projected to continue into the foreseeable future, means that 75% of Maine's tobacco settlement revenue is now being used for Medicaid, despite the 119th Legislature's youth-focused public health framework, and clear statutory restrictions on the supplantation of General Fund spending.

Diversions and supplantations have taken a tremendous toll on the Fund for a Healthy Maine

Data from the Office of Fiscal and Program Review show that since the Fund for a Healthy Maine was created, almost $113 million in Tobacco MSA revenue has supported general state operations – a clear diversion from the Fund's intended purpose (see Appendix D (budget)).

At the same time, supplantations can be quantified at a minimum of $181 million, based on Medicaid expenditures just since 2013, which were over and above the historical average of the Fund's first 12 years (see Appendix D (budget)).

In other words, since the Fund's inception in 1999, $294 million ($113 million in diversions plus $181 million in supplantations) – more than 23% of total revenue – has been used for purposes other than those enumerated under state law (see Appendix A).

This $294 million loss to diversions and supplantations has meant drastic spending cuts for chronic disease prevention programming, including:[1]

- 43% decrease in anti-tobacco programming;
- 66% decrease in childcare and child development programs;
- 59% decrease in low-cost prescription drug programs; and
- 32% decrease in substance use disorder programs.

With supplantation reaching this scale, the Fund for a Healthy Maine has become a de facto General Fund reserve account. In fact, while the Fund for a Healthy Maine has seen its balances used to support General Fund programs for 19 of its 20 years,[2] the Budget Stabilization Fund (the state's actual rainy-day fund) has seen its balances grow in all but 5 of those years (see p.117). In other words, the Fund for a Healthy Maine is serving as a buffer to protect the Budget Stabilization Fund – it is the rainy-day fund of the rainy-day fund.

The Fund's public health purpose is continually threatened by its political environment

The Fund no longer has the constituency of elected officials it once had and in recent years, it has become a source of extreme partisan division. This divide obscures the true narrative: independent, Democratic and Republican governors have all presented budgets that used the Fund for a Healthy Maine for outside purposes, and these budgets have been supported by legislatures with Democratic majorities and Republican majorities. The vulnerability of the Fund for a Healthy Maine to budget pressures transcends partisanship.

Over the years, there have been many attempts to protect the Fund

No legislature can bind a subsequent one. This is a simple but important concept. Acts of legislatures are statute, and statute can be changed or negated by successive legislatures. This explains how, despite the law that establishes the purposes of the Fund for a Healthy Maine, every legislature since the Fund's inception, has looked past the limits of the law and used the Fund for alternate purposes. Restricting the legislature's use of the Fund requires an amendment to the Constitution of Maine.

Early in the history of the Fund, supporters recognized the dangerous pattern of diversions and supplantations that had already started to happen. Determined to prevent further loss of the Fund's allocations, advocates undertook a legislative campaign in 2003 designed to protect the Fund permanently through a constitutional amendment. LD 1612 was introduced by Governor John Baldacci, sponsored by House Speaker Patrick Colwell, co-sponsored by Senate President Beth Edmonds, and had significant implied support of more than two thirds of the Maine Legislature who had formally pledged to protect the Fund (Democrats and Republicans alike). Despite this strong bipartisan expression of support, LD 1612 failed to achieve the supermajority needed to forward it for ratification by Maine voters.

The Maine Public Health Association and its partners have made various other attempts to protect the public health mission of the Fund. Other legislative proposals included a bill to revise the budget process whereby allocations from the Fund for a Healthy Maine would require legislative approval separate from votes on the

[1]Comparison between allocations in 2002 and 2019.
[2]Dudley B. 2021. FHM Accounting Spreadsheet. Moose Ridge Associates

General Fund budget. Another activity, mentioned above, was a pledge signed by more than 115 legislators to protect the Fund. In addition to these specific and proactive efforts, public health advocates must vigilantly defend against proposals seeking to divert or supplant the Fund for a Healthy Maine, rather than advise policymakers on the most effective investments to address Maine's highest public health priorities.

In the spring of 2019, Maine Public Health Association received funding from the Maine Cancer Foundation to conduct a public opinion poll about a range of tobacco-related issues.[3] The data show that among Maine voters:

- 71% believe that Maine's lawmakers should honor the original intended use of Maine's tobacco settlement funds to prevent chronic diseases – including tobacco-related illnesses – and promote good health among Maine people;
- 91% believe tobacco settlement funds should be used to prevent young people from starting to smoke and to help current tobacco users to quit; and
- 82% support the creation of a Trust in order to assure that tobacco settlement funds are used primarily to support public health efforts, including programs that prevent youth tobacco use.

Informed by these data, in the 129th legislature, the Maine Public Health Association, with support from the American Heart Association, American Lung Association, and several other leading public health partners, introduced a bill: LD 1961 – "An Act to Establish the Trust for a Healthy Maine," which would create a Trust, comprised of public health experts, to oversee the use of tobacco settlement revenue, including ensuring all the funds were directed to the Maine Center for Disease Control and Prevention or its designated agents and/or departments to promote disease prevention and the advancement of health equity through investments in data collection, analysis and reporting, local community partnerships, and funding for the state health plan. Due to the pandemic, this bill did not advance for a floor vote, and it has been reintroduced in the 130th legislature.

The Fund has delivered a host of significant public health advances in Maine

Despite diversions and supplantations, Fund for a Healthy Maine investments have resulted in impressive health outcomes, including cutting youth smoking rates by more than 75% (24.8% in 2001 to 6.8% in 2019),[4] helping more than 100,000 smokers who wanted to quit, stabilizing youth obesity rates, driving down Maine's teen pregnancy rate, increasing immunization rates, and reducing youth alcohol consumption. The Fund for a Healthy Maine has made it possible for students to get health care in their schools; created more childcare options for parents; and provided preventive oral health programs in 180 elementary schools across the state (see Appendix B for a more complete list of Fund-related outcomes).

The Fund has also supported a statewide network of community coalitions, branded in statute as Healthy Maine Partnerships (HMPs), which during their existence, helped fill the void in Maine's public health infrastructure at the county and municipal levels. The HMPs informed, educated, empowered, and mobilized

[3] Maine Public Health Association. 2019. Voter poll – public health issues. Critical Insights. https://mainepublichealth.org/wp-content/uploads/2019/09/Polling.Results-for-public-release_CTI-Presentation.pdf.
[4] U.S. CDC. Youth Risk Behavior Surveillance System: 2001 & 2019 Surveys. https://nccd.cdc.gov/Youthonline/App/Default.aspx

individuals, families, businesses, schools, municipalities, healthcare and social service organizations, and policymakers since the earliest days of the Fund for a Healthy Maine. They helped prevent tobacco use, improve nutrition, increase access to physical activity, and prevent substance use disorder among youth and young adults. They also provided platforms for communities to draw-down private, state, and federal resources for best-practice education, prevention programming, environmental change, emerging health threats, local policy change, and other traditional public health department services.

Unfortunately, the LePage administration redirected the funding that supported the Healthy Maine Partnerships, thereby recreating a gap in Maine's community health system.

The Fund for a Healthy Maine has been well-assessed for use and effectiveness. Since the Fund was created, there have been three separate legislative-initiated analyses conducted by Maine's Office of Program Evaluation and Government Accountability (OPEGA) — in 2009, 2011 and 2015. While each report was unique (see Appendix C), all three reached the common conclusion that Maine's tobacco settlement funds should continue to prioritize funding for disease prevention and health promotion programs, especially to reduce the number of youth and adults who use tobacco products.

What will become of the Fund for a Healthy Maine?

The history of the Fund for a Healthy Maine can be described as both a forward-thinking investment and a missed opportunity to improve lives, increase productivity, and reinvigorate Maine's economy. Maine did manage to do what most other states could not: invest a significant portion of its tobacco settlement funds in preventing tobacco-related illness and other chronic disease. Those investments deliver an impressive Return on Investment (ROI). Research conducted by the Trust for America's Health has demonstrated that the ROI for chronic disease prevention programs in Maine is $7.52 in economic output and $5.60 in health care savings for every $1.00 invested.

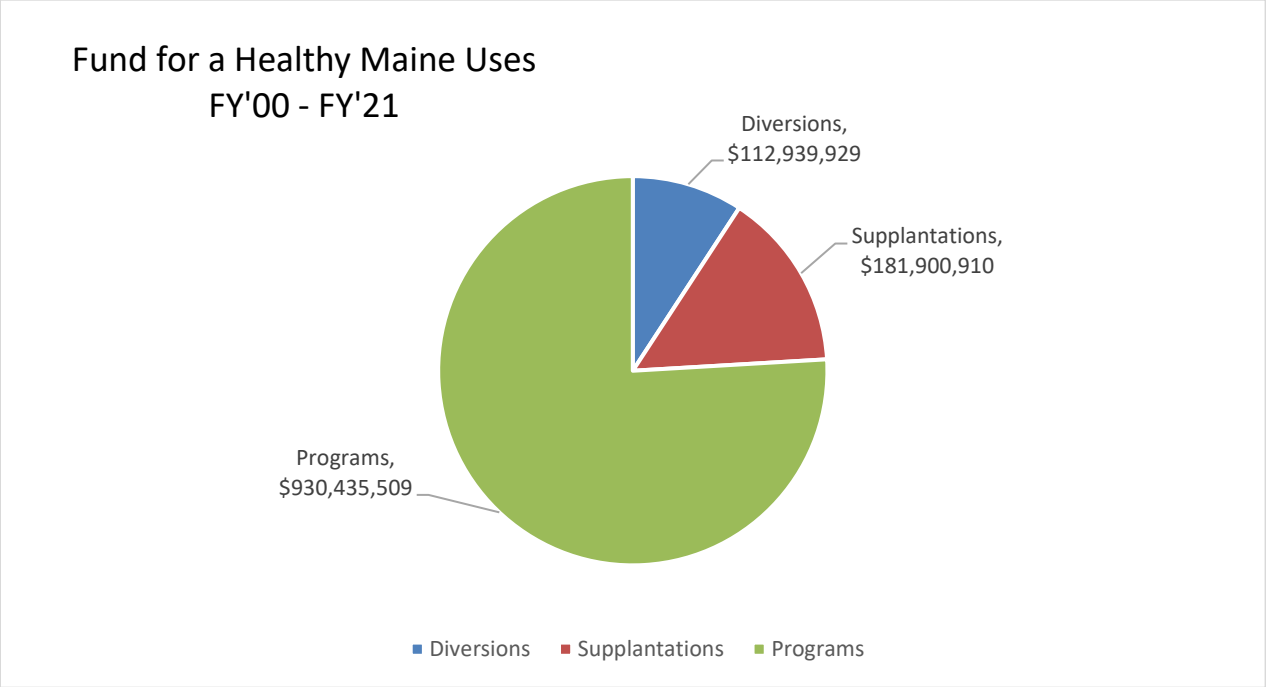
> In other words, had the $294 million that was diverted or supplanted from the Fund been invested in the prevention of chronic disease, it could have returned $2.2 billion in productive economic value for Maine.

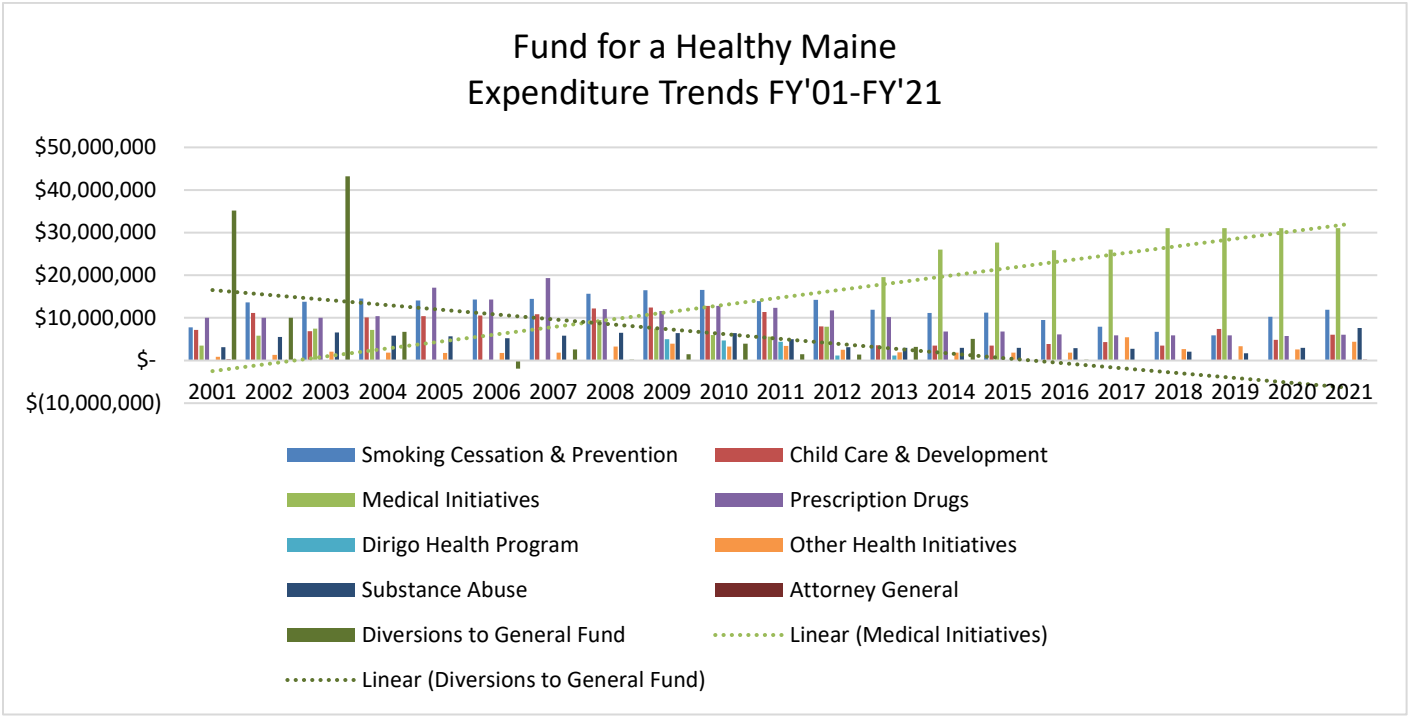
Is the Fund for a Healthy Maine a success story or a missed opportunity? The answer today is "both," but the Fund is at a crossroads. The Fund for a Healthy Maine budget is no longer sustainable and its use for preventing disease and promoting public health has been diminished. Significantly lower revenue projections for the FHM ($41 million/year), combined with a decade-long pattern of supplanting General Fund expenditures with FHM dollars, have made the Fund's FY 2021 budget for public health and medical care ($67 million total) impossible to maintain. Both the prevention of disease and assurance of affordable health care access are essential for protecting public health. In consideration of the Trust for America's Health analysis – that for every $1.00 invested in disease prevention, we gain $7.50 in economic output and $5.65 in health care savings, so investing these funds up front in the prevention of disease reaps significant gains for Maine people.

We have the benefit of 20 years of experience managing the Fund – it's time for a reconsideration of how the funds are used so that we can continue to invest in disease prevention, health promotion and the advancement of health equity for all people in Maine.

APPENDICES

APPENDIX A: Fund for a Healthy Maine diversions, supplantations, and trends: 2000 - 2017





APPENDIX B: Indicators of public health improvements in Maine since the establishment of the Fund for a Health Maine

TOBACCO

- Youth smoking rates have been cut by more than 75% from 24.8% to 6.8% (2001-2019).[1]
- Adult cigarette use has decreased by 23.9% to 17.6% (2001-2019).[2]
- Since inception, the Tobacco Helpline has helped 138,441+ clients quit smoking, fielding ~10,000 calls annually.[3]

YOUTH SUBSTANCE USE[4]

- Alcohol use among youth decreased from 64.1% in 2009 to 48.7% in 2019.
- The proportion of high school students who report consuming alcohol in the past month decreased from 31.7% in 2009 to 22.9% in 2019.
- The percentage of high school students who report using a prescription drug without a doctor's prescription decreased from 17.7% in 2009 to 5.0% in 2019.

OBESITY

- The obesity rate among high school has increased from 10.2% (14.3% overweight) in 2001 to 14.9% (14.8% overweight) in 2019.[1]
- The percentage of high school youth who report being physically active (5+ days/week) decreased from 56.9% in 2007 to 42.2% in 2019.[5]
- The percentage of high school students reporting not participating in Physical Education at least one day in a school week increased from 58.1% in 2001 to 61.5% in 2019.[1]
- The percentage of high school students reporting playing video or computer games, or using a computer for more than 3 hours per day more than doubled from 21.4% in 2007 to 43.5% in 2019.[5]
- The adult obesity rate has steadily increased from 27.8% (37.2% overweight) in 2011 to 31.7% (33.8% overweight) in 2019.[6]
- The number of adults who report participating in physical activities decreased from 76.8% to 69.9% (2011-2019).[6]

SCHOOL-BASED HEALTH CENTERS (SBHCs)[7]

- 15 SBHCs provide access to care for ~10,700+ students, allowing parents to stay at work instead of taking children to appointments, decreasing absenteeism and drop-out rates among students, and improving worktime for parents.
- Nearly a third (31%) of students in a school with a SBHC were enrolled with the center.
- 55% of SBHC users received a health risk assessment (those with risk identified received follow-up counseling).
- Nearly half (48%) of medical visits were for preventive screenings, such as immunization or well-child visits.
- ME SBHCs provided 6,700+ behavioral and mental health counseling visits, including 1,600+ after the pandemic struck through telehealth services.
- 92% of SBHC enrollees identified as needing mental health services received them at a SBHC.
- 53% of all SBHC users were screened for physical activity, nutrition, and sexual activity and 54% of users were screened for tobacco use, alcohol use and drug use.

ORAL HEALTH[8]

- 28% of Maine dentists participate in the Donated Dental Services (DDS) Program (national average is 19%), providing free comprehensive dental services to qualified disabled and elderly individuals through a part-time, DDS-paid coordinator. The average value of these services per individual was $5,306 in SFY 20, and the total donated treatment was more than $250,000.
- Last fiscal year, for every $1 received from FHM, $5.76 worth of care was donated through the DDS Program. Since the program's inception, 1,525+ vulnerable patients have received over $5.3 million in free dental services.

- Statewide, ~180 elementary schools, mostly in rural areas, offer classroom-based education, and about 50% also provide dental sealants and fluoride for second-graders. Between the 2018 and 2019 school years, 94 schools provided sealants to Maine's second graders, who received an average of 3.0 sealants each.
- 11 members of the National Health Service Corps provide dental care in underserved areas in Maine.
- As of March 2019, FAME's Dental Education & Loan Repayment Program has been awarded to more than 110 loan recipients (up to $20,000/year); 27 of which are still practicing in Maine.
- In 2019, the Maine Rural Health Program reinstated the Dental Tax Credit Program, which allows 5 recipients to receive a tax credit for up to 5 years.

TEEN PREGNANCY PREVENTION

- Maine's teen pregnancy rate has decreased from 42.8 pregnancies per 1,000 females (ages 15-19 years) to 22.9 per 1,000 females (2005-2017).[9]
- The percentage of high school students who have ever had sexual intercourse declined from 44.8% to 38.5% (2005-2019) – an all-time low.[10]

APPENDIX C: Fund for a Healthy Maine Reports by Maine's Office of Program Evaluation and Government Accountability (OPEGA)

- The 123rd Legislature authorized OPEGA to review the programs funded by FHM. OPEGA issued an information brief in March 2009, and a final report in October 2009.
- The 125th First Regular Session of the Legislature, passed *Resolve 2011, chapter 112* based on a recommendation from the Government Oversight Committee. This resolve created The Commission To Study Allocations of The Fund For A Healthy Maine. The Commission was a combination of Legislators, the Maine CDC Director, representing the LePage Administration, and public health experts. The Commission met 3 times in November of 2011 and issued their final report in December 2011.
- During the 127th Legislature, the Joint Standing Committee on Health and Human Services asked for permission to meet "off-session" to discuss FHM (*Resolve 2015, chapter 47*). In December 2015, they issued the following report.

This historical review of the Fund for a Healthy Maine was generously supported by the Bingham Program.

[1]U.S. Centers for Disease Control and Prevention (US CDC). 2001 & 2019 Youth Risk Behavior Survey Data. www.cdc.gov/yrbs. Accessed 3/11/2021.
[2]U.S. CDC. 2001 & 2019 Behavioral Risk Factor Surveillance System. www.cdc.gov/brfss/brfssprevalence. Accessed 3/11/2021.
[3]MaineHealth Center for Tobacco Independence. Tobacco Treatment and Prevention Reports. https://ctimaine.org/facts/tobacco-reports/. Accessed 3/11/2021.
[4]Maine Center for Disease Control and Prevention (Maine CDC) & Maine Department of Education (Maine DoEd). 2009 & 2019 Maine Integrated Youth Health Survey. https://data.mainepublichealth.gov/miyhs. Accessed 3/11/2021.
[5]Maine CDC & Maine DoEd. 2007 & 2019 Maine Integrated Youth Health Survey. https://data.mainepublichealth.gov/miyhs. Accessed 3/11/2021.
[6]U.S. CDC. 2011 & 2019 Behavioral Risk Factor Surveillance System. www.cdc.gov/brfss/brfssprevalence. Accessed 3/11/2021.
[7]Wheeler T, Baker M, Dumont R & Shaler G. (2020). All schools summary: School-based health center - 2019-20 year-end report. Muskie School of Public Service. University of Southern Maine.
[8]Maine CDC's Rural Health & Primary Care Program, Maine Dental Association, and Finance Authority of Maine. 2021
[9]Maddow-Zimet I & Kost K. (2021). Pregnancies, births, and abortions in the United States, 1973–2017: National and state trends by age. New York: Guttmacher Institute. Appendix Tables. www.guttmacher.org/report/pregnancies-births-abortions-in-united-states-1973-2017#. Accessed 3/11/2021.
[10]U.S. CDC. 2005 & 2019 Youth Risk Behavior Survey Data. www.cdc.gov/yrbs. Accessed 3/11/2021.

FY2023 State Rankings:
States Ranked by Percent of CDC-Recommended Funding Levels

(Annual funding amounts only include state funds)*

State	FY2023 Current Annual Funding (millions)	CDC Annual Recommendation (millions) §	FY2023 Percent of CDC's Recommendation	Current Rank
Oregon	$53.1	$39.3	135.1%	1
Maine	$15.9	$15.9	100.0%	2
Utah	$15.5	$19.3	80.3%	3
Oklahoma	$33.0	$42.3	78.0%	4
Delaware	$9.7	$13.0	74.5%	5
Alaska	$6.5	$10.2	63.5%	6
North Dakota	$5.7	$9.8	58.0%	7
California	$199.5	$347.9	57.3%	8
Hawaii	$7.6	$13.7	55.3%	9
Colorado	$24.7	$52.9	46.7%	10
Maryland	$20.6	$48.0	42.9%	11
Connecticut	$13.6	$32.0	42.6%	12
Florida	$77.7	$194.2	40.0%	13
South Dakota	$4.5	$11.7	38.5%	14
Montana	$4.9	$14.6	33.2%	15
Vermont	$2.7	$8.4	32.0%	16
Wyoming	$2.5	$8.5	29.0%	17
Idaho	$4.4	$15.6	28.5%	18
Arizona	$17.7	$64.4	27.5%	19
New Mexico	$5.7	$22.8	24.9%	20
Arkansas	$9.0	$36.7	24.5%	21
Mississippi	$8.7	$36.5	23.8%	22
Minnesota	$11.7	$52.9	22.1%	23
New York	$39.2	$203.0	19.3%	24
District of Columbia	$1.9	$10.7	17.8%	25
Iowa	$4.3	$30.1	14.2%	26
North Carolina	$13.4	$99.3	13.5%	27
Virginia	$11.9	$91.6	13.0%	28
Nebraska	$2.6	$20.8	12.4%	29
Nevada	$3.5	$30.0	11.5%	30
Ohio	$14.8	$132.0	11.2%	31
Pennsylvania	$15.5	$140.0	11.1%	32
Washington	$6.6	$63.6	10.3%	33
Indiana	$7.5	$73.5	10.2%	34

State	FY2023 Current Annual Funding (millions)	CDC Annual Recommendation (millions) [§]	FY2023 Percent of CDC's Recommendation	Current Rank
South Carolina	$5.0	$51.0	9.8%	35
Massachusetts	$6.1	$66.9	9.2%	36
Wisconsin	$5.3	$57.5	9.2%	36
Louisiana	$5.1	$59.6	8.6%	38
Illinois	$10.1	$136.7	7.4%	39
New Jersey	$7.1	$103.3	6.9%	40
Missouri	$2.9	$72.9	3.9%	41
Kansas	$1.0	$27.9	3.6%	42
Kentucky	$2.0	$56.4	3.5%	43
Rhode Island	$415,452	$12.8	3.2%	44
Alabama	$1.7	$55.9	3.1%	45
New Hampshire	$490,000	$16.5	3.0%	46
Tennessee	$2.0	$75.6	2.6%	47
Georgia	$2.1	$106.0	2.0%	48
Michigan	$1.8	$110.6	1.7%	49
West Virginia	$445,000	$27.4	1.6%	50
Texas	$3.5	$264.1	1.3%	51

* All amounts are annual and in millions of dollars per year, except where otherwise indicated. Full values are listed for amounts below one million.

§ CDC annual recommendations are based on CDC *Best Practices for Comprehensive Tobacco Control Programs*, 2014, http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm?s_cid=cs_3281.

U.S. STATE AND LOCAL ISSUES

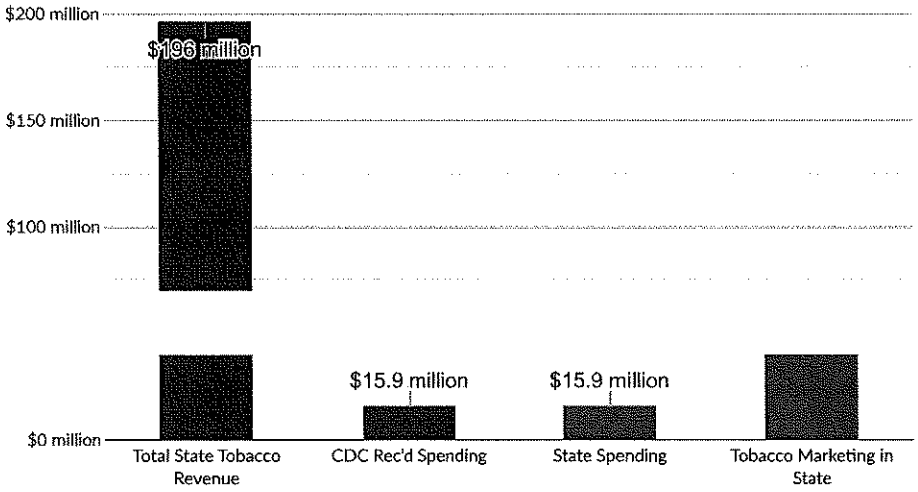
BROKEN PROMISES TO OUR CHILDREN

< Return to main State Report page

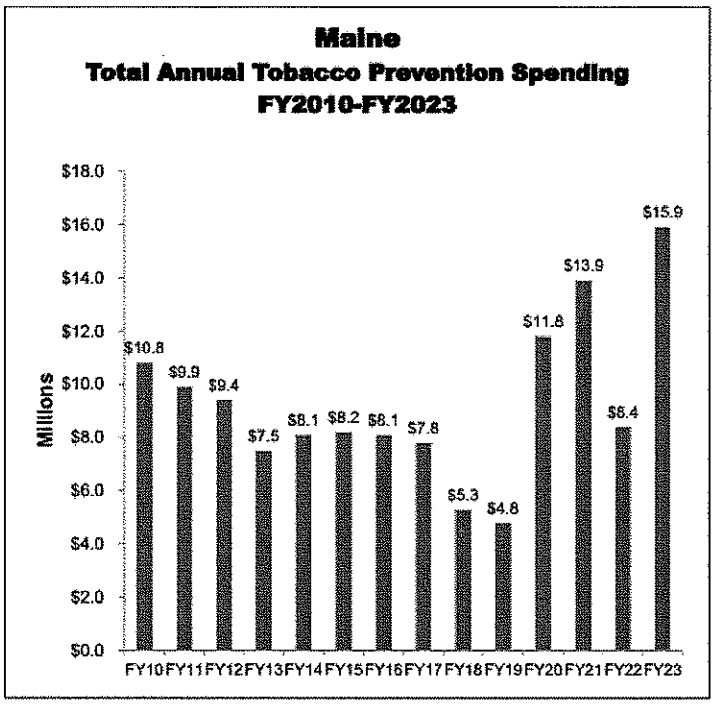
Maine

	FY2023	FY2022
State Ranking	2	10
State Spending on Tobacco Prevention	$15.9 million	$8.4 million
Percent of CDC Recommended Spending ($15.9 million)	100%	52.7%

Maine's Tobacco Revenue, CDC Recommended Spending, State Spending and Tobacco Industry Marketing



Trend in Spending Maine Tobacco Prevention



CDC Recommended Spending: $15.9 million

Download

(Oct. 08, 2023)

Adults who smoke	15.0% (168,000)
High school students who smoke	4.3% (2,700)
High school students who use e-cigarettes	17.5%
Death caused by smoking each year	2,400
Annual health care costs directly caused by smoking	$942 million
Proportion of cancer deaths attributable to smoking	33.8%
Residents' state and federal tax burden from smoking-caused government expenditures	$1,177 per household

Estimated annual tobacco industry marketing in state	$49.7 million

Last updated: May 20, 2023

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FUND NAME	SOURCE OF REVENUE	STATUTE	CURRENT ALLOCATIONS/ USE OF FUNDS	NOTES
Liquor Operation Revenue Fund	The Liquor Operation Revenue Fund is a nonlapsing fund established within the Maine Municipal Bond Bank. The Fund receives funds derived from contracts for wholesale spirits activities and marketing.	30-A MRSA - §6054	The Liquor Operation Revenue Fund (in Maine Municipal Bond Bank) is used to pay hospital bond debt and ancillary costs. If excess funds above the required bond payments (which retired in 2023) exist in any year, up to $7 million may be used for (1) revolving loan funds for drinking water systems–DHHS; (2) revolving loans for wastewater treatment–DEP; and (3) highway/bridge construction–DOT.	• LD 259, Part H was enacted and provides that after all liquor operation revenue bonds and any ancillary obligations secured by the fund have been retired, the first $7,000,000 of any amounts received pursuant to Title 28 A, section 90 must be deposited as undedicated revenue to the General Fund and any amount in excess of $7,000,000 must be deposited as undedicated revenue to the Highway Fund. • LD 226, carried over on the Special Appropriations Table, provides that, prior to excess funds being directed to the Highway Fund, beginning July 1, 2025 and ending June 30, 2028, $40,000,000 must be credited

				annually to the Maine State Housing Authority for programs to support the development and construction of affordable housing and programs. that encourage and support homeownership for single-family homes and for first-time homebuyers.
Regional Greenhouse Gas Initiative Fund	The Regional Greenhouse Gas Initiative Fund receives revenue derived from auction of carbon dioxide emissions allowances, conducted by the Regional Greenhouse Gas Initiative. Statute authorizes Maine's participation in Cap and Trade Program. The funds are managed by the Efficiency Maine Trust.	35-A MRSA §10108 38 MRSA §580-A	Statute requires that funds must be allocated for measures, investments, loans, technical assistance and arrangements that reduce electricity consumption, increase energy efficiency or reduce greenhouse gas emissions and lower energy costs at commercial or industrial facilities and for investment in measures that lower residential heating energy demand and reduce greenhouse gas emission. The Efficiency Maine Trust ensures funds are spent	See information on the Efficiency Maine Trust

			in accordance with the requirements of the law.	
Adult Use Cannabis Public Health and Safety and Municipal Opt-in Fund	The Adult Use Cannabis Public Health and Safety and Municipal Opt-in Fund receives revenue derived from sales and excise taxes imposed on recreational cannabis	Adult Use Cannabis Public Health and Safety and Municipal Opt-In Fund (28-B MRSA §1101) Sales Tax 36 MRSA §1811 Excise Tax 36 MRSA §4923	Money credited to the fund may be used to fund public health and safety awareness and education programs, initiatives, campaigns and activities relating to the sale and use of adult use cannabis and adult use cannabis products conducted in accordance with section 108 by the department, another state agency or to fund enhanced law enforcement training programs relating to the sale and use of adult use cannabis and adult use cannabis products for local, county and state law enforcement officers conducted in accordance with section 109 by the department, the Maine Criminal Justice Academy, another	

			state agency or department or any other public or private entity. Funds may also be used to provide reimbursement to a municipality for qualifying expenses incurred as a result of the municipality's opting to permit the operation of some or all adult use cannabis establishments within the municipality. For the purposes of this paragraph, "qualifying expenses" means legal fees and costs associated with the drafting and adoption of a warrant article or the adoption or amendment of an ordinance, including the conduct of a town meeting or election, by a municipality that opted to permit the operation of some or all cannabis	

			establishments within the municipality.	
Sports Betting	Revenue so far is limited to licensing and application fees to date, but revenue in amount of 9 million annually is anticipated	8 MRSA Chapter 35	Sports betting operators must collect and distribute 10% of adjusted gross sports wagering receipts to the director to be forwarded by the director to the Treasurer of State for distribution in accordance with statute, as follows: A. One percent of the adjusted gross sports wagering receipts must be deposited in the General Fund for the administrative expenses of the Gambling Control Unit within the department; B. One percent of the adjusted gross sports wagering receipts must be deposited in the Gambling Addiction Prevention and Treatment Fund established by Title 5, section 20006-B;	

			C. Fifty-five hundredths of 1% of the adjusted gross sports wagering receipts must be paid to the State Harness Racing Commission for distribution as described in section 290, subsection 2; D. Fifty-five hundredths of 1% of the adjusted gross sports wagering receipts must be deposited in the Sire Stakes Fund established in section 281; E. Four-tenths of 1% of the adjusted gross sports wagering receipts must be deposited in the Agricultural Fair Promotion Fund established pursuant to Title 7, section 103; and F. Six and one-half percent of the adjusted gross sports wagering receipts must be deposited in the General Fund	

Casino revenue	Revenue consists of sales from slot machines	8 MRSA Chapter 31, subchapter 3	Funds allocated in accordance with Title 8 § 1036. This includes some current funding for FHM (see statute for specific allocations)	
Opioid Settlement	Revenue consists of settlement funds received by the state from litigation with pharmaceutical companies	Maine Recovery Council 5 MRSA §203-C	30% of settlement funds go to 39 Maine counties, cities and towns. Another 20% goes to the AG's Office and 50% to the Maine Recovery Fund, which is administered by the Maine Recovery Council.	The Recovery Fund has not yet distributed any funds. The state allows the Counsel to distribute funds in accordance with the "approved uses" described in the MOU signed as part of the settlement. Maine Subdivision 2022 Memorandum of Understanding Regarding Opioid Settlement Funds.pdf

APPROVED
JUNE 16, 2023
BY GOVERNOR

CHAPTER
189
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 164 - L.D. 259

An Act Making Unified Allocations from the Highway Fund and Other Funds for the Expenditures of State Government and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2023, June 30, 2024 and June 30, 2025

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the 90-day period may not terminate until after the beginning of the next fiscal year; and

Whereas, certain obligations and expenses incident to the operation of state departments and institutions will become due and payable immediately; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. Appropriations and allocations. The following appropriations and allocations are made.

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF

Budget - Bureau of the 0055

Initiative: BASELINE BUDGET

HIGHWAY FUND	**2023-24**	**2024-25**
POSITIONS - LEGISLATIVE COUNT	1.000	1.000
Personal Services	$125,710	$126,698
All Other	$8,893	$8,893

6006-G 10.25% of the excise tax after the distribution of taxes pursuant to section 2903-D imposed under subsection 1.

Sec. G-2. 36 MRSA §3203, sub-§4, as amended by PL 2009, c. 496, §19, is further amended to read:

4. Highway Fund. All taxes and fines collected under this chapter must be credited to the Highway Fund, except that beginning July 1, 2009 and ending June 30, 2023, the Treasurer of State shall deposit monthly into the TransCap Trust Fund established in Title 30-A, section 6006-G 7.5% of the excise tax imposed under subsection 1-B, and beginning July 1, 2023, the Treasurer of State shall deposit monthly into the TransCap Trust Fund established in Title 30-A, section 6006-G 10.25% of the excise tax imposed under subsection 1-B.

PART H

Sec. H-1. 22-A MRSA §216, as enacted by PL 2013, c. 269, Pt. B, §1, is repealed.

Sec. H-2. 30-A MRSA §6053, sub-§1, as enacted by PL 2013, c. 269, Pt. B, §2, is repealed.

Sec. H-3. 30-A MRSA §6053, sub-§5, as enacted by PL 2013, c. 269, Pt. B, §2, is repealed.

Sec. H-4. 30-A MRSA §6054, sub-§2, as amended by PL 2015, c. 494, Pt. A, §35, is further amended to read:

2. Funding. Beginning July 1, 2014 and ending June 30, 2023, there must be deposited directly into the fund any amounts received pursuant to Title 28-A, section 90 and Title 22-A, former section 216 and any other money or funds transferred or made available to the bond bank only for the purposes of the fund from any other source including without limitation amounts required to be deposited in the fund by the terms of any ancillary obligation or other agreement related to liquor operation revenue bonds.

Sec. H-5. 30-A MRSA §6054, sub-§5, as corrected by RR 2021, c. 2, Pt. A, §112, is repealed and the following enacted in its place:

5. Use of fund after bond retirement. After all liquor operation revenue bonds and any ancillary obligations secured by the fund have been retired, the first $7,000,000 of any amounts received pursuant to Title 28-A, section 90 must be deposited as undedicated revenue to the General Fund and any amount in excess of $7,000,000 must be deposited as undedicated revenue to the Highway Fund.

Sec. H-6. Effective date. This Part takes effect July 1, 2023.

PART I

Sec. I-1. 36 MRSA §1821 is enacted to read:

§1821. Tax on sales by automobile dealers and sales and use taxes collected by Bureau of Motor Vehicles related to motor vehicles

Beginning July 1, 2023, and every July 1st thereafter, the assessor shall notify the State Controller of the amount of revenue attributable to the sales tax collected under this Part at the rate of 5.5% for the first 6 months of the prior fiscal year from automobile dealers licensed by the Bureau of Motor Vehicles pursuant to Title 29-A, chapter 9 and the amount

L.D. 226

Date: (Filing No. H-)

HOUSING

Reproduced and distributed under the direction of the Clerk of the House.

STATE OF MAINE

HOUSE OF REPRESENTATIVES

131ST LEGISLATURE

FIRST SPECIAL SESSION

COMMITTEE AMENDMENT " " to H.P. 147, L.D. 226, "An Act to Address Maine's Affordable Housing Crisis"

Amend the bill by inserting after the title and before the enacting clause the following:

'**Emergency preamble. Whereas,** acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the lack of available affordable housing in the State is greatly contributing to the current housing crisis; and

Whereas, demand for programs to assist with the development and construction of affordable housing has been so great that funding for those programs is exhausted soon after it is appropriated; and

Whereas, programs exist that have proven to be successful in creating affordable housing and can continue to do so with adequate, predictable and reliable funding; and

Whereas, to prevent a future housing crisis, it is critical that the State invest resources before the end of the 90-day period in programs that have demonstrated success in creating affordable housing and supporting homeownership; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,'

Amend the bill by striking out everything after the enacting clause and inserting the following:

'**Sec. 1. 30-A MRSA §4748** is enacted to read:

§4748. Report to Legislature

In addition to the powers and duties listed in section 4722, beginning February 1, 2024 and at least annually thereafter, the authority shall submit a report to the joint standing

committee of the Legislature having jurisdiction over housing matters or a joint select committee of the Legislature having jurisdiction over housing matters regarding the distribution of funds credited in accordance with section 6054, subsection 6. The report must describe the amounts distributed to programs dedicated to supporting homeownership and programs established to create affordable housing in the State, including any other source of funding used in addition to funds credited under section 6054, subsection 6.

Sec. 2. 30-A MRSA §6054, sub-§5, as repealed and replaced by PL 2023, c. 189, Pt. H, §5 and affected by §6, is amended to read:

5. Use of fund after bond retirement. After all liquor operation revenue bonds and any ancillary obligations secured by the fund have been retired, the first $7,000,000 of any amounts received pursuant to Title 28-A, section 90 must be deposited as undedicated revenue to the General Fund ~~and~~. Except as provided in subsection 6, any amount in excess of $7,000,000 must be deposited as undedicated revenue to the Highway Fund.

Sec. 3. 30-A MRSA §6054, sub-§6 is enacted to read:

6. Exception; funds credited to Maine State Housing Authority. Notwithstanding any provision of subsection 5 to the contrary, beginning July 1, 2025 and ending June 30, 2028, $40,000,000 must be credited annually to the Maine State Housing Authority for programs to support the development and construction of affordable housing and programs that encourage and support homeownership for single-family homes and for first-time homebuyers.

This subsection is repealed July 1, 2028.

Sec. 4. Appropriations and allocations. The following appropriations and allocations are made.

HOUSING AUTHORITY, MAINE STATE

Housing Authority - State 0442

Initiative: Provides one-time funds in fiscal year 2023-24 and fiscal year 2024-25 only to increase affordable housing in the State.

GENERAL FUND	**2023-24**	**2024-25**
All Other	$40,000,000	$40,000,000
GENERAL FUND TOTAL	$40,000,000	$40,000,000

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment replaces the bill. The amendment provides funding in the amount of $40,000,000 annually through fiscal year 2027-28 to support programs administered by the Maine State Housing Authority to support homeownership for single-family homes and for first-time homebuyers and the development of affordable housing in the State. Funding in

the current biennium will come from the General Fund. The remaining funding for fiscal years 2025-26 to 2027-28 will be credited to the Maine State Housing Authority from the Liquor Operation Revenue Fund. The amendment also requires the Maine State Housing Authority to report on the use of the funds and the amounts distributed to support homeownership programs and rental housing development programs.

FISCAL NOTE REQUIRED

(See attached)

§6054. Liquor Operation Revenue Fund

1. Fund established. The Liquor Operation Revenue Fund, referred to in this section as "the fund," is a nonlapsing fund established within the bond bank to receive the amounts referred to in subsection 2 and to pay amounts due under the liquor operation revenue bonds and any ancillary obligations. The fund must be held separate and apart from all other money, funds and accounts of the bond bank.
[PL 2013, c. 269, Pt. B, §2 (NEW).]

2. Funding. Beginning July 1, 2014, there must be deposited directly into the fund any amounts received pursuant to Title 28-A, section 90 and Title 22-A, section 216 and any other money or funds transferred or made available to the bond bank only for the purposes of the fund from any other source including without limitation amounts required to be deposited in the fund by the terms of any ancillary obligation or other agreement related to liquor operation revenue bonds.
[PL 2015, c. 494, Pt. A, §35 (AMD).]

3. Use of fund during bond retirement period; fiscal years before July 1, 2017. Money in the fund must be held and applied solely to the payment of the liquor operation revenue bonds and any ancillary obligations secured by the fund as the bonds and ancillary obligations become due and payable and for the retirement of liquor operation revenue bonds, including costs of administering the fund, the bonds and the ancillary obligations and the payment of any redemption premium required to be paid when any liquor operation revenue bonds are redeemed or retired before maturity or for the payment of ancillary obligations; except that, to the extent there is money in the fund not needed in accordance with terms of the liquor operation revenue bonds and ancillary obligations, before June 30th of each year, the bond bank shall withdraw an amount not exceeding $16,714,844 in the fiscal year ending June 30, 2015, $16,639,000 in the fiscal year ending June 30, 2016 and $16,817,000 in the fiscal year ending June 30, 2017 to be paid to the State and distributed as follows:

A. First, to the General Fund as undedicated revenue up to $9,714,884 in the fiscal year ending June 30, 2015, $9,639,000 in the fiscal year ending June 30, 2016 and $9,817,000 in the fiscal year ending June 30, 2017; [PL 2013, c. 269, Pt. B, §2 (NEW).]

B. Second, the remainder, if any, in each fiscal year divided in equal amounts to an account within the Department of Health and Human Services and an account within the Department of Environmental Protection, up to $3,500,000 per account or the maximum amount allowed for federal matching funds purposes under federal water programs, whichever is less, to be used for revolving loan funds for drinking water systems and wastewater treatment; and [PL 2013, c. 269, Pt. B, §2 (NEW).]

C. Third, the remainder, if any, to an account within the Department of Transportation to be used for the construction of highways and bridges. [PL 2013, c. 269, Pt. B, §2 (NEW).]

[PL 2013, c. 269, Pt. B, §2 (NEW).]

4. Use of fund during bond retirement period; from July 1, 2017 until bonds retired. Money in the fund must be held and applied solely to the payment of the liquor operation revenue bonds and any ancillary obligations secured by the fund as the bonds and ancillary obligations become due and payable and for the retirement of liquor operation revenue bonds, including costs of administering the fund, the bonds and the ancillary obligations and the payment of any redemption premium required to be paid when any liquor operation revenue bonds are redeemed or retired before maturity or for the payment of ancillary obligations; except that, to the extent there is money in the fund not needed in accordance with terms of the liquor operation revenue bonds and ancillary obligations, before June 30th of each year, the bond bank shall withdraw an amount not exceeding $7,000,000 to be paid to the State and distributed as follows:

A. First, in equal amounts to an account within the Department of Health and Human Services and an account within the Department of Environmental Protection, up to $3,500,000 per account or the maximum amount allowed for federal matching funds purposes under federal water programs, whichever is less, to be used for revolving loan funds for drinking water systems and wastewater treatment; and [PL 2013, c. 269, Pt. B, §2 (NEW).]

B. The remainder, if any, to an account within the Department of Transportation to be used for the construction of highways and bridges. [PL 2013, c. 269, Pt. B, §2 (NEW).]

Immediately upon retirement of all outstanding liquor operation revenue bonds and ancillary obligations secured by the fund, the bond bank shall withdraw any excess money in the fund and transfer it to the Maine Budget Stabilization Fund established in Title 5, section 1532.
[PL 2013, c. 269, Pt. B, §2 (NEW).]

5. Use of fund after bond retirement. After all liquor operation revenue bonds and any ancillary obligations secured by the fund have been retired, additional proceeds credited to the fund from Title 22-A, section 216 and Title 28-A, section 90 must be disbursed on a quarterly basis to the State, after payment of costs of administering the fund, and credited by the State Controller as follows:

A. Thirty percent to the State Water and Wastewater Infrastructure Fund established pursuant to section 6006-H and divided as follows:

(1) Forty-five percent to an account within the State Water and Wastewater Infrastructure Fund for drinking water purposes divided as follows:

(a) Up to the maximum amount allowed for the state match for federal funds provided to the safe drinking water revolving loan fund established under section 6006-B to an account within the Department of Health and Human Services for revolving loan funds for drinking water systems; and

(b) The remainder to the Maine Drinking Water Fund established pursuant to Title 22, section 2610; and

(2) Fifty-five percent to an account within the State Water and Wastewater Infrastructure Fund for wastewater purposes divided as follows:

(a) Up to the maximum amount allowed for the state match for federal funds provided to the revolving loan fund established under section 6006-A to an account within the Department of Environmental Protection for revolving loans for wastewater treatment; and

(b) The remainder to the Maine Clean Water Fund established pursuant to Title 38, section 411-C; [PL 2019, c. 423, §2 (RPR).]

B. Thirty-five percent to an account within the Department of Transportation for construction of highways and bridges; and [PL 2013, c. 269, Pt. B, §2 (NEW).]

C. The remainder to the Maine Budget Stabilization Fund established in Title 5, section 1532. [RR 2021, c. 2, Pt. A, §112 (COR).]
[RR 2021, c. 2, Pt. A, §112 (COR).]

SECTION HISTORY

PL 2013, c. 269, Pt. B, §2 (NEW). PL 2015, c. 494, Pt. A, §35 (AMD). PL 2019, c. 423, §2 (AMD). RR 2021, c. 2, Pt. A, §112 (COR).

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§10109. Regional Greenhouse Gas Initiative Trust Fund

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carbon dioxide allowance" has the same meaning as in Title 38, section 580-A, subsection 2. [PL 2009, c. 372, Pt. B, §3 (NEW).]

B. "Trade association aggregator" means an entity that gathers individual members of a trade association together for the purpose of receiving electrical efficiency services or bidding on electrical efficiency contracts. [PL 2009, c. 372, Pt. B, §3 (NEW).]

C. "Trust fund" means the Regional Greenhouse Gas Initiative Trust Fund established in subsection 2. [PL 2009, c. 372, Pt. B, §3 (NEW).]

[PL 2009, c. 372, Pt. B, §3 (NEW).]

2. Establishment of Regional Greenhouse Gas Initiative Trust Fund. The Regional Greenhouse Gas Initiative Trust Fund is established and is the successor to the fund that was established under former section 10008. The trust fund is established to support the goals and implementation of the carbon dioxide cap-and-trade program established under Title 38, section 580-B. The trust fund is established as a nonlapsing fund administered by the trust for the purposes established in this section. The trust is authorized to receive, and shall deposit in the trust fund and expend in accordance with this section, revenue resulting from the sale of carbon dioxide allowances, pursuant to Title 38, section 580-B, and any forward capacity market or other capacity payments from the regional transmission organization that may be attributable to projects funded by the trust under this section. The trust fund may not be used for any other purpose and money in the trust fund is considered to be held in trust for the purposes of benefiting consumers.

A. The trustees have a fiduciary duty to the customers of the State's transmission and distribution utilities in the administration of the trust fund. Upon accepting appointment as a trustee, each trustee must acknowledge the fiduciary duty to use the trust fund only for the purposes set forth in this section. [PL 2009, c. 372, Pt. B, §3 (NEW).]

B. The trustees shall ensure that the goals and objectives of the trust fund, as established in this section and in rules adopted by the trust, are carried out. The trustees shall represent the interests of the trust fund in the development of the triennial plan. [PL 2009, c. 372, Pt. B, §3 (NEW).]

[PL 2009, c. 372, Pt. B, §3 (NEW).]

3. Ceiling on energy efficiency spending.

[PL 2013, c. 369, Pt. A, §14 (RP).]

3-A. Payments.

[PL 2021, c. 716, §1 (RP).]

4. Expenditures; projects. Except for other costs authorized in accordance with this chapter, funds in the trust fund must be expended in accordance with this subsection.

A. Trust funds must be allocated for measures, investments, loans, technical assistance and arrangements that reduce electricity consumption, increase energy efficiency or reduce greenhouse gas emissions and lower energy costs at commercial or industrial facilities and for investment in measures that lower residential heating energy demand and reduce greenhouse gas emissions. The measures that lower residential heating demand must be fuel-neutral and may include, but are not limited to, energy efficiency improvements to residential buildings, energy storage systems and upgrades to efficient heating systems that will reduce residential energy costs and greenhouse gas emissions, as determined by the board. The trust shall ensure that measures to reduce the cost of residential heating are available for low-income households as defined by the trust. When promoting electricity cost and consumption reduction, the trust may consider measures at

commercial and industrial facilities that also lower peak capacity demand, including energy storage systems. Subject to the apportionment pursuant to this subsection, the trust shall fund conservation programs that give priority to measures with the highest benefit-to-cost ratio, as long as cost-effective collateral efficiency opportunities are not lost, and that:

(1) Reliably reduce greenhouse gas production and heating energy costs by fossil fuel combustion in the State at the lowest cost in funds from the trust fund per unit of emissions; or

(2) Reliably increase the efficiency with which energy in the State is consumed at the lowest cost in funds from the trust fund per unit of energy saved. [PL 2021, c. 298, §3 (AMD).]

B. Expenditures from the trust fund relating to conservation of electricity and mitigation or reduction of greenhouse gases must be made predominantly on the basis of a competitive bid process for long-term contracts, subject to rules adopted by the board under section 10105. Rules adopted by the board to implement the competitive bid process under this paragraph may not include an avoided cost methodology for compensating successful bidders. Bidders may propose contracts designed to produce greenhouse gas savings or electricity conservation savings, or both, on a unit cost basis. Contracts must be commercially reasonable and may require liquidated damages to ensure performance. Contracts must provide sufficient certainty of payment to enable commercial financing of the conservation measure purchased and its installation. [PL 2009, c. 372, Pt. B, §3 (NEW).]

C. The board may target bid competitions in areas or to participants as they consider necessary, as long as the requirements of paragraph A are satisfied. [PL 2009, c. 372, Pt. B, §3 (NEW).]

D. Community-based renewable energy projects, as defined in section 3602, subsection 1, may apply for funding from the trust to the extent they are eligible under paragraph A. [PL 2013, c. 369, Pt. A, §16 (AMD).]

E. The size of a project funded by the trust fund is not limited as long as funds are awarded to maximize energy efficiency and support greenhouse gas reductions and to fully implement the triennial plan. [PL 2009, c. 372, Pt. B, §3 (NEW).]

F. No more than $800,000 of trust fund receipts in any one year may be used for the costs of administering the trust fund pursuant to this section. The limit on administrative costs established in this paragraph does not apply to the following costs that may be funded by the trust fund:

(1) Costs of the Department of Environmental Protection for participating in the regional organization as defined in Title 38, section 580-A, subsection 20 and for administering the allowance auction under Title 38, chapter 3-B; and

(2) Costs of the Attorney General for activities pertaining to the tracking and monitoring of allowance trading activity and managing and evaluating the trust's funding of conservation programs. [PL 2009, c. 372, Pt. B, §3 (NEW).]

G. In order to minimize administrative costs and maximize program participation and effectiveness, the trustees shall, to the greatest extent feasible, coordinate the delivery of and make complementary the energy efficiency programs under this section and other programs under this chapter. [PL 2009, c. 372, Pt. B, §3 (NEW).]

H. The trust shall consider delivery of efficiency programs by means of contracts with service providers that participate in competitive bid processes for reducing energy consumption within individual market segments or for particular end uses. [PL 2009, c. 372, Pt. B, §3 (NEW).]

I. A trade association aggregator is eligible to participate in competitive bid processes under this subsection. [PL 2009, c. 372, Pt. B, §3 (NEW).]

J. Trust fund receipts must, upon request by the Department of Environmental Protection, fund research approved by the Department of Environmental Protection in an amount of up to $100,000

per year to develop new categories for carbon dioxide emissions offset projects, as defined in Title 38, section 580-A, subsection 6, that are located in the State. Expenditures on research pursuant to this paragraph are not considered administrative costs under paragraph F, subparagraph (1). [PL 2013, c. 369, Pt. A, §17 (AMD).]

K. The trust shall establish an industrial climate transition initiative to develop and support climate change mitigation strategies designed to reduce greenhouse gas emissions at industrial facilities in the State. In establishing the initiative and developing climate change mitigation strategies for industrial facilities, the trust shall:

(1) Prioritize mitigation strategies identified in the State's climate action plan, as adopted and updated under Title 38, section 577, that offer the most cost-effective means of reducing greenhouse gas emissions at industrial facilities; and

(2) Consider mitigation strategies and other recommendations identified by any working group, task force or other advisory body that is established by the Maine Climate Council, established under Title 38, section 577-A, to develop strategies and other recommendations to reduce greenhouse gas emissions at industrial facilities in the State.

The trust may allocate funds from the trust fund, and may expend any federal funds or other public or private funding that may be available, to establish the initiative under this paragraph and to develop and support climate change mitigation strategies designed to reduce greenhouse gas emissions at industrial facilities in the State. [PL 2021, c. 716, §2 (NEW).]

[PL 2021, c. 716, §2 (AMD).]

5. Effective date. This section takes effect July 1, 2010.

[PL 2009, c. 372, Pt. B, §3 (NEW).]

SECTION HISTORY

PL 2009, c. 372, Pt. B, §3 (NEW). PL 2009, c. 565, §6 (AMD). PL 2009, c. 565, §9 (AFF). PL 2013, c. 369, Pt. A, §§14-17 (AMD). PL 2015, c. 498, §§1, 2 (AMD). PL 2017, c. 282, §§1, 2 (AMD). PL 2019, c. 69, §1 (AMD). PL 2021, c. 298, §3 (AMD). PL 2021, c. 716, §§1, 2 (AMD).

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§1101. Adult Use Cannabis Public Health and Safety and Municipal Opt-in Fund

The Adult Use Cannabis Public Health and Safety and Municipal Opt-in Fund, referred to in this section as "the fund," is established as a dedicated, nonlapsing fund within the department for the purposes specified in this section. [PL 2021, c. 645, §4 (AMD); PL 2021, c. 669, §5 (REV).]

1. Sources of fund. The State Controller shall credit to the fund:

A. Money received from the excise tax imposed on the sale of adult use cannabis pursuant to Title 36, chapter 723 in the amount required under Title 36, section 4925; [PL 2019, c. 231, Pt. B, §6 (AMD); PL 2021, c. 669, §5 (REV).]

B. Money received from the sales tax imposed on the sale of adult use cannabis and adult use cannabis products by a cannabis store licensee to a consumer pursuant to Title 36, section 1811 in the amount required under Title 36, section 1818; [PL 2017, c. 409, Pt. A, §6 (NEW); PL 2021, c. 669, §5 (REV).]

C. All money from any other source, whether public or private, designated for deposit into or credited to the fund; and [PL 2017, c. 409, Pt. A, §6 (NEW).]

D. Interest earned or other investment income on balances in the fund. [PL 2017, c. 409, Pt. A, §6 (NEW).]

[PL 2019, c. 231, Pt. B, §6 (AMD); PL 2021, c. 669, §5 (REV).]

2. Uses of fund. Money credited to the fund pursuant to subsection 1 may be used by the department as provided in this subsection.

A. Money credited to the fund may be expended by the department to fund public health and safety awareness and education programs, initiatives, campaigns and activities relating to the sale and use of adult use cannabis and adult use cannabis products conducted in accordance with section 108 by the department, another state agency or department or any other public or private entity. [PL 2021, c. 645, §4 (AMD); PL 2021, c. 669, §5 (REV).]

B. Money credited to the fund may be expended by the department to fund enhanced law enforcement training programs relating to the sale and use of adult use cannabis and adult use cannabis products for local, county and state law enforcement officers conducted in accordance with section 109 by the department, the Maine Criminal Justice Academy, another state agency or department or any other public or private entity. [PL 2021, c. 645, §4 (AMD); PL 2021, c. 669, §5 (REV).]

C. Money credited to the fund may be expended by the department to provide reimbursement to a municipality for qualifying expenses incurred as a result of the municipality's opting to permit the operation of some or all adult use cannabis establishments within the municipality. For the purposes of this paragraph, "qualifying expenses" means legal fees and costs associated with the drafting and adoption of a warrant article or the adoption or amendment of an ordinance, including the conduct of a town meeting or election, by a municipality that opted to permit the operation of some or all cannabis establishments within the municipality. Each municipality may receive funds, not to exceed $20,000, only once for the reimbursement of qualifying expenses in accordance with this paragraph. Nothing in this paragraph may be construed to require the department to reimburse qualifying expenses incurred by a municipality if the department determines there are insufficient funds available to provide reimbursement. Under no circumstances may a municipality submit an initial application for the reimbursement of qualifying expenses more than 3 years after the municipality adopts a warrant article or adopts or amends an ordinance to allow for the operation of some or all adult use cannabis establishments within the municipality. The department may adopt rules to implement and administer the reimbursement of qualifying expenses to municipalities. Rules adopted pursuant to this paragraph are routine technical rules as defined in

Title 5, chapter 375, subchapter 2-A. The department may not reimburse qualifying expenses under this paragraph accrued after July 1, 2027. [PL 2021, c. 645, §4 (NEW); PL 2021, c. 669, §5 (REV).]

[PL 2021, c. 645, §4 (AMD); PL 2021, c. 669, §5 (REV).]

3. Application of fund to departmental expenses prohibited. Money in the fund may not be applied to any expenses incurred by the department in implementing, administering or enforcing this chapter.

[PL 2017, c. 409, Pt. A, §6 (NEW).]

SECTION HISTORY

PL 2017, c. 409, Pt. A, §6 (NEW). PL 2019, c. 231, Pt. B, §6 (AMD). PL 2021, c. 645, §4 (AMD). PL 2021, c. 669, §5 (REV).

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§1218. Allocation of funds

1. Tax imposed; allocation of funds. An operator shall collect and distribute 10% of adjusted gross sports wagering receipts to the director to be forwarded by the director to the Treasurer of State for distribution as follows:

A. One percent of the adjusted gross sports wagering receipts must be deposited in the General Fund for the administrative expenses of the Gambling Control Unit within the department; [PL 2021, c. 681, Pt. J, §6 (NEW).]

B. One percent of the adjusted gross sports wagering receipts must be deposited in the Gambling Addiction Prevention and Treatment Fund established by Title 5, section 20006-B; [PL 2021, c. 681, Pt. J, §6 (NEW).]

C. Fifty-five hundredths of 1% of the adjusted gross sports wagering receipts must be paid to the State Harness Racing Commission for distribution as described in section 290, subsection 2; [PL 2021, c. 681, Pt. J, §6 (NEW).]

D. Fifty-five hundredths of 1% of the adjusted gross sports wagering receipts must be deposited in the Sire Stakes Fund established in section 281; [PL 2021, c. 681, Pt. J, §6 (NEW).]

E. Four-tenths of 1% of the adjusted gross sports wagering receipts must be deposited in the Agricultural Fair Promotion Fund established pursuant to Title 7, section 103; and [PL 2021, c. 681, Pt. J, §6 (NEW).]

F. Six and one-half percent of the adjusted gross sports wagering receipts must be deposited in the General Fund. [PL 2021, c. 681, Pt. J, §6 (NEW).]

[PL 2021, c. 681, Pt. J, §6 (NEW).]

2. Due dates; late payments. The director may adopt rules establishing the dates on which payments required by this section are due. All payments not remitted when due must be paid together with interest on the unpaid balance at a rate of 1.5% per month.

[PL 2021, c. 681, Pt. J, §6 (NEW).]

SECTION HISTORY

PL 2021, c. 681, Pt. J, §6 (NEW).

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§1036. Allocation of funds

1. Distribution for administrative expenses of board. A slot machine operator licensed under section 1011, subsection 2 or a casino operator that is a commercial track that was licensed to operate slot machines under section 1011, subsection 2 on January 1, 2011 shall collect and distribute 1% of gross slot machine income to the Treasurer of State for deposit in the General Fund for the administrative expenses of the board.
[PL 2011, c. 417, §7 (AMD).]

2. Distribution of net slot machine income from casino with commercial track. A slot machine operator licensed under section 1011, subsection 2 or a casino operator that is a commercial track that was licensed to operate slot machines under section 1011, subsection 2 on January 1, 2011 shall collect and distribute 39% of the net slot machine income from slot machines operated by the slot machine operator to the board for distribution by the board as follows:

A. Three percent of the net slot machine income must be deposited to the General Fund for administrative expenses of the board in accordance with rules adopted by the board, except that of the amount calculated pursuant to this paragraph, the following amounts must be transferred annually to the Gambling Addiction Prevention and Treatment Fund established by Title 5, section 20006-B:

(1) For the fiscal year beginning July 1, 2011, $50,000;

(2) For the fiscal year beginning July 1, 2012, $50,000; and

(3) For the fiscal year beginning July 1, 2013 and for each fiscal year thereafter, $100,000;
[PL 2009, c. 622, §2 (AMD).]

B. Ten percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the fund established in section 298 to supplement harness racing purses; [PL 2005, c. 663, §12 (AMD).]

C. Three percent of the net slot machine income must be credited by the board to the Sire Stakes Fund created in section 281; [PL 2005, c. 663, §12 (AMD).]

D. Three percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Agricultural Fair Support Fund established in Title 7, section 91; [PL 2007, c. 466, Pt. A, §29 (RPR).]

E. Ten percent of the net slot machine income must be forwarded by the board to the State Controller and except as otherwise provided in this paragraph credited to the Fund for a Healthy Maine established by Title 22, section 1511 and segregated into a separate account under Title 22, section 1511, subsection 11, with the use of funds in the account restricted to the purposes described in Title 22, section 1511, subsection 6, paragraph E. For the fiscal years ending June 30, 2010, June 30, 2011 and June 30, 2012, the amount credited annually by the State Controller to the Fund for a Healthy Maine under this paragraph may not exceed $4,500,000 annually and any funds in excess of $4,500,000 annually during these fiscal years must be credited as General Fund undedicated revenue, and, for the fiscal year ending June 30, 2013, the amount credited by the State Controller to the Fund for a Healthy Maine under this paragraph is $0; [PL 2011, c. 657, Pt. E, §1 (AMD).]

F. Two percent of the net slot machine income must be forwarded by the board to the University of Maine System Scholarship Fund created in Title 20-A, section 10909 and to the Board of Trustees of the Maine Maritime Academy to be applied by the board of trustees to fund its scholarship program. The slot machine income under this paragraph must be distributed as follows:

(1) The University of Maine System share is the total amount of the distribution multiplied by the ratio of enrolled students in the system to the total number of enrolled students both in the system and at the Maine Maritime Academy; and

(2) The Maine Maritime Academy share is the total amount of the distribution multiplied by the ratio of enrolled students at the academy to the total number of enrolled students both in the system and at the academy; [PL 2013, c. 118, §1 (AMD).]

G. One percent of the net slot machine income must be forwarded by the board to the board of trustees of the Maine Community College System to be applied by the board of trustees to fund its scholarships program under Title 20-A, section 12716, subsection 1; [PL 2005, c. 663, §12 (AMD).]

H. Four percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Fund to Encourage Racing at Maine's Commercial Tracks, established in section 299; [PL 2015, c. 493, §4 (AMD).]

I. Two percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Fund to Stabilize Off-track Betting Facilities established by section 300, as long as a facility has conducted off-track wagering operations for a minimum of 250 days during the preceding 12-month period in which the first payment to the fund is required. After 48 months of receiving an allocation of the net slot machine income from a licensed operator, the percent of net slot machine income forwarded to the Fund to Stabilize Off-track Betting Facilities is reduced to 1% with the remaining 1% to be forwarded to the State in accordance with subsection 1; and [PL 2005, c. 663, §12 (AMD).]

J. One percent of the net slot machine income must be forwarded directly to the municipality in which the slot machines are located. [PL 2005, c. 663, §12 (AMD).]
[PL 2015, c. 493, §4 (AMD).]

2-A. Distribution from casino of slot machine income. A casino operator shall collect and distribute 46% of the net slot machine income from slot machines operated by the casino operator to the board for distribution by the board as follows:

A. Twenty-five percent of the net slot machine income must be forwarded directly by the board to the Treasurer of State, who shall credit the money to the Department of Education, to be used for essential programs and services for kindergarten to grade 12 under Title 20-A, chapter 606-B; [PL 2017, c. 284, Pt. C, §1 (AMD).]

B. Four percent of the net slot machine income must be forwarded by the board to the University of Maine System Scholarship Fund created in Title 20-A, section 10909 and to the Board of Trustees of the Maine Maritime Academy to be applied by the board of trustees to fund its scholarship program. The slot machine income under this paragraph must be distributed as follows:

(1) The University of Maine System share is the total amount of the distribution multiplied by the ratio of enrolled students in the system to the total number of enrolled students both in the system and at the Maine Maritime Academy; and

(2) The Maine Maritime Academy share is the total amount of the distribution multiplied by the ratio of enrolled students at the academy to the total number of enrolled students both in the system and at the academy; [PL 2013, c. 118, §2 (AMD).]

C. Three percent of the net slot machine income must be forwarded by the board to the Board of Trustees of the Maine Community College System to be applied by the board of trustees to fund its scholarships program under Title 20-A, section 12716, subsection 1; [IB 2009, c. 2, §45 (NEW).]

D. Four percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall distribute the funds to the tribal governments of the Penobscot Nation and the Passamaquoddy Tribe; [IB 2009, c. 2, §45 (NEW).]

E. Three percent of the net slot machine income must be deposited to the General Fund for administrative expenses of the board, including gambling addiction counseling services, in accordance with rules adopted by the board; [IB 2009, c. 2, §45 (NEW).]

F. Two percent of the net slot machine income must be forwarded directly to the municipality in which the casino is located; [IB 2009, c. 2, §45 (NEW).]

G. One percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Agricultural Fair Support Fund established in Title 7, section 91; [IB 2009, c. 2, §45 (NEW).]

H. One percent of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the fund established in section 298 to supplement harness racing purses; [IB 2009, c. 2, §45 (NEW).]

I. One percent of the net slot machine income must be credited by the board to the Sire Stakes Fund created in section 281; [IB 2009, c. 2, §45 (NEW).]

J. One percent of the net slot machine income must be forwarded directly to the county in which the casino is located to pay for mitigation of costs resulting from gaming operations; [PL 2011, c. 625, §3 (AMD).]

K. [PL 2011, c. 625, §3 (AMD); PL 2011, c. 657, Pt. W, §5 (REV); MRSA T. 8 §1036, sub2A, ¶K (RP).]

L. Beginning July 1, 2013, 1/2 of 1% of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Maine Milk Pool, Other Special Revenue Funds account within the Department of Agriculture, Conservation and Forestry to help fund dairy farm stabilization pursuant to Title 7, sections 3153-B and 3153-D; and [PL 2011, c. 625, §4 (NEW); PL 2011, c. 657, Pt. W, §5 (REV).]

M. Beginning July 1, 2013, 1/2 of 1% of the net slot machine income must be forwarded by the board to the Treasurer of State, who shall credit the money to the Dairy Improvement Fund established under Title 10, section 1023-P. [PL 2011, c. 625, §4 (NEW).]

If a recipient of net slot machine income in paragraph D, H or I owns or receives funds from a slot machine facility or casino, other than the casino in Oxford County or the slot machine facility in Bangor, then the recipient may not receive funds under this subsection, and those funds must be retained by the Oxford County casino operator.
[PL 2017, c. 284, Pt. C, §1 (AMD).]

2-B. Distribution from casino of table game income. A casino operator licensed in accordance with section 1011, subsection 2-A, paragraph A shall collect and distribute 16% of the net table game income from table games operated by the casino operator to the board for distribution by the board as follows:

A. Ten percent of the net table game income must be forwarded directly by the board to the Treasurer of State, who shall credit the money to the Department of Education, to be used for essential programs and services for kindergarten to grade 12 under Title 20-A, chapter 606-B; [PL 2017, c. 284, Pt. C, §2 (AMD).]

B. Three percent of the net table game income must be deposited to the Gambling Control Board administrative expenses Other Special Revenue Funds account, which is a nonlapsing dedicated account; [PL 2011, c. 417, §9 (AMD).]

C. Two percent of the net table game income must be forwarded directly to the municipality in which the table games are located; and [IB 2009, c. 2, §46 (NEW).]

D. One percent of the net table game income must be forwarded directly to the county in which the table games are located to pay for mitigation of costs resulting from gaming operations. [IB 2009, c. 2, §46 (NEW).]

[PL 2017, c. 284, Pt. C, §2 (AMD).]

2-C. Distribution of table game income from casino with a commercial track. A casino operator that is a commercial track and was licensed to operate slot machines on January 1, 2011 shall collect and distribute 16% of the net table game income from table games operated by the casino operator to the board for distribution by the board as follows:

A. Nine percent of the net table game income must be deposited to the General Fund for administrative expenses of the board, including gambling addiction counseling services, in accordance with rules adopted by the board; [PL 2011, c. 417, §10 (NEW).]

B. Three percent of the net table game income must be deposited to the Gambling Control Board administrative expenses Other Special Revenue Funds account, which is a nonlapsing dedicated account; [PL 2011, c. 417, §10 (NEW).]

C. Two percent of the net table game income must be forwarded directly to the municipality in which the table games are located; and [PL 2011, c. 417, §10 (NEW).]

D. Two percent of net table game income must be deposited into the Coordinated Veterans Assistance Fund established in Title 37-B, section 514. [PL 2013, c. 128, §1 (AMD).]

[PL 2013, c. 128, §1 (AMD).]

3. Failure to deposit funds. A slot machine operator or casino operator who knowingly or intentionally fails to comply with this section commits a Class C crime. In addition to any other sanction available by law, the license of the operator may be revoked by the board and the slot machines or table games operated by that slot machine operator or casino operator may be disabled, and the slot machines or table games, slot machines' or table games' proceeds and associated equipment may be confiscated by the board and are subject to forfeiture under Title 17-A, section 959 or 960.

[IB 2009, c. 2, §47 (AMD).]

4. Late payments. The board may adopt rules establishing the dates on which payments required by this section are due. All payments not remitted when due must be paid together with interest on the unpaid balance at a rate of 1.5% per month.

[PL 2003, c. 687, Pt. A, §5 (NEW); PL 2003, c. 687, Pt. B, §11 (AFF).]

5. Annual report on use of funds.

[PL 2011, c. 358, §5 (RP).]

SECTION HISTORY

PL 2003, c. 687, §A5 (NEW). PL 2003, c. 687, §B11 (AFF). PL 2005, c. 109, §1 (AMD). PL 2005, c. 563, §10 (AMD). PL 2005, c. 663, §§11,12 (AMD). PL 2007, c. 466, Pt. A, §29 (AMD). PL 2009, c. 462, Pt. H, §1 (AMD). PL 2009, c. 571, Pt. FFF, §1 (AMD). PL 2009, c. 622, §2 (AMD). IB 2009, c. 2, §§45-47 (AMD). PL 2011, c. 358, §§4, 5 (AMD). PL 2011, c. 380, Pt. II, §1 (AMD). PL 2011, c. 417, §§7-10 (AMD). PL 2011, c. 477, Pt. DD, §1 (AMD). PL 2011, c. 625, §§3, 4 (AMD). PL 2011, c. 657, Pt. E, §1 (AMD). PL 2011, c. 657, Pt. W, §5 (REV). PL 2013, c. 118, §§1, 2 (AMD). PL 2013, c. 128, §1 (AMD). PL 2015, c. 493, §4 (AMD). PL 2017, c. 284, Pt. C, §§1, 2 (AMD).

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§203-C. Maine Recovery Council

1. Definitions. As used in this section, unless the context indicates otherwise, the following terms have the following meanings.

A. "Approved uses" means the substance use disorder abatement purposes defined as "Approved Uses" in the memorandum of understanding. [PL 2021, c. 661, §3 (NEW).]

B. "Maine Recovery Fund" means the fund described by the memorandum of understanding. [PL 2021, c. 661, §3 (NEW).]

C. "Memorandum of understanding" means the Maine State Subdivision Memorandum of Understanding and Agreement Regarding Use of Settlement Funds, dated and signed on January 26, 2022, including Schedule A, Core Strategies and Schedule B, Approved Uses. [PL 2021, c. 661, §3 (NEW).]

[PL 2021, c. 661, §3 (NEW).]

2. Maine Recovery Council established. The Maine Recovery Council, as established in section 12004-I, subsection 94 and referred to in this section as "the council," shall direct the disbursement of funds within the Maine Recovery Fund for approved uses.

[RR 2021, c. 2, Pt. A, §6 (COR).]

3. Membership. The council is composed of the 11 members identified by the memorandum of understanding and of 4 additional voting members as follows:

A. One member who is a medical professional with direct experience providing medication-assisted treatment, appointed by the President of the Senate; [PL 2021, c. 661, §3 (NEW).]

B. One member representing reentry services for incarcerated and formerly incarcerated individuals and their families, appointed by the President of the Senate; [PL 2021, c. 661, §3 (NEW).]

C. One member representing a nonprofit community-based provider of mental health treatment, appointed by the Speaker of the House; and [PL 2021, c. 661, §3 (NEW).]

D. One member representing the harm reduction community, appointed by the Speaker of the House. [PL 2021, c. 661, §3 (NEW).]

In making these appointments, the President of the Senate and the Speaker of the House shall endeavor to select individuals that reflect the racial, ethnic, gender and indigenous diversity of the State.

[PL 2021, c. 661, §3 (NEW).]

4. Vacancy. In the event of a vacancy in the council membership, the vacancy must be filled in the manner of the original appointment for the remainder of the term. For the purposes of reappointment, any partial term filled after a vacancy must be considered a full term.

[PL 2021, c. 661, §3 (NEW).]

5. Report. The Attorney General shall, by February 1st of each year, submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters describing the activities of the council and the status of the Maine Recovery Fund and listing information on disbursements from the fund and information related to the outcomes of funded activities.

[PL 2021, c. 661, §3 (NEW).]

SECTION HISTORY

PL 2021, c. 661, §3 (NEW). RR 2021, c. 2, Pt. A, §6 (COR).

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AMENDMENT TO
MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING AND AGREEMENT REGARDING USE OF SETTLEMENT FUNDS

Whereas, the State of Maine, through its Attorney General, and certain Subdivisions, through their elected representatives and counsel, entered into a Memorandum of Understanding ("MOU"), dated January 26, 2022, entitled "MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING ANDAGREEMENT REGARDING USE OF SETTLEMENT FUNDS"; and

Whereas the State and its Subdivisions desire to amend the MOU;

Now therefore, the State and its Subdivisions hereby agree to amend the MOU in its entirety, to read as follows:

MAINE STATE-SUBDIVISION MEMORANDUM OF UNDERSTANDING AND AGREEMENT REGARDING USE OF SETTLEMENT FUNDS

Whereas, the people of the State of Maine and its communities have been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and,

Whereas, the State of Maine, though its Attorney General, and certain Subdivisions, through their elected representatives and counsel, are separately engaged in litigation seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance; and,

Whereas, the State of Maine, through its Attorney General, and its Subdivisions share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State of Maine;

Now therefore, the State and its Subdivisions, subject to completion of formal documents effectuating the Parties' agreements, enter into this Memorandum of Understanding ("MOU") relating to the allocation and use of the proceeds of Settlements described.

This agreement is subject to the requirements of the National Opioid Settlement, as well as applicable law. Terms used in this MOU have the same meaning as in those used in the National Opioid Settlement unless otherwise defined herein.

I. DEFINITIONS

A. "Approved Uses" shall mean those uses identified in the List of Opioid Remediation Uses, attached as Exhibit E to the National Opioid Settlement, and those uses identified as "Approved Opioid Abatement Uses" in Schedules A and B to Exhibit G to the Noticeof

Filing of Eighth Plan Supplement Pursuant to the Fifth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and its Affiliated Debtors, In re: Purdue Pharma L.P., et al., Case No. 19-23649-RDD, Dkt. 3121 (Bankr. S.D. N.Y. July 8, 2021), and attached as Exhibits I and 2 to this Memorandum of Understanding.

B. "Direct Share Subdivisions" means a plaintiff subdivision that has filed a complaint against a Pharmaceutical Supply Chain entity and/or a subdivision with a population equal to or greater than 10,000. For the avoidance of doubt, the 39 eligible Direct Share Subdivisions are as identified on Exhibit 3 hereto.

C. "Effective Date" means the date on which a court of competent jurisdiction, including any bankruptcy court, enters the first Settlement by order or consent decree. The Parties anticipate that more than one Settlement will be administered according to the terms of this MOU, but that the first entered Settlement will trigger the formation of the Recovery Council.

D. The "Maine Recovery Fund" means the fund created by this Agreement, the funds of which will be used for the purposes of opioid abatement.

E. The "National Opioid Settlement" means the National Distributor and J&J Settlements Agreement, dated as of July 21, 2021, and any revision thereto.

F. "Pharmaceutical Supply Chain" shall mean the process and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

G. "Recovery Fund Council" means the Council created in Section III of this MOU.

II. DISTRIBUTION OF FUNDS

A. **Applicability of Agreement.** These terms shall apply to the National Distributor Settlement, the Purdue Pharma and Mallinckrodt bankruptcy settlements.

B. **Approved Uses.** All Opioid Funds, regardless of allocation, shall be utilized for approved uses.

C. **Division of Funds.** All Opioids Funds allocated to the State of Maine and the Subdivisions are to be distributed as follows:

1. **20%** to the State of Maine Attorney General to be used on Approved Uses.

2. **30%** to the Direct Share Subdivisions for spending on Approved Uses to be allocated in accordance with Exhibit 3.

3. **50%** to be placed in the Maine Recovery Fund which are to be spent on Approved Uses as directed by the Recovery Council.

D. The Direct Share Subdivisions' shares shall be distributed directly to each Direct Share Subdivision by the National Settlement Administrator. Monies in the Maine Recovery Fund shall be distributed by the Treasurer of the State as described below. Any Direct Share Subdivision may

form agreements or ventures or otherwise work in collaboration with federal, state. local, tribal or private sector entities in pursuing Opioid Remediation activities funded from their directshare distribution or funded by the Recovery Fund.

III. THE MAINE RECOVERY COUNCIL

A Recovery Fund Council (the "Council") consisting of representatives appointed by the State and subdivisions, shall be created to direct the disbursement of recovery funds for recovery purposes on a statewide basis for the uses allowed by this MOU.

Membership: The Recovery Council shall consist of eleven (11) members, who shall serve in their official capacity only.

Subdivision Members: The Recovery Council shall include at least 4 members from the plaintiff cities or counties to be selected by them.

State Members. Four (4) members shall be appointed by the State as follows:

a. The Governor shall appoint two members
b. The Speaker of the House or his designee
c. The President of the Senate or his designee

Public Members. The Attorney General shall appoint three (3) public members from among the following:

a. Individuals or family members impacted by the Opioid Crisis
b. Individuals with substance use disorder and recovery community experience,
c. Public health experts in treatment and or prevention.

The Legislature may add members to the Council for up to a maximum of fifteen (15).

Terms: The Recovery Council shall be established within ninety (90) days of the Effective Date and initial members appointed. Members may serve no more than two (2) consecutive two-year terms, for a total of four (4) consecutive years.

Duties: The Recovery Council is primarily responsible for ensuring that the distribution of Recovery Funds complies with the terms of the MOU and the Agreement entitled "Maine School Administrative Units' Inclusion in Maine's Recovery Fund".. It shall meet at least twice within each calendar year either in person or via a remote meeting method as allowed by Maine law.

Governance: The Recovery Council shall draft its own bylaws or other governing documents, which must include appropriate conflict of interest provisions, in accordance with this MOU and the following principles:

a. Authority: The Recovery Council does not have any rulemaking authority. The terms of the MOU and Agreement and any Settlement, as entered by a Court of competent jurisdiction control the authority of the Recovery Council and the Recovery Council shall not stray outside the bounds of the authority and power vested by this MOU and any Court approved Settlement.

b. Administration: The Recovery Council is responsible for accounting of all Recovery Funds. and for releasing Recovery Funds.

Transparency: The Recovery Council shall operate with all reasonable transparency and in compliance with Maine's Freedom of Access Law 1 MRS sections 401 et seq.

A. The Recovery Council shall develop a centralized public dashboard or other repository for publication of expenditure data from any party or Regional Council that receives Recovery Funds. The Council may require outcome related data from any entity that receives Recovery Funds. For purposes of funding the centralized dashboard, the Council shall make every effort to use existing state resources.

Collaboration: The Recovery Council shall facilitate collaboration among the State, subdivisions, Regional Councils and other stakeholders for the purposes of sharing data, outcomes, strategies and other relevant information related to abating the opioid crisis in Maine.

Decision Making: The Recovery Council shall make all decisions by consensus. In the event consensus cannot be achieved, unless otherwise required by this MOU, the Council shall make decisions by 3/5 vote of its members.

Legal Representation: The Attorney General shall provide legal counsel and administrative support to the Recovery Council. The Council may use funds to hire additional administration support if necessary.

Compensation: No member of the Recovery Council shall be compensated for their work related to the Abatement Council.

IV. THE MAINE RECOVERY FUND

A. Fund Established. The Maine Recovery Fund is established for the purposes specified in this chapter as a separate and distinct fund for accounting and budgetary reporting purposes.

B. Sources of Fund. The State Controller shall credit to the fund:

1. All money designated to the Maine Recovery Fund for abatement in this agreement in settlement of litigation by the state or one of its subdivisions against Johnson & Johnson, Janssen Pharmaceuticals, Inc., Purdue Pharma L.P., Mallinckrodt, PLC, Cardinal Health, Inc., AmerisourceBergen Corporation, and McKesson Corporation.

2. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and

3. Interest earned or other investment income on balances in the fund.

C. Unencumbered Balances. Any unencumbered balance remaining at the end of any fiscal year lapses back to the Maine Recovery Fund, the account within the Office of the Attorney General established pursuant to this section, and may not be made available for expenditurewithout specific legislative approval.

D. 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 Maine Recovery Fund may not be transferred to the General Fund without specific legislative approval.

E. Report by Attorney General. The Attorney General 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.

F. 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 approved uses. Money credited to a restricted account established under this subsection may be applied only to the purposes to which the account is restricted.

G. Adjustment to Allocations. For state fiscal years beginning on or after July 1, 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.

H. Separate Accounts; Annual Reporting. A state agency that receives allocations from the fund, and a county, a city, and a contractor or vendor that receives funding allocated from the fund shall maintainthat money in a separate account and shall report by September 1st of each year to the Recovery Council providing a description of how those funds for the prior state fiscal year were targeted to the Approved Uses. The Attorney General shall by October 1st of each year compile the reports provided under this subsection and forward the information in a report to the Legislature.

I. **Legislative Committee Review of Legislation.** Whenever a 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 amajority 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 to the committee of jurisdiction and to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.

V. PAYMENT OF COUNSEL AND LITIGATION EXPENSES.

National Attorney Fee Fund. The National Settlement Agreements provide for the payment of all or a portion of the attorney fees and costs owed by the litigating subdivisions to private attorneys retained to file suit in the national opioid litigation. Private attorneys for subdivisions must waive enforcement of their contingent fee agreements to receive payment fromthe National Attorney Fee Fund. Judge Polster recognized that a state backstop fund can be designed to incentivize private attorneys to waive their right to enforce contingent fee agreements and instead apply to the National Attorney Fee Fund, with the goal of achieving greater subdivision participation and higher total payouts to Maine. Accordingly, in order to seek payment from the Backstop Fund, Counsel must agree to waive enforcement of their contingency fee agreements with the subdivisions and first apply to the National Attorneys Fee Fund.

The Parties agree that the litigation and nonlitigating (i.e., participating) subdivisions will create a supplemental attorney fees fund (the "Backstop Fund") to be used to compensate private attorneys that filed opioid lawsuits on or before December 31, 2019.

Backstop Fund Source. The Backstop Fund will be funded by seven percent (7%) of the share of each payment made to the participating subdivisions from the National Opioid settlement agreements. Counsel for Participating Subdivisions may apply to the Backstop Fund for only a shortfall, that is, the difference between what their fee agreements would entitle them to as set forth in Judge Polster's order dated August 6, 2021 Exhibit 4 hereto, minus what they have been awarded from the Common Benefit Fund (including both the "common benefit" and "contingency fee" calculations, if any). If they are awarded fees/costs for common benefit work in the nationalfee fund, these fees/costs will be allocated proportionally across all their local government opioid clients based on the allocation model used in the Negotiation Class website to allocate the appropriate portion to the specific litigating Maine client represented by the law firm.

Special Master. A Special Master will administer the Backstop Fund, including overseeing any distribution, evaluating requests of counsel for payment and determining the amount of any payment. The Special Master will be compensated from the backstop fund. The Special Master shall be selected jointly as follows. The participating subdivisions shall provide a list of at least (3) three candidates for the Special Master position to the Attorney General. The Attorney General shall select the Special Master from those names provided by the subdivisions. The Attorney General may ask the subdivisions to provide additional names. Any successor backstop special master will be selected in the same manner.

Special Master Determinations. The Special Master will determine the amount and timing of any payment to Counsel from the Backstop Fund. The Special Master shall make one determination regarding payment of attorney's fees to Counsel, which will apply through the term of the recovery from the National Opioid Settlement. In making such determinations, the Special Master will consider the amounts that have been or will be received by the private attorney's firm from the National Opioid Settlement common benefit and contingency fee funds relating to subdivisions, the dollar amount of recovery for the Maine subdivisions, the complexity of the legal issues involved in the opioid litigation, and work done to directly benefit the Maine subdivisions. In the interest of transparency, Counsel shall provide information in their initial feeapplication

about the total amount of fees that Counsel have received or will receive from the National Attorney Fee common benefit and contingency fee funds related to litigating subdivisions. For subdivisions that have not entered into contingency fee agreements, the total fees paid to counsel, including from the National Opioid Settlement's Contingency Fee and Common Benefit Funds, may not exceed fifteen 15% of the total gross recovery of the subdivisions' share of funds from the National Opioid Settlement. Counsel seeking payment from the Backstop Fund may also provide written submissions to the Special Master, which may include declarations from counsel, summaries relating to the factors described above, and/or attestation regarding total payments awarded or anticipated from the National Settlement Agreements' contingency fee and common benefit funds. Private attorneys shall not be required to disclose work product, proprietary or confidential information, included but not limited to detailed billing or lodestar records. Any documents filed with the Special Master shall be public and the special master's fee awards shall be transparent, public, final and not appealable.

To the extent the Special Master determines that the Backstop Fund exceeds the amount necessary for payment to Counsel, the special master shall distribute any excess amount to the subdivisions according to the percentages set forth in Exhibit 3.

The Backstop Fund will be administered for (a) the length of the National Litigation Settlement Payments; or (b) until all Counsel for the litigating subdivisions have either (i) received payments equal to the Backstop Fund payment cap, above or (ii) received the full amount determined by the Special Master, whichever occurs first.

For the avoidance of doubt no portion of the State recovery fund will be used to Fund the Backstop Fund or in any other way to fund any subdivisions' attorney's fees and expenses.

Dated: June 13, 2022

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Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("**Core Strategies**").[1]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("MAT") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

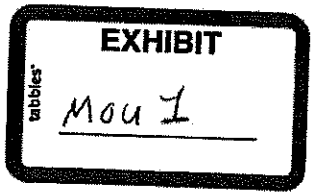
4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

[1] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the National Opioid Abatement Trust Distribution Procedures.



3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools.;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE.**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following[1]:

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[1] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the National Opioid Abatement Trust Distribution Procedures.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance

programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

    2. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail

or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

    1. Increase the number of prescribers using PDMPs;

    2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

    3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide

care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

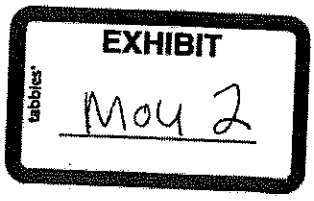
1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.



C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

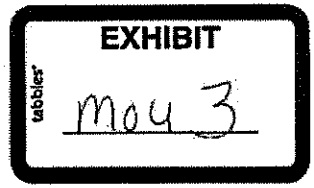
7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State	County	City	Consolidated State Allocation
ME	ANDROSCOGGIN COUNTY		1.6799535986%
ME	ANDROSCOGGIN COUNTY	Lewiston city	4.3451006968%
ME	ANDROSCOGGIN COUNTY	Auburn city	2.6283332826%
ME	AROOSTOOK COUNTY		4.0537116218%
ME	CUMBERLAND COUNTY		3.5025701951%
ME	CUMBERLAND COUNTY	Portland city	7.2016026249%
ME	CUMBERLAND COUNTY	South Portland city	2.2275994495%
ME	CUMBERLAND COUNTY	SCARBOROUGH TOWN	1.8363769930%
ME	CUMBERLAND COUNTY	BRUNSWICK TOWN	1.6113929261%
ME	CUMBERLAND COUNTY	Westbrook city	1.5416150467%
ME	CUMBERLAND COUNTY	GORHAM TOWN	1.4582940317%
ME	CUMBERLAND COUNTY	FALMOUTH TOWN	1.2353278939%
ME	CUMBERLAND COUNTY	WINDHAM TOWN	0.1935482073%
ME	CUMBERLAND COUNTY	STANDISH TOWN	0.0664145731%
ME	FRANKLIN COUNTY		1.9717572454%
ME	HANCOCK COUNTY		3.8494340111%
ME	KENNEBEC COUNTY		4.9959268385%
ME	KENNEBEC COUNTY	Augusta city	3.6779545807%
ME	KENNEBEC COUNTY	Waterville city	2.8132809688%
ME	KNOX COUNTY		2.1010369789%
ME	KNOX COUNTY	Rockland city	0.6184398003%
ME	LINCOLN COUNTY		2.1621727981%
ME	OXFORD COUNTY		3.8454418782%
ME	PENOBSCOT COUNTY		6.7801027597%
ME	PENOBSCOT COUNTY	Bangor city	5.2042873123%
ME	PENOBSCOT COUNTY	ORONO TOWN	0.2094180830%
ME	PISCATAQUIS COUNTY		1.2760851978%
ME	SAGADAHOC COUNTY		1.9708146889%
ME	SOMERSET COUNTY		3.6977198467%
ME	WALDO COUNTY		2.4723925078%
ME	WASHINGTON COUNTY		2.6998574469%
ME	WASHINGTON COUNTY	Calais city	0.8369049504%
ME	YORK COUNTY		6.7950503019%
ME	YORK COUNTY	Biddeford city	2.7393997300%
ME	YORK COUNTY	Sanford city	2.6908215844%
ME	YORK COUNTY	YORK TOWN	2.1005084476%
ME	YORK COUNTY	Saco city	0.4366518238%
ME	YORK COUNTY	WELLS TOWN	0.2541311729%
ME	YORK COUNTY	KENNEBUNK TOWN	0.2185679049%



UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	)	**MDL 2804**
	)	**Case No. 1:17-md-2804**
THIS DOCUMENT RELATES TO:	)	**Judge Dan Aaron Polster**
All Cases	)	**ORDER**

This Order addresses contingent attorney fee contracts between all States and political subdivisions eligible to participate in the Opioid Settlement Agreements and their counsel.

For the reasons stated below, the Court hereby notifies all eligible participants to the July 21, 2021 Settlement Agreements, and also notifies their private counsel, that a contingent fee in excess of 15% of the participant's award under the Settlement Agreements is presumptively unreasonable. Accordingly, the Court caps all applicable contingent fee agreements at 15%.

This fee cap order applies *only* if counsel seeks to enforce a fee contract.[1] It does not apply to limit fees that may be received from the Settlement Agreement Attorney Fee Fund and any applicable "State Back-Stop."[2]

The Court **ORDERS** all counsel for any client that is eligible to participate in the recently-announced Settlement Agreements to share this Order with all of those clients. Further, the Court **ORDERS** the Plaintiffs Executive Committee to broadly publicize this Order.

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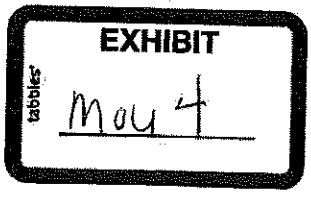
[1] Further, this percentage cap applies ***only*** to distributions received by a State or subdivision under the two Settlement Agreements discussed below. The Court does not now decide whether this or any other fee cap will apply to any future settlement agreement (global or otherwise), or to any verdict in any case. That said, it is extremely likely a similar cap will apply to any global settlement between the Settling Defendants and any Indian Tribe.

[2] *But see* footnote 17.



The Settlement Agreements

Recently, AmerisourceBergen, Cardinal Health, McKesson, and Johnson & Johnson (the "Settling Defendants") reached Settlement Agreements with: (a) a group of State Attorneys General ("AGs") (representing the interests of the 50 States and U.S. territories), and (b) the MDL Plaintiffs' Executive Committee ("PEC") (which represents the interests of, among others, political subdivisions – *e.g.*, individual cities and counties within the States) to resolve the lawsuits against those Defendants related to the opioid crisis.[3] The Agreements are virtually unprecedented in their size and complexity and represent years of difficult negotiation among the several parties, having required hundreds of thousands of hours of work by various stakeholders, their representatives, and counsel, as well as the Court and Special Masters.

The Settlement Agreements provide for total payments of $26.0 Billion, assuming full participation by all States and political subdivisions (payments may be reduced if States and political subdivisions opt out of the Agreements). Of this amount, $2.3 Billion, or about 8.8%, is reserved for payment of attorney fees. Specifically, $1.6 Billion will be placed into an Attorney Fee Fund, from which privately-retained counsel ("Individually-Retained Plaintiff's Attorneys" or "IRPAs") can receive payment upon application to an independent fee-panel. The $1.6 Billion is divided into a sub-fund of 60% ($960 Million) to pay for common benefit fees and 40% ($640 Million) to pay for contingent fees otherwise owed to IRPAs by participating subdivisions. Another $350 Million is reserved for reimbursement and payment of attorney fees incurred by State Attorneys General for outside-counsel; and $350 Million is also reserved for reimbursement

[3] Specifically, the parties entered into two Settlement Agreements: (1) the "Distributors Master Settlement Agreement," settling claims against the "Big Three Distributor Defendants," AmerisourceBergen, Cardinal Health, and McKesson, dated July 21, 2021; and (2) the "J&J Master Settlement Agreement," settling claims against Manufacturer Defendant Johnson & Johnson, dated July 21, 2021. These two Agreements are posted at www.NationalOpioidSettlement.com. The general discussion below of settlement amounts refers to the combined amounts under both Settlement Agreements.

of attorney fees and costs incurred by State Attorneys General for in-house-counsel.[5] Various other amounts are designated for payment of litigation costs, administrative costs, and so on. Ultimately, about $23.5 Billion will be allocated to plaintiffs for abating social ills caused by the opioid crisis. Roughly half of this amount will be paid to States and Territories, and the other half to political subdivisions.[7]

The amounts set aside for payment of attorney fees are the result of a multiple-years-long negotiation between the Settling Defendants, the AGs, and the PEC, with additional input from plaintiffs' counsel nationwide (including those litigating Opioid cases only in State courts). The amounts reflect a consensus, after significant deliberation and with this Court's assistance, on what is a reasonable amount for attorney's fees payable to IRPAs in this case.

To be eligible for payment from the Attorney Fee Fund, an IRPA must submit an application and also waive any right to enforce a contingent fee contract with their subdivision-client.[8] Given that an IRPA may have a contingent fee contract calling for the subdivision-client to pay 20% (or 25%, or an even-higher share) of any recovery the subdivision ultimately receives, an IRPA is very likely to receive from the Attorney Fee Fund an amount far less than the contract would otherwise require.[9] All of the firms that are members of the PEC have agreed to this

[5] *See* Distributors Master Settlement Agreement, Exhs. S, T.

[7] More precisely, the Settlement Agreements have a "default allocation" providing that 15% will go to States, 15% will go to subdivisions, and 70% will go to a fund shared by States and subdivisions. *See* Distributors Master Settlement Agreement §V.C.1, at 29. A given State and its subdivisions can agree to modify this allocation. This raises the question of what should be the amount against which an IRPA may charge their contingent fee. For ease of calculation, the Court assumes the amount against which a contingent fee is charged by an IRPA representing a political subdivision would be 50% of the total default allocation—that is, the 15% the subdivision receives directly, plus half of the 70% shared fund. *See also* footnote 28, below.

[8] *See* Distributors Master Settlement Agreement, Exh. R §§G.2 & G.3.a.

[9] Of the 35,000 or so political subdivisions in the United States that are eligible to participate in the Settlement Agreements, about 75% by population entered into contingent fee contracts with IRPAs. If every one of these contracts calls for payment of only a 20% contingent fee (which is clearly a low estimate), and assuming half of the $23.5 Billion is allocated to the subdivisions (with the rest allocated to the States), then total contingent fees owed

arrangement.[10] This last sentence is worth repeating – the plaintiffs' attorneys who have actually shouldered the enormous load in obtaining the Settlement Agreements (and expended well over $100 Million in out-of-pocket expenses) have committed to waiving all of their contingent fee contracts and accepting instead the amount of contingent fees available from the Attorney Fee Fund. This amount is almost certain to be less than 10%.[11]

That said, a few States have put into place what the parties refer to as a "Back-Stop," which may provide additional funds to further compensate IRPAs who represent participating subdivisions within that State.[12] The Back-Stop is designed to further incentivize IRPAs to waive their right to enforce contingent fee contracts and instead apply to the Attorney Fee Fund, by making additional funds available to compensate IRPAs. Thus, for example, an IRPA representing a State subdivision may: (1) waive their right to enforce their 25% contingent fee contract; (2) apply for payment from the Attorney Fee Fund and receive a 7.5% fee; and (3) also apply for payment from the State Back-Stop and receive an additional 7.5% fee.[14] Alternatively, the IRPA

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would be roughly $1.76 Billion ($23.5 Billion x 75% x 20% x 50%)—which is more than the entire Attorney Fee Fund.

[10] PEC attorneys have agreed to waive their contingent fee contracts with subdivision clients who, as a group, stand to be allocated over half of the settlement funds.

[11] Back-of-the-envelope calculations suggest an IRPA who applies to the Attorney Fee Fund for payment of fees otherwise owed by a client-subdivision under a contingent fee contract may receive in the range of 6-10% of the amount allocated to the subdivision. Specifically: (1) 40% of the Attorney Fee Fund ($640 Million) is reserved for payment of IRPAs' contingent fees; (2) assuming half of the $23.5 Billion is allocated to the subdivisions, they will receive $11.75 Billion; (3) about 75% of the $11.75 Billion ($8.8125 Billion) is subject to a contingent fee contract; and (4) the resulting ratio is 7.3% ($640M / $8.8125B). Allocation of contingent fees from the Attorney Fee Fund, however, will not be uniformly pro rata, so a given IRPA's percentage will fall within a range near 7%.

[12] *See* Distributors Master Settlement Agreement, Exh R §I.R (defining "State Back-Stop Agreement" as "Any agreement by a Settling State and private counsel for Participating Subdivisions in that State (or legislation enacted in that State) to provide, adjust, or guarantee attorneys' fees and costs, whether from the Attorney Fee Fund or any other source recognized in the agreement or legislation.").

[14] This example is hypothetical. The Court does not know exactly how much an attorney might expect to receive from the Attorney Fee Fund for contingent fees, or from any State Back-Stop, because multiple factors go into those calculations. Further, different States have put into place, or are contemplating, different Back-Stop provisions with different payout rates, different Back-Stop fee caps, and so on. Indeed, it may even be the case (for example) that a State Back-Stop allows for payment of additional contingent fees up to another 15% (on top of the 7.5% from the

may choose to forgo compensation from the Attorney Fee Fund and State Back-Stop and instead enforce their 25% contingent fee contract—which, of course, would lead to the subdivision-client ultimately receiving 25% less for abatement of opioid-related social ills than if the IRPA waived the contract and applied to the Attorney Fee Fund.[15]

Finally, it is critical to note that, ***even taking into account State Back-Stops***, the Settlement Agreements still provide for an over-all attorney fee cap: "In no event may less than eighty-five percent (85%) of the [total settlement funds] . . . be spent on Opioid Remediation."[16]

With all of those mechanisms and considerations in mind, and for the reasons discussed below, the Court now orders that contingent fee contracts for all IRPAs representing entities that participate in the Settlement Agreements shall be capped at 15% – which is still a much higher percentage than PEC attorneys will receive.[17] In other words, IRPAs who represent any subdivision that **opts in** to the Settlement Agreements have the following choice: (1) forgo payment of any kind from the Attorney Fee Fund and any State Back-Stop, and instead enforce their contingent fee contract, ***but the contingent amount is hereby capped at 15%***; or (2) waive

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Attorney Fee Fund), but State funds earmarked to pay for those additional contingent fees are sufficient to pay only a supplemental 10%.

The fundamental reason for a State's adoption of a Back-Stop is that the Settlement Agreements call for different payment levels to the States and subdivisions depending upon participation rates; and subdivision participation rates will be higher if subdivisions know they will not have to pay a percentage of their recovery to an IRPA (even though they agreed to do so). Put simply, the Attorney Fee Fund and Back-Stops combine to incentivize greater subdivision participation and thus higher ultimate payouts by the Settling Defendants to both the States and subdivisions. A State may therefore rationally conclude that a portion of the settlement funds it receives is well-spent on payment of a portion of contingent fees otherwise owed to attorneys representing subdivisions within the State.

[15] Because the Settlement Agreements provide for payment to subdivisions over 18 years, IRPAs who choose to enforce their contingent fee contract will receive their fees over that same time period. In contrast, IRPAs who choose to waive their contingent fee contract and apply to the Attorney Fee Fund will be paid their contingent fees over seven years. *See* Distributors Master Settlement Agreement, Exh. R §II.A.

[16] Distributors Master Settlement Agreement §V.B.1, at 28.

[17] As did the court in *In re Oil Spill by the Oil Rig DEEPWATER HORIZON in the Gulf of Mexico, on Apr. 20, 2010*, this Court addresses contingent attorney fees now, prior to final consummation of the settlement agreement, so that subdivisions contemplating participation can fully weigh their options and the parties can more quickly gauge participation levels. *See* 2012 WL 2236737, at *1, n.1 (E.D. La. June 15, 2012).

their right to enforce their contingent fee contract, apply to the Attorney Fee Fund for contingent and common benefit fees, and also apply for any applicable State Back-Stop funding.[18]

A subdivision may choose not to participate in the Settlement Agreements at all (that is, **opt out**), in which case this Order has no effect on any contingent fee contract the subdivision may have with an IRPA. If the subdivision does participate in the Settlement Agreements, however, then any contingent fee contract that subdivision has with an IRPA is hereby capped at 15%.[19] Stated differently, the 15% cap the Court imposes with this Order applies to all contingent fee contracts any IRPA has with any entity that chooses to participate in the Settlement Agreements—including subdivisions that have not filed any litigation against the Settling Defendants, those that have filed litigation pending in State courts, and those that have cases pending in this MDL.[21] The Court's reasons and jurisdictional basis for this Order are set out below.

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[18] This Order does ***not*** prohibit an IRPA from receiving more than a total of a 15% fee ***if received from the Attorney Fee Fund and/or a State Back-Stop***. Those funds have already been reserved for payment of fees and an IRPA's receipt of payment through that mechanism will not work directly to decrease the amount of funds the IRPA's subdivision-client finally obtains for abatement of the opioid crisis. This Order only prohibits an IRPA from receiving more than a total of a 15% fee if subtracted directly from the settlement proceeds received by the subdivision-client (which would, of course, work to decrease what the subdivision-client can ultimately spend on abatement of the opioid crisis). The reason for this difference is that what makes for a "reasonable fee" depends in large part on how the fee affects the client's net recovery. All of that said, **the Court further believes it begins to become unreasonable if the total contingent fees an attorney receives from the Attorney Fee Fund and any State Back-Stop combined exceeds 15%.** But the Court chooses not to strictly cap contingent fees available from State Back-Stops at this time. In any event, it appears the State Back-Stop agreements currently in place generally provide for supplemental funding that yields a total fee at or below 15% of the local governments' total share of the settlement.

[19] This Order does not address an IRPA's contractual right to recover costs. It addresses only attorney fees.

[21] This Order also caps contingent fees owed to attorneys who have contracted with State Attorneys General, although those attorneys will receive a portion of their fees from a different settlement fund. *See* Distributors Master Settlement Agreement Exh. S (creating a "State Outside Counsel Fee Fund"). The Court is quick to confirm, however, as it has before, that it is not exercising jurisdiction over any case filed by any Attorney General; it is exercising jurisdiction only over attorneys who come to the MDL Court to seek attorney fees pursuant to the Settlement Agreements. *See* docket no. 146 at 1 ("The Court recognizes it has no jurisdiction over (i) the AGs or their representatives, (ii) the State cases they have filed, or (iii) any civil investigations they may be conducting."). Of course, all of the attorneys who will seek fees from the State Outside Counsel Fee Fund will also be seeking fees from the Attorney Fee Fund, which this Court is administering.

Discussion

Mass tort MDLs, such as this Opioid Crisis Litigation, can serve an invaluable public good.[22] As Judge Weinstein observed, "[l]itigations like the present one are an important tool for the protection of consumers in our modern corporate society, and they must be conducted so that they will not be viewed as abusive by the public; they are in fact highly beneficial to the public when adequately controlled." *In re Zyprexa Prods. Liab. Litig.*, 424 F.Supp.2d 488, 494 (2006).

Recognizing the value of mass torts, contingent fee contracts are accepted in the American legal system to incentivize attorneys to bring these cases. Contingent fee contracts are often viewed skeptically by the public, however, especially when the amounts earned by plaintiffs' attorneys are extremely large. Because mass tort MDLs, by definition, affect vast numbers of individuals in our society—which is undeniably the case in the opioid crisis—these MDLs are closely followed and highly scrutinized by the media and the public. This is even more true with the Opioid MDL, because plaintiffs are, in large part, governmental entities stewarded by politicians who are obligated to share the progress of the case with their constituents.

When attorneys' contingent fee contracts yield unreasonable or excessive amounts, the outsized payments to lawyers can undermine public faith in the judicial system. *See In re Guidant Corp. Implantable Defibrillators Prods. Liab. Litig.*, 2008 WL 682174, at *17 (D. Minn. Mar. 7, 2008) ("The fairness of the terms of such agreements reflects directly on the Court and the legal profession."); *see also Fla. Patient's Comp. Fund v. Rowe*, 472 So. 2d 1145, 1149-50 (Fla. 1985), *holding modified by Standard Guar. Ins. Co. v. Quanstrom*, 555 So. 2d 828 (Fla. 1990) (quoting *Baruch v. Giblin*, 122 Fla. 59, 63, 164 So. 831, 833 (1935)) ("The attorney's fee is, therefore, a

[22] *See Contingent Fees in Mass Tort Litigation*, 42 Tort Trial & Ins. Prac. L.J. 105, 111 (2006) ("The purposes of mass tort litigation are to deter activities that harm people and to compensate people who are harmed.").

very important factor in the administration of justice, and if it is not determined with proper relation to that fact it results in a species of social malpractice that undermines the confidence of the public in the bench and bar. It does more than that. It brings the court into disrepute and destroys its power to perform adequately the function of its creation."). This is why rules of professional conduct invariably impose upon contingency fee contracts a "requirement of reasonableness." *In re Vioxx Prods. Liab. Litig.*, 650 F.Supp.2d 549, 559 (2009) (citing Model Rules of Professional Conduct R. 1.5(a)).

It is incumbent, then, upon this Court to maintain public confidence in the legal system by ensuring the contingent fee contracts applicable to funds distributed under the Settlement Agreements are "reasonable under the circumstances." *Bowling v. Pfizer, Inc.*, 102 F.3d 777, 779 (6th Cir. 1996). The Court is also cognizant that "the circumstances" include the economic realities of bringing mass tort cases such as the Opioid Crisis Litigation. Aggregation of large numbers of cases can be expensive to administer and prosecute. There are enormous overhead costs in the early stages of litigation. And the contingent nature of the fee arrangements can make the cases risky to bring. Given these factors, the Court must carefully balance appropriate compensation for high-quality attorneys against those same lawyers' ethical obligation to charge no more than a reasonable fee.[23]

Although orders capping fees are often unpopular with the plaintiffs' bar,[24] it is indisputable that the Court has the authority to examine and modify attorneys' contingent fee

[23] For a thorough discussion of the competing incentives that must be balanced when contemplating the regulation of contingent fee contracts, see *Contingent Fees in Mass Tort Litigation*, 42 Tort Trial & Ins. Prac. L.J. 105 (2006) (cited favorably by J. Fallon in his opinions in *In re Vioxx*, 574 F.Supp.2d 606 (2008), and 650 F.Supp.2d 549 (2009)).

[24] *See* Eldon E. Fallon, *Common Benefit Fees in Multidistrict Litigation*, 74 La. L. Rev. 371, 379 (2014) ("At the outset, it is important to recognize that judicial review of the fee arrangements of the attorneys appearing before the court is not only controversial but unpleasant.").

contracts. Specifically, "[i]n the context of mass tort litigation, 'a court that exercise[s] inherent power to prevent a violation of the lawyers' professional responsibility to charge only reasonable rates would be acting within the parameters of inherent authority as described by the Supreme Court.'" *In re Vioxx*, 650 F.Supp.2d at 560 (quoting *Contingent Fees in Mass Tort Litigation*, 42 Tort Trial & Ins. Prac. L.J. 105, 127 (2006)). *See also In re Zyprexa Prods. Liab. Litig.*, 424 F.Supp.2d 488, 492 (2006) ("The judiciary has well-established authority to exercise ethical supervision of the bar in both individual and mass actions. This authority includes the power to review contingent fee contracts for fairness."); *In re Rio Hair Naturalizer Prod. Liab. Litig.*, 1996 WL 780512, at *20 (E.D. Mich. Dec. 20, 1996) ("It is well-settled that the court has the inherent authority to regulate contingency fees to ensure that they are not excessive or unreasonable.") (quoting *In re A.H. Robbins Co., Inc.*, 86 F.3d 364 (4th Cir. 1996)).[25]

In addition to this inherent supervisory authority to regulate contingent fees, several courts have relied upon their equitable powers under a quasi-class action theory. *See In re Vioxx*, 650 F.Supp.2d at 558-59; *In re Zyprexa*, 424 F.Supp.2d at 491-92; *In re Guidant*, 2008 WL 682174, at *17. The Opioid MDL is not a class action and the Settlement Agreements are not class action settlements.[26] Other MDL courts overseeing cases that also were not class actions, however, found equitable authority for fee cap orders in the text of the MDL statute, 28 U.S.C. § 1407. Judge Fallon again:

> Admittedly, the Federal Rules of Civil Procedure expressly provide that district courts may require reasonable fees in class actions while the MDL statute lacks an analogous provision. *Compare* Fed. R. Civ. P. 23(g)(1)(C)(iii), *and* Fed. R. Civ. P.

[25] *See also In re Guidant*, 2008 WL 682174, at *18 (same); Expert Report of William B. Rubenstein, MDL No. 2323, Doc. No. 9526 (Dec. 11, 2017) (adopted by *In re Nat'l Football League Players' Concussion Inj. Litig.*, 2018 WL 1658808, at *3 (E.D. Pa. Apr. 5, 2018) ("Myriad prior class action and non-class action MDL courts have concluded that a court's inherent authority over lawyers practicing before it enables the court to cap contingent fee contracts.") (listing cases).

[26] *See In re Nat'l Prescription Opiate Litig.*, 976 F.3d 664 (6th Cir. 2020) (Doc. 3509) (reversing certification of a settlement "negotiation class").

> 23(h), *with* 28 U.S.C. § 1407. This statutory difference, however, is not the end of the story. First, the MDL statute requires that transferee courts "promote the just and efficient conduct of such actions." 28 U.S.C. § 1407(a). In the context of contingent fee arrangements, implementing a reasonable cap promotes justice for all parties by allowing claimants to benefit (as their attorneys have) from the economies of scale and increased efficiency that an MDL provides. Certainly, this statutory language lends support to the proposition that MDL courts, like class action courts, can exercise equitable authority to examine the reasonableness of fees.

In re Vioxx, 650 F.Supp.2d at 558.

Although not a class action, the Opioid MDL retains many important characteristics of a class action, so treatment as a quasi-class action is appropriate. Most notably, while many mass-tort MDL settlements define eligible claimants as those with pending cases filed by a date certain, the Settlement Agreements here contemplate virtually ***all*** States and their political subdivisions as eligible claimants, even if they have not filed a case and regardless of whether they have retained counsel. As a practical matter, the Settlement Agreements function much like a class action settlement, where the rights of non-MDL claimants (and non-litigating claimants) are affected. Thus, the Court has the equitable authority and responsibility to carefully monitor the Settlement Agreements and all related fee agreements to ensure they are fair to all potential stakeholders.[27]

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[27] In sum, the Court's authority to enter this fee cap Order derives from: (1) the Court's inherent supervisory authority to regulate contingent fees and to superintend attorney professional conduct; and (2) its equitable powers under a quasi-class action theory. Judge Fallon also identifies a third source of authority: express authority granted in the agreement itself by the parties to the settlement agreement. This third source of the Court's authority is also present here. *See, e.g.*, Distributors Master Settlement Agreement, Exh. R, §I.C (defining the "Attorney Fee Fund" as "An account consisting of funds allocated to pay attorneys' fees approved pursuant to Section II of this Fee Agreement established by Order of, and under the ongoing jurisdiction of, the MDL Court"). Even without this express authority, however, the Court would still be allowed and obligated to cap contingent fee contracts as appropriate.

The Court notes these sources of authority are similar to those frequently cited in common benefit cases, *see* Eldon E. Fallon, *Common Benefit Fees in Multidistrict Litigation*, 74 La. L. Rev. 371, 379 (2014) ("By and large, the legal bases relied on by courts that have reviewed and altered contingent fee contracts in MDL cases for reasonableness are similar to the justifications for creating a common benefit fee fund."), and common benefit fee assessments on attorneys with cases not before the MDL judge is an unsettled issue. *Compare In re Avandia Mktg., Sales Pracs. & Prod. Liab. Litig.*, 617 F. App'x 136, 141 (3d Cir. 2015) and *In re Gen. Motors LLC Ignition Switch Litig.*, 477 F. Supp. 3d 170, 180 (S.D.N.Y. 2020) (allowing the assessment); with *In re Roundup Prods. Liab. Litig.*, No. 16-md-02741-VC (N.D. Cal. Jun. 22, 2021) (ECF. 13192) and *In re Genetically Modified Rice Litig.*, 2010 WL 716190, at

In light of all of these considerations, the Court concludes a cap on individual contingent fee contracts of 15% of the client's total award[28] yields a maximum, reasonable fee under the circumstances of this case. Participating subdivisions and their counsel can, of course, agree to something less than the Court's cap under the unique circumstances of their relationship. But the Court is convinced of the reasonableness of its cap for several reasons: (1) it prevents subdivisions from effectively paying attorney fees twice; (2) it promotes equity in the distribution of the fund; (3) the PEC attorneys who negotiated the settlement have indicated to the Court they intend to waive their contingent fee contracts and utilize the Attorney Fee Fund; and (4) the proposed settlement amount is so large that customary contingent fee percentages would disproportionately over-compensate attorneys and reflect poorly on the legal profession. The Court explicates each of these reasons below.

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*1 (E.D. Mo. Feb. 24, 2010), *aff'd*, 764 F.3d 864 (8th Cir. 2014) (stating the court did not have jurisdiction to make such an assessment).

While the justifications for the Court's authority are similar and the reasoning of those cases is enlightening, assessment of a common benefit fee to reimburse attorneys who perform common benefit work is not the issue addressed here. In each of those cases, the court determined it had some level of jurisdiction (or not) over non-MDL cases by virtue of counsel in those cases having used common benefit work. *Compare In re Gen. Motors*, 477 F. Supp. 3d at 180 ("If Common Benefit Work Product is used in non-Common Benefit claims or actions, they shall be subject to the assessment."); with *In re Roundup*, No. 16-md-02741-VC at 23-24, 30-31 (ECF. 13192). Here, the Court asserts its authority by virtue of the Settlement Agreements Attorney Fee Fund, and the Court caps contingent fee contracts for subdivisions who opt in to the Agreements and receive funds from the Settlement administered by the Court.

[28] It is not entirely clear to the Court how IRPAs representing subdivisions will calculate the amount against which a contingent fee is charged. As noted earlier, the Settlement Agreements have a "default allocation" providing that 15% of the settlement funds will go to States, 15% will go to subdivisions, and 70% will go to a fund shared by States and subdivisions. *See, e.g.*, Distributors Master Settlement Agreement §V.C.1 at 29. Thus, there is room for argument that the contingent fee should be charged against: (a) only the 15% portion that goes directly to the subdivisions; *or* (b) this 15% portion *plus* half (or some other fraction) of the 70% portion shared by the subdivisions with the State; *or* (c) some other division of the settlement payment. Further, State-specific agreements between the State and its subdivisions may alter the default allocation and/or clarify what the share is against which a contingent fee should be charged. The Court takes no firm position on this question here, but it appears the fairest and most equitable result, absent explicit agreement otherwise, is that an IRPA should charge the contingent fee against, at most, 50% of the total allocation. *See* Distributors Master Settlement Agreement, Exh. S, ¶5.b (stating the multiplicand against which the contingency percentage will be applied by IRPAs retained by States will be 50% of the total allocation).

Double Payment

The Attorney Fee Fund, which amounts to $1.6 Billion, contains a $640 Million sub-fund specifically for payment of IRPA fees. In other words, money that would otherwise go to political subdivisions to abate the opioid crisis in their communities has already been reserved to pay their individual attorneys as part of the structure of the deal. The same is true for the State Outside Counsel Fee Fund – $350 Million has been reserved to pay individual attorneys hired by States; this is money that would otherwise go to the States to abate the opioid crisis. This totals nearly $1 Billion earmarked to pay IRPA fees.

Were the Court to allow IRPAs to collect their ***uncapped*** contingent fees from their clients' settlement distribution, those clients would effectively be paying attorney fees twice: (1) $1 Billion of settlement funds otherwise available to participating States and subdivisions under the Settlement Agreements is automatically reserved instead to pay for contingent fees; and (2) if the IRPA opts to enforce their contingency fee contract, then the client must pay the IRPA's fee out of the client's disbursement from the remaining $23.7 Billion in settlement funds. The fee cap works to limit the second payment, to the extent that payment is required.

While attorneys are still entitled, under the settlement agreement, to forgo the Attorney Fee Fund and instead seek fees from their subdivision-clients' share of the settlement distribution, counsel's contingent fee is now capped to ensure an appropriate share of the money intended for abatement of the opioid crisis is actually used for that purpose. The Court's cap is necessary to ensure that client-subdivisions, and not just their attorneys, benefit from the economies of scale provided by aggregation. *See In re Vioxx*, 650 F.Supp.2d at 558 ("In the context of contingent fee arrangements, implementing a reasonable cap promotes justice for all parties by allowing claimants to benefit (as their attorneys have) from the economies of scale and increased efficiency that an MDL provides.").

In sum, the Settlement Agreements already provide for payment of a fair portion of an IRPA's contingent fee; this Order ensures an IRPA will not over-reach and require their client to pay still more contingent fees beyond a reasonable amount.

Equitable Distribution

The Court again makes clear that the 15% fee cap applies to ***all*** contracts between ***all*** participating States and political subdivisions and their IRPAs, not just those who may have cases already transferred into the MDL. Any entity that opts in to the Settlement Agreements subjects its counsel to the jurisdiction of this Court for the limited purpose of ensuring counsel receives no more than reasonable fees.

Indeed, to hold otherwise would produce deeply inequitable and even absurd results. Consider the following hypothetical. Two similarly-sized and -populated counties in the same State—County A and County B—opt in to the proposed settlement agreement and are each entitled to receive $1 Million of settlement funds. Both Counties signed 25% contingent fee contracts with an IRPA. County A's IRPA drafted and filed a complaint in the MDL, reviewed ARCOS data, and amended County A's complaint appropriately. In contrast, County B's IRPA did nothing beyond entering into a contingent fee contract for 25% of his client's settlement proceeds.

If the Court were to cap the contingent fees of only those attorneys with cases in the MDL, then:

- **County A's attorney** would choose between: (1) a capped 15% contingent fee of $150,000; or (2) payment from the Attorney Fee Fund and State Back-Stop, amounting to (say) $160,000; but
- **County B's attorney** could enforce his contingent fee contract for $250,000, receiving almost twice the fees for virtually no work.

This result not only provides compensation far in excess of a reasonable fee for the work County B's attorney performed, it is also terribly inequitable between the two attorneys and their client-subdivisions. County A would ultimately receive either $850,000 (if the IRPA enforced the capped contingent fee contract) or $1 Million (if the IRPA waived his contract and obtained payment under the Settlement Agreements) to abate the opioid crisis. County B, which received far fewer services from its attorney, would receive only $750,000.[29] The Court's contingent fee cap, therefore, adds a deep measure of uniformity and equity to the extraordinarily complicated Settlement Agreements. The fee cap will work to benefit IRPAs who worked diligently on behalf of their clients, the clients themselves, and also the individuals in this country who are suffering the social ills caused by the opioid crisis.

Ultimately, the fee cap ensures local governments will receive more resources to address and abate the opioid crisis, so that the general public is the true beneficiary of the Settlement Agreements.

PEC Attorneys

The Court is also persuaded of the reasonableness of its cap by the fact that all of the PEC attorneys, who have worked diligently for well over three years to attain these extraordinary settlements, negotiated the structure of the Attorney Fee Fund and have committed to using it themselves. The Court puts great weight on the judgment of those attorneys—all of whom have their own individual subdivision-clients—who have invested immense amounts of time and money into this MDL. That they believe the Attorney Fee Fund is reasonable and intend to use it themselves in lieu of their own contingent fee agreements indicates to the Court that the percentage

[29] Notably, a hypothetical, similarly-situated County C, which did not retain counsel at all, would receive the entire $1 Million settlement distribution.

they implicitly negotiated (roughly 6-10%) is reasonable. The Court is skeptical, therefore, of the reasonableness of contingent fee contracts that would allow IRPAs to receive fees far in excess of what they could receive through the Attorney Fee Fund. From this perspective, a 15% cap is generous.

Proportionality

The settlement in this case easily qualifies as a "mega fund."[30] It is among the largest in our nation's history. Were the Court to allow IRPA contingent fees to exceed the Court's capped percentage, total attorney fee awards would be enormous. This would reflect poorly on the legal profession and the judicial system.[31] Further, the fees would be "in excess of a *reasonable* fee" measured against the work performed, and so would violate an IRPA's ethics rules. Ohio Rules of Professional Conduct, R. 1.5(a) (2020) (emphasis in original). This conclusion is buttressed most strongly by the fact that ***all parties*** to the Settlement Agreements concurred that at least 85% of the total settlement funds must be spent on remediation of the opioid crisis.

Having carefully considered all of the factors discussed above, the various positive and negative incentives engendered by a fee cap, and the ultimate goal of the MDL, the Court concludes a 15% fee cap is reasonable to compensate IRPAs for their work. A contingent fee in

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[30] As the value of the monetary relief in a settlement goes up, contingent fees should generally go down. *See* FEDERAL JUDICIAL CENTER, MANUAL FOR COMPLEX LITIGATION (Fourth) §14.121 at 188-89 (citing *In re Prudential Ins. Co. of Am. Sales Practices Litig.*, 148 F.3d 283, 339-40 (3d Cir. 1998)) ("Accordingly, in 'mega-cases' in which large settlements or awards serve as the basis for calculating a percentage, courts have often found considerably lower percentages of recovery to be appropriate. One court's survey of fee awards in class actions with recoveries exceeding $100 million found fee percentages ranging from 4.1% to 17.92%."); *see also In re Zyprexa Prods. Liab. Litig.*, 424 F.Supp.2d 488, 495-96 (2006) (reviewing state laws that reduce the percentage an attorney can accept on contingency as the value of the award goes up).

[31] *See* Dennis E. Curtis & Judith Resnik, *Contingency Fees in Mass Torts: Access, Risk, and the Provision of Legal Services When Layers of Lawyers Work for Individuals and Collectives of Clients*, 47 DePaul L. Rev. 425, 434 n.27 (1998) (discussing how "a one-third attorney fee in million and billion dollar cases stuns even professionals accustomed to large payments.") (citing Fight over Attorney Fees Overshadows Tobacco Deal, Orlando Sentinel, Oct. 5, 1997).

excess of 15% of the client's total award under the Settlement Agreements is presumptively unreasonable.

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Finally, the Court allows that some IRPAs may have performed extraordinary work on behalf of their subdivision-clients and taken on substantial risk that is far beyond the norm in these opioid cases. A 15% fee cap is reasonable to compensate IRPAs for the work actually performed litigating against the Settling Defendants in the vast majority of opioid cases, but it is conceivable, in rare circumstances, that a 15% capped contingent fee would not adequately compensate an IRPA for work actually performed. *See In re Vioxx Prods. Liab. Litig.*, 650 F.Supp.2d 549, 564-65 (2009). In those rare cases, the Court will permit an IRPA who forgoes application to the Attorney Fee Fund and instead enforces their contingent fee contract to move for an upward departure from the fee cap and present evidence of exceptional work, extraordinary risk, and insufficient compensation.

IT IS SO ORDERED.

/s/ Dan Aaron Polster August 6, 2021
DAN AARON POLSTER
UNITED STATES DISTRICT JUDGE