STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 13, 2013

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401

Re: SB 234 – Maryland Health Improvement and Disparities Reduction Act of 2012 - (Ch. 3 of the Acts of 2012) and Health-General Article § 20-1407

Dear Governor O'Malley, President Miller and Speaker Busch:

The Department of Health and Mental Hygiene (the Department) and Community Health Resources Commission (CHRC) respectfully request an extension for submission of the annual legislative report of the Health Enterprise Zone (HEZ) Initiative, which is required under the *Maryland Health Improvement and Disparities Reduction Act of 2012* (Ch. 3 of the Acts of 2012). This legislation requires that on or before December 15 of each year, the CHRC and Department must submit to the Governor and General Assembly a report that includes: (1) the number and types of incentives granted in each HEZ; (2) evidence of the impact of the incentives in attracting practitioners to the HEZs and in reducing health disparities and improving health outcomes; and (3) evidence of the progress in reducing health costs and hospital admissions and readmissions in HEZs. This extension will enable the CHRC and Department to finalize several pieces of information that have been requested from the five Health Enterprise Zones and include this information in the annual report.

The Department and CHRC expect to submit the report by January 13, 2014. If you have any questions regarding this request, please contact Christi Megna, Assistant Director of Governmental Affairs, at (410) 767-6509 or at christi.megna@maryland.gov or Mark Luckner, Executive Director, CHRC, at (410) 260-7046 or at mark.luckner@maryland.gov.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

cc: Christi Megna
Mark Luckner
Patrick Dooley
Simon Powell, DLS

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 13, 2014

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

Re: Health-General Article § 20-1407-2013 Annual Report
Report of Health Enterprise Zones Implementation Year One

Dear Governor O'Malley, President Miller, and Speaker Busch:

Pursuant to Maryland Health-General Article, Section 20-1407, the Department of Health and Mental Hygiene (the Department) and the Community Health Resources Commission (the Commission) submit this 2013 Report of the first year of the Maryland Health Enterprise Zones (HEZ) implementation, including incentives granted. The Report describes a variety of start-up activities by both the Department and the Commission. Under Health-General Article, Section 20-1402, the purposes of the HEZs are to reduce health disparities, improve health outcomes, reduce health costs, and to reduce hospital admissions and readmissions in specific areas of the State.

Calendar year 2013 was the first year of HEZ operations and was largely dedicated to start-up activities to launch this innovative and collaborative community-based public health intervention in communities with high poverty and persistent health disparities. The enclosed Report describes these start-up activities and initial results, including successes and challenges.

If you have questions concerning this Report, please contact Christi Megna, Assistant Director of Governmental Affairs, at (410) 767-6509, Mark Luckner, Executive Director, Community Health Resources Commission, at (410) 260-7046 or Carlessia Hussein, Director, Office of Minority Health and Health Disparities at (410) 767-0094.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Sincerely,

John Hurson
Chairman, Community Health Resources Commission

Enclosure

cc: Patrick Dooley
Christi Megna, J.D.
Carlessia A. Hussein, R.N., Dr. P.H.
Sarah Albert, MSAR#9344
Mark Luckner, M.A.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

and

COMMUNITY HEALTH RESOURCES COMMISSION

Health General Article § 20-1407
Annotated Code of Maryland

HEALTH ENTERPRISE ZONES

2013 REPORT

January 2014

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene

The Honorable John Hurson
Chairman
Community Health Resources Commission

Maryland Health Enterprise Zone Program (HEZ)
2013 Annual Report

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I. Executive Summary

Maryland has a number of advantages that allow its citizens to access quality health care. Despite these advantages, Maryland lags behind other states in several health indicators. Health disparities by race/ethnicity and by place of residence are seen throughout the State. In response to these persistent health disparities, Maryland Lieutenant Governor Anthony G. Brown convened the Maryland Health Quality and Cost Council's Health Disparities Workgroup charged with investigating strategies to reduce and eliminate health disparities. The Workgroup led by Dean E. Albert Reece, MD, PhD, MBA, of the University of Maryland School of Medicine, articulated the concept of applying principles of economic development and revitalization to public health and healthcare delivery.

The recommendations of the Workgroup led to the introduction of SB 234, the Maryland Health Improvement and Disparities Reduction Act of 2012 (the "Act"), championed by Lt. Governor Anthony G. Brown. The purpose of the Act is to target state resources to: (1) Reduce health disparities; (2) Improve health outcomes; and (3) Reduce health costs and hospital admissions and readmissions in specific areas of the state. The Act created the policy framework to establish and implement the Health Enterprise Zones (HEZs) Initiative. In its wisdom, the Maryland General Assembly authorized the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Community Health Resources Commission (CHRC) to collaborate in implementing provisions of the Act.

Solicitation for HEZ proposals took place in late 2012 with designations being made by DHMH Secretary Sharfstein in January 2013 based on recommendations from CHRC. Under the Act, non-profit community-based organizations or local government agencies were eligible to apply for HEZ designation status on behalf of a local community. The Call for Proposals generated a total of 19 applications from 17 jurisdictions, representing rural, urban, and suburban areas of the state. The five HEZs are located in Anne Arundel, Dorchester/Caroline, Prince George's, and St. Mary's Counties and Baltimore City. These Zones exhibited measurable and documented economic disadvantages and poor health outcomes and proposed creative and sustainable plans for targeted investments in community health. These designations involved local coordinating organizations/coalitions led by three hospital systems and two local health departments, and result in two rural, one urban, and two suburban HEZs.

Technical assistance and guidance was provided to the HEZs by the HEZ Team's program directors from CHRC and DHMH, with lead responsibility in Health Systems and Infrastructure, Prevention and Health Promotions, Minority Health and Health Disparities, Behavioral Health and the Community Health Resources Commission. A variety of assistance was provided by these programs through written guidelines, on-site consultation, and conference calls.

The HEZs articulated a collective recruitment goal for Year One of recruiting 38 new health care practitioners. As of this Report, 43 new practitioners have been added, including physicians, nurse practitioners, registered nurses, social workers and a psychiatrist. Four of the HEZs have achieved their Year-One practitioner recruitment goals. Though the HEZs achieved their overall Year-One practitioner recruitment goals, several of the Zones, especially in rural areas, reported challenges in recruiting primary care physicians. The Zones are confronting the challenges

involved with collecting and reporting individual patient clinical outcome data and aggregating this data across multiple different EMR systems and paper-based systems.

Loan repayment assistance was provided in the HEZ Statute as an incentive to recruit and retain providers to HEZs. Two types of tax credits are offered as incentives by the Act: (1) hiring tax credits and (2) income tax credits. For full use of these two incentives, submitted Health Care Practitioner Income Tax Credit regulations and Employer Hiring Tax Credit amendments need to be executed. Both actions are expected by summer of 2014.

The impact of the HEZ programs and incentives on disparities, admissions, health outcomes and cost cannot be measured at the end of Year One. The first year has been dedicated to hiring, establishing protocols, training and recruitment of practitioners. While activity data are being collected, sufficient data will not be available for analysis due to the lag time in collecting hospital admission data and state mortality and morbidity data for the respective HEZs.

The HEZ Team members from DHMH and CHRC provided public health guidelines, operational technical assistance, budget/fiscal guidance, and in-person consultation to the HEZs as a collective and individually throughout start up efforts during this first year. The technical assistance included advice on accessing incentives, measuring performance and outcomes, cultural competency standards, chronic disease interventions, behavioral health support, reporting, and evaluation.

The individual HEZs are conducting their own internal evaluation by tracking start up and program intervention tasks as outlined in their approved proposals. An external evaluation, to be conducted by an outside entity, will utilize the internal program tracking information and employ a quantitative evaluation model to measure overall outcomes and impact on the established goals of reducing health disparities, improving health outcomes, and reducing health costs, admissions and readmissions in the HEZs.

In Year Two, calendar year 2014, the HEZ Team in partnership with the HEZs will ensure that all start-up activities are complete, operations are modified based on lessons learned, and ongoing oversight focuses on achievement of the stated objectives for each HEZ. Additional resources will be provided in the form of federal grants, data analyst experts, training and other support to strengthen each HEZ's capacity to revitalize public health with community partnerships at the local level.

II. Authorizing Legislation, Funding and Joint Management

A. Maryland Health Improvement and Disparities Reduction Act

Maryland has a number of advantages that allow its citizens to access quality health care. Maryland has outstanding medical schools, and among the 50 states, it has the highest median household income and the fifth highest number of primary care physicians. Despite these advantages, Maryland lags behind other states in several health indicators. In America's Health Rankings, a ranking system where 1st is best, Maryland ranked 36th in infant mortality, 31st in cardiovascular deaths, 26th in cancer deaths, and 25th in obesity prevalence in the 2013 edition. For these and for other key health indicators, important and persistent health disparities by race/ethnicity and by place of residence are seen in Maryland.

In response to these persistent health disparities, Maryland Lt. Governor Anthony G. Brown convened the Maryland Health Quality and Cost Council's Health Disparities Workgroup, composed of public health experts, research scholars, and community health leaders, and charged this group with investigating strategies to reduce and eliminate health disparities. The Workgroup was led by Dean E. Albert Reece, MD, PhD, MBA, of the University of Maryland School of Medicine. The Workgroup articulated the concept of applying principles of economic development and revitalization to public health and healthcare delivery, recommending a range of incentives including tax credits, loan repayment assistance, and grant funding to expand access in underserved areas, reduce health disparities, and improve health outcomes. These incentives would serve to attract primary care clinicians to expand or open practices and would support community-level interventions such as community health workers and other strategies to address social determinants of health. The key recommendation of the Workgroup was the creation of "Health Enterprise Zones," which are contiguous geographic areas where the population experiences poor health outcomes that contribute to racial/ethnic and geographic health disparities and are small enough for incentives to have a measurable impact.

The recommendations of the Workgroup led to the introduction of SB 234, the Maryland Health Improvement and Disparities Reduction Act of 2012 (the "Act") (Appendix A), which was championed by Lieutenant Governor Anthony G. Brown. The Maryland General Assembly passed SB 234 during the 2012 session, and Governor Martin O'Malley signed the bill into law in April 2012. The purpose of the Act is to target state resources to: (1) Reduce health disparities; (2) Improve health outcomes; and (3) Reduce health costs and hospital admissions and readmissions in specific areas of the state. The Act created the policy framework to establish and implement the Health Enterprise Zones (HEZs) Initiative. Funding for this initiative was placed in the budget of the Maryland Community Health Resources Commission (CHRC) consistent with their charge to direct resources to communities where poor health persists despite ongoing services provided by the public and private sectors. The Department of Health and Mental Hygiene (DHMH) was charged to apply their public health expertise in Core Public Health Services and their State authority to ensure *assessment, policy development, and assurance* that quality, safe and effective health services are delivered. In its wisdom, the Maryland General Assembly authorized the two organizations (DHMH and CHRC) to collaborate in implementing provisions of the Act. Nine of the Act's provisions are the sole responsibility of DHMH, seven are jointly shared, and one provision is the sole responsibility of CHRC.

B. Funding and Resources

The Act provides $4 million per year over the four-year duration of the program and creates the Health Enterprise Zone Reserve Fund, a special, non-lapsing fund which is administered by the Community Health Resources Commission. The Act provides access to a range of incentives and resources to Health Enterprise Zones, including: (1) Income tax credits; (2) Hiring tax credits; (3) Loan repayment assistance; (4) Priority participation in the Maryland Patient-Centered Medical Home Program; and (5) Grant funding provided by the CHRC. In addition to these incentives and resources, the state also supports the Zones with specific technical assistance and program guidance [which is detailed in the report in section IV].

C. DHMH and CHRC Shared Management

Secretary Joshua M. Sharfstein (DHMH) and Chairman John A. Hurson (CHRC) established an HEZ Team under the direction of the DHMH Secretary. Members of the Team include staff from CHRC and leaders in DHMH from Health Systems Infrastructure Administration (HSIA), Prevention and Health Promotion Administration (PHPA), the Office of Minority Health and Health Disparities (MHHD), Behavioral Health and Disabilities (BHD), and the DHMH Virtual Data Unit (VDU). The HEZ Team met frequently, working together to establish guidelines for implementation, chronic disease metrics and measures, periodic reporting, budget expenditure guidance, and technical assistance on health equity.

A shared management model is being used, with leadership of the overall HEZ Team's work guided by CHRC and DHMH, and with each program area expert providing guidance and technical assistance. The HSIA guided the Loan Repayment project, the PHPA provided chronic disease guidance, the MHHD provided principles for cultural competency assessment and training, the BHD provided behavioral health guidance, and the VDU along with the entire HEZ team assisted with identifying performance metrics for base-line, final tracking, and evaluation.

III. Health Enterprise Zone Implementation

A. Solicitation and Designation

After the Act was signed into law, DHMH and the CHRC held a public comment period to solicit feedback on the selection criteria for the HEZs, the potential uses of HEZ funding, and the outcome metrics that should be developed to monitor the progress and implementation of the HEZs. This public comment was summarized in a Joint Chairmen's Report submitted to the legislature in August 2012 (Appendix B). Public comments were incorporated into the Call for Proposals issued by CHRC which can be found in Appendix C. Under the Act, non-profit community-based organizations or local government agencies were eligible to apply for HEZ designation status on behalf of a local community. Applicants were encouraged to reflect inclusion, community participation, and collaboration and to support the priorities identified in the Local Health Improvement Process. Applications for HEZ designation were required to have demonstrated need and intervention strategies to improve health outcomes in the potential Zone. The Call for Proposals generated a total of 19 applications (Appendix D) from 17 jurisdictions, representing rural, urban, and suburban areas of the state. These applications were evaluated competitively on 13 review principles by an independent HEZ Review Committee comprised of experts in the fields of public health, health care finance, health disparities, and health care delivery.

On January 24, 2013, based on recommendations from CHRC, DHMH Secretary Sharfstein designated Maryland's first five HEZs:

- Jurisdiction: Anne Arundel County
  Community: Annapolis, Morris Blum Public Housing Building (zip code 21401)
  Coordinating Organization: Anne Arundel Medical Center
  Project Title: Anne Arundel Health System's Health Enterprise Zone

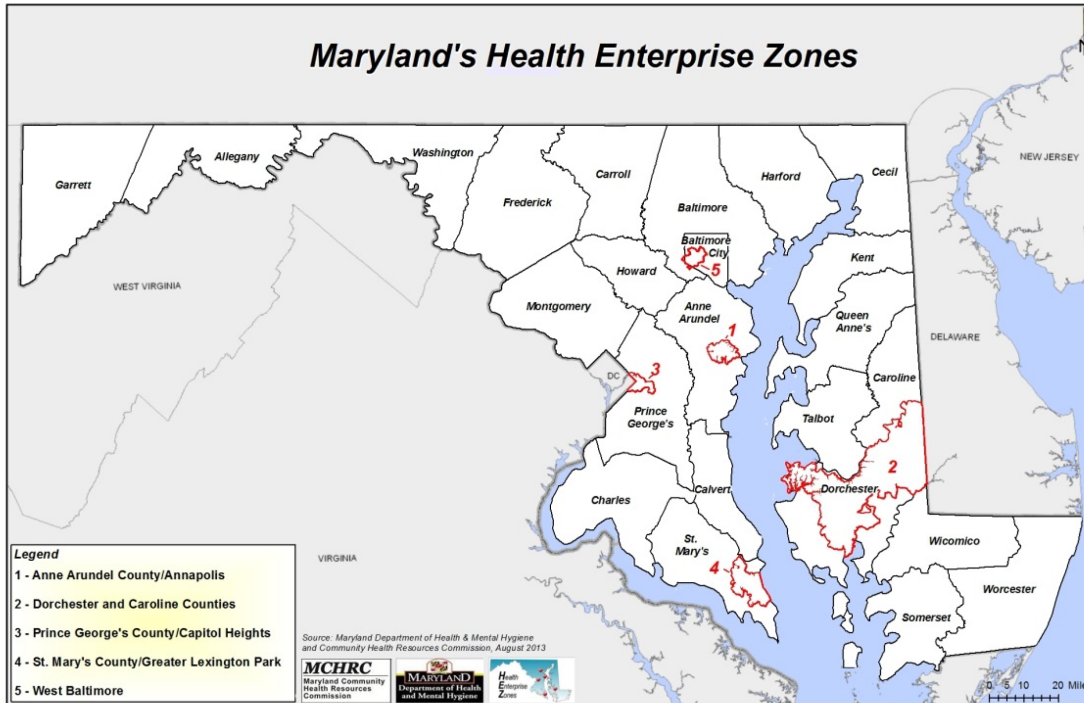
- Jurisdiction: Dorchester and Caroline Counties
  Community: Mid-Shore Region (zip codes 21613, 21631, 21643, 21835, 21659, 21664, 21632)
  Coordinating Organization: Dorchester County Health Department
  Project Title: Competent Care Connection

- Jurisdiction: Prince George's County
  Community: Capitol Heights (zip code 20743)
  Coordinating Organization: Prince George's County Health Department
  Project Title: Prince George's County Health Enterprise Zone

- Jurisdiction: St. Mary's County
  Community: Greater Lexington Park (zip codes 20653, 20634, 20667)
  Coordinating Organization: MedStar St. Mary's Hospital
  Project Title: St. Mary's County Health Enterprise Zone Consortium

- Jurisdiction: Baltimore City
  Community: West Baltimore (zip codes 21216, 21217, 21223, 21229)
  Coordinating Organization: Bon Secours Baltimore Health System
  Project Title: West Baltimore Primary Care Access Collaborative

Map of the first five HEZs



These Zones exhibited measurable and documented economic disadvantages and poor health outcomes and proposed creative and sustainable plans for targeted investments in community health. These designations involve local coordinating organizations/coalitions led by three hospital systems and two local health departments, and will develop two rural, one urban, and two suburban HEZs.

Brief Overview of 5 HEZs

*Annapolis/Morris Blum (Suburban), Year One Budget: $200,000***.**   This Zone is utilizing HEZ funds to establish a new primary care health center based in the Morris Blum public housing building. The goals of this HEZ include a reduction in diabetes-related and smoking illnesses, obesity, and cardiovascular disease of the Morris Blum residents.

*Dorchester/Caroline Counties (Rural), Year One Budget: $755,000***.** The Zone targets primary care and behavioral health issues and is utilizing funds to support health care services teams that include peer recovery support specialists, community health outreach workers, mobile health care crisis teams, and school-based wellness programs. The goals of this HEZ include a reduction in behavioral health emergency department (ED) visits and hospitalization rates for hypertension, and obesity prevention.

Prince George's County Health Department/Capitol Heights (Suburban), Year One Budget: $1,100,000. This Zone focuses on Capitol Heights and is utilizing resources to expand primary care access and recruit providers to establish five patient-centered medical homes to serve a minimum of 10,000 residents. The goals of this HEZ are to reduce hospitalization rates for asthma, diabetes, and hypertension.

St. Mary's County/Greater Lexington Park. (Rural), Year One Budget: $750,000. The Zone is utilizing funds to expand access to primary and behavioral health services. The goals of this HEZ are to reduce emergency department and hospital admissions for behavioral health conditions and for key chronic conditions such as hypertension, asthma, pulmonary disease, heart failure, and diabetes.

West Baltimore Primary Care Collaborative (Urban), Year One Budget: $1,050,000. This Zone targets reducing cardiovascular disease and utilizes HEZ resources to support recruitment of primary care providers, deploy community health workers, and increase access to community health resources such as gyms and healthy food retailers. The goals of this HEZ are to reduce hospitalization rates for cardiovascular disease, diabetes, and hypertension.

B. Technical Assistance and Guidance

The HEZ Team organized its responsibilities consistent with the assigned provisions in the Act to identify CHRC and DHMH programs that had direct responsibility and authority to implement, manage, and provide technical assistance and consultation during the four year cycle of this Initiative. Six domains were identified wherein State program directors had lead responsibility and oversight. The following are the domains and the types of assistance that was provided:

Cultural Competency: Minority Health and Health Disparities (MHHD) in DHMH

Resources and Assistance:

- Cultural Competency Standards published 2012 by MHHD: Group train-the-trainer guide for presentations to HEZ Coordinating Organizations and partners
- Cultural Competency Primer published 2013 by MHHD: Resource Guide for academic institutions partnering with the HEZ, to support development of training programs
- Upon Request: Response to Disparities-related inquiries to enhance program intervention
- TA Methodology: Web-based information, scheduled trainings, and site visit meetings

Health Data**:** Virtual Data Unit (VDU) in DHMH

Resources and Assistance**:**

- Quarterly report of HEZ Client utilization data and other performance metrics
- Quarterly analysis and review of HEZ Dash Board
- Extensive exploration of best and available outcome metrics for use by the HEZs was conducted by the HEZ Team as a whole
- Access to Cross Industry Standard Process (CRISP) data resources and services: (1) Reporting/ Geographic Information System (GIS) services; (2) Encounter Notification Services; and (3) Query Portal

Public Health: Prevention and Health Promotion Administration (PHPA) in DHMH

Resources and Assistance:

Maternal & Child Health

- Provide quarterly review of Fetal Infant Mortality Team data and trends with Maternal and Child Health Bureau Analyst, Fetal and Infant Mortality Review Coordinator, and Epidemiologist to address trends by partnering with other programs
- Provide on-site training to Family Planning Programs to implement evidence-based tool for assessing alcohol/drug use, smoking, and risk for domestic violence
- Provide training on what to do when a woman screens positive and how Family Planning Program can establish warm referrals
- Provide on-site training on the importance of improving the health of women & children to WIC, family planning, and home visiting programs
- Provide technical assistance to substance abuse treatment programs to provide family planning services on-site to assist in reducing unintended pregnancies and improved birth outcomes (not currently being done). A needs assessment would proceed this TA
- TA Methodology: conference call, site visits, webinars, and staff trainings

Cancer & Chronic Disease

- Engaging partners to protect residents from second-hand smoke exposure in outdoor areas
- Support employers in implementing worksite wellness initiatives as part of the Healthiest Maryland Businesses
- Provide guidance on chronic disease self-management programs
- Provide training on Million Hearts implementation guide
- TA Methodology: conference call, site visits, webinars, staff trainings, and/or best practices resource guides

Behavioral Health: Behavioral Health and Disabilities (BHD) in DHMH

Resources and Assistance:

- Provide review of behavioral health data submitted by Mid-Shore Mental Health Systems (MSMHS)
- Provide review of program management by MSMHS

Delivery Reform: Health Systems and Infrastructure Administration (HSIA) in DHMH

Resources and Assistance**:**

- Workforce Loan Assistance Repayment Program in collaboration with MHEC
- Tax Credit support and processing
- Community Integrated Medical Home framework overview and integration

- Centers for Medicare and Medicaid Services (CMS) Challenge Grant proposal development and submission:
    - Payment Model
    - Data Integration and Quality Improvement – Local Health Improvement Coalition support and capacity building

<u>HEZ Administration and Safety-net Support</u>**:** Community Health Resources Commission (CHRC)

Resources and Assistance:

- Provide administrative coordination of initial HEZ Call for Proposals, review of proposals, and designation of HEZs
- Manage the HEZ Reserve Fund and individual HEZ grant awards and provided fiscal oversight for program
- Collaborate with individual DHMH program directors and the Secretary to achieve seamless oversight and management of HEZ program implementation
- Direct and coordinate the day-to-day work of the HEZ Team members to assist the designated HEZs to start up their respective programs
- Work with the Maryland Comptroller's Office and the Maryland Department of Business and Economic Development to coordinate implementation of the financial incentives built in the legislation
- Access to capacity-building grant opportunities. In addition to funding made available under the Act, the CHRC released its annual Call for Proposals in October 2013, providing potential grant support for the following types of programs: (1) Reducing infant mortality; (2) Increasing dental care services; (3) Supporting new access point and expanding primary care access; (4) Integrating behavioral health services in the community; (5) Promoting administrative capacity-building; and (6) Reducing childhood obesity. This Call for Proposals generated 66 proposals with direct funding requests of $27.1 million. At the time of the submission of this report, the proposals are under evaluation by independent "subject matters" experts who will issue their recommendations to the CHRC Board in early January 2014. A select number of top-scoring applicants will be invited to present to the CHRC Board on January 30, and funding decisions will be made immediately following these presentations. The CHRC is in a position to award approximately $2.85 million this fiscal year (FY 2014).

C. Start-Up Successes and Challenges

Following the designations made in January 2013, implementation of the Zones began in earnest this past spring. At the time of this report, the Zones have approximately six months of program implementation. Following is a synopsis of some of the initial successes and early challenges experienced by the Zones.

Initial Successes

Expanding capacity to deliver services. Across all five zones, a total of eight care delivery sites have been opened or expanded. All five Zones are now providing clinical and other support services supported with resources provided under the Act.

Meeting first year recruitment goals. The Zones articulated a collective Year-One goal of recruiting 38 new health care practitioners, and report the addition of 43 new practitioners, which include physicians, nurse practitioners, and registered nurses to deliver primary care services and licensed clinical social workers and a psychiatrist to deliver behavioral health services. Four of the five HEZs have achieved their Year-One practitioner recruitment goals.

Promoting job creation. The Zones reported the creation of a collective total of 87 jobs during their first six months of operations. This total includes HEZ practitioners, community health workers, and other staff that will deliver care and support the goals of each HEZ.

Early Challenges

Practitioner recruitment challenges. Though the HEZs achieved their overall Year-One practitioner recruitment goals, several of the Zones, especially in rural areas, reported challenges in recruiting primary care physicians. Though loan repayment assistance is available to help with practitioner recruitment efforts, requirements surrounding these incentives created difficulties for the Zones to utilize the assistance fully. Reasons for underutilization by the Zones vary. For example, one nurse practitioner could not access loan repayment assistance because of current statutory requirements that the applicant attend a Maryland school. Challenges to identify and recruit practitioners are not unique to HEZs, as they exist for all health care entities in the state.

Collecting individual patient outcome data across multiple provider sites. Most of the HEZs involve multiple care delivery sites and practitioners, some of whom currently have electronic medical record (EMR) systems while some do not. The Zones are confronting the challenges involved with collecting and reporting individual patient clinical outcome data and aggregating this data across multiple different EMR systems and paper-based systems. The state plans to provide technical assistance with the Zones in Year-Two to help address this data collection and reporting challenge.

IV. Measuring Progress

A. Incentives Available to the HEZs

Loan Repayment

Loan Repayment Assistance was provided in the Health Enterprise Zone Statute as an incentive to recruit and retain providers to HEZs. DHMH is collaborating with the Maryland Higher Education Commission to offer loan repayment to the HEZs through two existing State programs; the Maryland Loan Assistance Repayment Program for Physicians and the Janet L. Hoffman Loan Assistance Repayment Program. The State programs are being utilized to maximize current HEZ dollars. The Maryland Loan Assistance Repayment Program for Physicians (state and federal funds) offers loan repayment to primary care physicians. The Janet L. Hoffman Loan Assistance Repayment Program offers loan repayment to nurses, nurse practitioners, physician's assistants, and social workers.

Tax Credits

Two types of tax credits are offered as incentives by the Act: (1) hiring tax credits and (2) income tax credits. To date, all tax credit materials for both types of tax incentives have been developed. They have not at this time, however, been executed for use in the HEZ. The regulations for the Health Care Practitioner Income Tax Credit have been submitted to the legislature for approval. DHMH and CHRC hope to have the materials for the Health Care Practitioner Income tax credit available in February 2014 once the final regulations are approved. Practitioners who worked in the zone in 2013 will be able to utilize this tax credit once it is posted.

The Employer Hiring Tax Credit requires some statutory amendments to include for-profit and non-profit entities. DHMH and CHRC hope to have the employer hiring tax credit materials available to the HEZs in early summer of 2014 depending on the outcome of the 2014 legislative session. The delay will not have great impact on the HEZs, as they must have an employee working in the zone for at least 12 months before they can claim the hiring tax credit.

A letter of support will be required by the HEZ for all health care practitioner or entities that are applying for tax credit. This letter of support was added to ensure that the practitioners or entities applying for tax credits are directly supporting the HEZ effort. The Zones requested a total of $264,145 in tax credits for Year-One.

B. Impact of Incentives in Attracting HEZ Practitioners to the Zone

The Zones report hiring a total of 43 HEZ practitioners (defined in the Act as licensed primary care providers who offer medical, behavioral health or dental services). This number surpassed the practitioner recruitment goal of 38 originally proposed by the HEZs. In all, 87 jobs have been created by the HEZs. Sixty-one of these jobs were direct hires (defined as those jobs that are supported by HEZ funds or were recruited by the use of HEZ incentives), and 26 were indirect hires (defined as jobs created by the HEZ for their activities but not supported by HEZ funds or hired with the use of HEZ incentives).

Anne Arundel – In 2013, no practitioners from Anne Arundel applied for or received loan payment assistance, nor did they request any tax credits. The HEZ met their goal of hiring two

practitioners for the year, as well as two additional direct hires and three indirect hires. Total jobs created in this Zone in Year One were seven (four direct and three indirect);

Dorchester/Caroline – One practitioner from Dorchester/Caroline applied for the loan repayment program but was found to be ineligible. The HEZ has requested $60,000 in tax incentives for the first year on the program. The practitioner goal for the HEZ was nine for the first year, and the HEZ hired seven. Total jobs created in this Zone in Year One were 16 (16 direct and no indirect).

Prince George's – No practitioners applied for the loan repayment program from Prince George's County, but this Zone requested $64,145 in tax credits. The hiring goal for Prince George's in 2013 was seven practitioners and the Zone was successful in hiring seven practitioners. Total jobs created in this Zone in Year One were 14 (13 direct jobs and one indirect).

St. Mary's – No practitioners from St. Mary's applied for the loan assistance program but the Zone requested $50,000 in tax assistance funds. St. Mary's was successful in reaching their goal of attracting four new practitioners to the Zone. Total jobs created in this Zone in Year One were 12 (eight direct and four indirect).

West Baltimore – Five practitioners from West Baltimore applied for the loan repayment program, with four being found to be eligible for this incentive. Additionally, West Baltimore requested $90,000 in tax credits. The Zone attracted 23 new practitioners, surpassing their goal of 16. Total jobs created in this Zone in Year One are 38 (20 direct and 18 indirect).

C. Impact on Disparities, Health Outcomes, Admissions, Readmissions, and Costs

The ultimate goals of the HEZ program are to improve health outcomes within the HEZs generally, to improve health outcomes in racial and ethnic minority populations within the HEZs in particular, and thereby contribute to reductions in racial/ethnic and geographic health disparities in Maryland. Important outcome measures by which to assess this improvement, explicitly mentioned in the legislation, are hospital admission rates, readmission rates, and hospital costs.

The hospital admission data has about a nine month lag time between the end of a calendar quarter and the availability of the data. As a result, data on hospital admission rates after HEZ inception are still pending. Progress in reporting impact on Disparities, Health Outcomes, Admissions, Readmissions, and Costs in the first year of the HEZ program is to be found in two areas:

- Defining the metrics and data sets to be used for assessment of those impacts, and
- Computing the 2012 baseline values for those metrics.

Metrics that will be used for impact assessment will be the hospital admission rate and the percent of hospital admissions that are readmissions. The data source for these metrics will be the Health Services Cost Review Commission (HSCRC) and the Chesapeake Regional Information System for our patients. Baseline data for all-cause admission rates for each quarter of 2012 have been determined and are summarized in the table below. Baseline values for all-cause admission rates and for disease-specific admission rates (for conditions such as diabetes, high blood pressure, asthma, etc.) are currently being finalized.

V. Program Guidance and Accomplishments

The HEZ Team members from the DHMH and the CHRC provided public health guidelines, operational technical assistance, and in-person consultation to the HEZs as a collective and individually throughout start up efforts during this first year. The following sections describe selected assistance that was provided.

A. Loan Repayment and Tax Credits

The HEZ Initiative provides a range of public incentives and resources to help attract private health care practitioners to serve in underserved communities. These incentives include tax credits and loan repayment. Tax credits and loan repayment were included in the HEZ statute as incentives for recruiting and retaining providers in these underserved areas.

As mentioned in previous sections, Tax Credits have not been launched at this time. CHRC and DHMH anticipate that both tax credits will be launched by spring 2014 and will be utilized to the fullest extent.

DHMH has been working closely with the Maryland Higher Education Commission (MHEC) to align the current available loan repayment programs Maryland Loan Assistance Repayment Program for Physicians (MLARP), and Janet L. Hoffman Loan Assistance Repayment Program with the HEZ initiative to maximize HEZ dollars. Through utilization of existing loan repayment programs, DHMH and CHRC, have been able to provide an additional $510,000 for loan repayment through non-HEZ funding sources thus increasing available HEZ dollars by 12.5%.

In July 2013, one loan repayment recipient was awarded loan repayment through MLARP. DHMH and CHRC anticipate that three more recipients (pending MHEC review) will be awarded loan repayment funding in early 2014. DHMH has increased marketing efforts for loan repayment programs. This includes presentations, webinars, and social media. The increased marketing has brought in more applications for loan repayment but very few applications from the HEZs.

In utilizing the available State programs as a mechanism for funding, DHMH and CHRC have discovered some barriers which may be affecting the utilization of loan repayment programs by the HEZ. The statutory guidelines for MLARP may be too restrictive to accommodate all providers who are interested in loan repayment through the HEZ. Some barriers identified were the numbers hours the provider is required to work per week and their specific work location (i.e. inpatient vs. outpatient). The same is true for the State funded program, the Janet L. Hoffman Loan Assistance Repayment Program which has a maximum salary cap, and the provider must have graduated from a State of Maryland institution to be eligible. DHMH is working closely with MHEC to see if the identified barriers have a possible solution to make the programs more accessible to the HEZs.

B. Performance Measures and Tracking

The activities of each of the five Zones are closely monitored by its coordinating organization (the designee) and by the State. The Zones have developed work plans with key milestones and deliverables and monitor program execution internally with key partners of the Zone. These work plans are made available to the State.

Monitoring by the State occurs through site visits, conference calls, and quarterly progress grant reports. Each Zone is required to submit the quarterly progress reports to the State as a condition for payment of public funds. In addition, the State has developed an "HEZ Dashboard" to assess performance towards key milestones and deliverables and overall progress towards key goals of each Zone. The Dashboards facilitate public reporting, accountability of the Zones, and fiscal stewardship of public resources. In addition, clinical outcome metrics based on national standards such as National Quality Forum and Uniform Data System measures will be incorporated in year two of the program. Zones are required to develop annual performance goals, such as the number of primary care providers hired or number of residents assisted by community health workers. Progress towards reaching these goals is then tracked on a quarterly basis by the State.

There will also be independent evaluation of the HEZ Initiative. In July 2013, the Department of Health and Mental Hygiene and the Community Health Resources Commission issued a call for public comment on how best to evaluate both the impact of individual HEZs and the success of the overall initiative on improving the health of the populations of the HEZs. The evaluation is expected to begin in the first quarter of 2014 and will conclude after the duration of the program (end of calendar year 2016).

C. Cultural Competency Guidelines

The Cultural and Linguistic Competency Workgroup of the Maryland Health Disparities Collaborative is a panel of experts affiliated with community-based organizations, statewide health advocacy organizations, health systems and health plans, health licensing boards, local health departments, and academic institutions. In June 2012, the group submitted a report which included recommendations for assessing the level of cultural and linguistic competence of Health Enterprise Zone applicants.

In 2013, the assessment criteria recommended by the group were used to development an assessment tool for organizations requesting tax incentives as part of the HEZ program. The HEZ tax incentive program has reporting requirements for organizations which include an assessment of cultural competency and submission of the results to DHMH. The tool, MHHD's Cultural Competency Assessment Survey, has been made available online to the HEZs.

Additional cultural competency reporting requirements have been developed by MHHD for healthcare providers seeking loan repayments or tax incentives through the HEZ program. Each provider is required to complete 6 continuing education credits in cultural competency within 12 months of the initial application, with proof of completion to be sent to DHMH.

In fall 2013, DHMH, CHRC, and the HEZs held conference calls to discuss the technical assistance that would be provided by DHMH to each HEZ. MHHD is offering the HEZs cultural competency training to be held in the first half of 2014. A standard curriculum has been

developed for these training sessions which include separate sessions for the HEZ leadership and staff.

D. Behavioral Health Program Resources and Assistance

Mid-Shore Mental Health Systems, Inc. (MSMHS) has been an integral partner in the HEZ project since the planning stage for submitting an application. Behavioral Health is a major component of the Dorchester-Caroline project known locally as Competent Care Connections. Funding has allowed for the expansion of Eastern Shore Mobile Crisis Services (ESMCS) for a team to specifically serve Dorchester and Caroline Counties. MSMHS contracted with Affiliated Santé Group to provide the additional team with program oversight provided by MSMHS on an ongoing basis. MSMHS is a member of the Dorchester-Caroline HEZ Advisory Committee and attends quarterly meetings for the project in preparation for submission of quarterly reports. MSMHS participated in a meeting held at AHEC on November 15th with CHRC to review outcomes for the project. Review of data submitted specific to the Caroline/Dorchester team is conducted on a monthly basis to ensure compliance with DHMH requests. Through the month of November, there have been 143 dispatches of the new team.

Monthly case reviews with ESMCS are held with MSMHS as well as monthly administrative meetings with MSMHS Community Programs Administrator, the ESMCS Director and Eastern Shore Operations Center (ESOC-Crisis Call Center) Coordinator to ensure the quality of operations between the call center and mobile crisis teams.

E. Chronic Disease Guidelines and Assistance

The Prevention and Health Promotion Administration (PHPA) has taken an active interest in providing guidance and technical assistance to the HEZs. PHPA was an active participant in discussions regarding the criteria for including geographic areas to apply to be an HEZ, providing data and maps, as well as staff to help organize this effort. Once the HEZs were selected, PHPA participated in five technical assistance calls with the HEZs and offered Maternal and Child Health and Cancer and Chronic Disease resources and assistance found in the HEZ: Technical Assistance and Guidance section of this report.

As many of the program HEZ outcome goals were chronic disease related, the Center for Chronic Disease Prevention and Control (CCDPC) provided expertise and technical assistance on an individual basis.

The following list shows specific examples of technical assistance provided by CCDPC:

- Prince George's HEZ - offered Healthiest Maryland Businesses (HMB) training to Prince George's County Health Department and three Mayors (Fairmont Heights, Seat Pleasant, and Capital Heights) so they may outreach to local businesses to join their efforts to improve health outcomes.
- St. Mary's HEZ - CCDPC responded to a request for evidence-based faith-based nutrition initiatives with detailed information for three programs: Healthy Bodies, Healthy Souls, ADA's Project Power, and Body and Soul, a program used by the Mid-Shore LHIC. Links to these programs, along with evidence that supports these programs were also provided.

- West Baltimore HEZ/PCMH Maryland Learning Collaborative - CCDPC met with Dr. Khanna to discuss the Patient Centered Medical Homes' role in the West Baltimore HEZ and the quality metrics to be utilized in the HEZ. Team-based care models and available Million Hearts resources can be incorporated into private practices, Federally Qualified Health Centers, and State and Local Health Departments.
- CCDPC provided uniform data measures to align chronic disease and associated risk factor outcomes in primary care from care provided by practices and FQHCs in each HEZ.

CCDPC also identified funding to support Maryland Million Hearts Coordinators in four jurisdictions in Maryland, including two jurisdictions that contain HEZs (St. Mary's County - $110,500 and Baltimore City - $123,000). These coordinators will focus on improving hypertension control through clinical quality improvement efforts in alignment with the expanded chronic care model by implementing the following activities:

- Engaging community partners
- Identifying community resources for patients with hypertension
- Developing a hypertension response plan in each jurisdiction to address obesity, nutrition, and social determinants of health to comprehensively treat patients with hypertension
- Collaborating with public and private health care providers on meaningful data use and aggregating NQF 18 (hypertension control) data where possible
- Reducing emergency department visits for hypertension through care coordination, use of Community Health Workers, and community pharmacists

F. Evaluation

Evaluation is the term that describes a formal process for assessing the success of a program across all of its aspects: establishment and set-up, ongoing operations, and impact on targeted outcomes. External evaluation by an outside party is considered to be the best way to obtain an unbiased assessment of a project. The HEZ program plan calls for an external evaluation. The accomplishments to date regarding evaluation of the HEZ program are development of a quantitative evaluation framework, and drafting the Request for Proposals for the external evaluation.

Quantitative evaluation of the HEZ program will follow the Donabedian model of health services assessment, which divides the analysis into Structure, Process, and Outcome components:

Structure: Evaluation of structure focuses on the degree to which **service capacity** and/or **service quality** has been enhanced in the HEZs as a result of new physical plant, new personnel, and/or new skills developed in training programs. Structural metrics will measure new sites opened, FTE's of new personnel hired, new care encounter capacity added to the zones, and training rates for zone employees.

Process: Evaluation of process is evaluation of **operations:** here it focuses the **utilization rate** of the new service capacity within the HEZs, and the degree of **quality of those services** as compared to national benchmarks. Utilization rate process metrics assess the productivity of the newly deployed capacity, indicate the value for dollar in terms of service delivery, define the reach of the HEZ program, and are critical for understanding the long term solvency and sustainability of the newly-established HEZ providers. Process metrics will measure provider productivity, reach to persons previously without a provider, productivity and reach of community health workers, and how well provider care follows national guidelines.

Outcome: Evaluation of outcomes focuses on whether the enhancements to capacity and the operations using that capacity have made an **impact on the health** of the people served, and on the health of the HEZ more generally. Outcome assessment is the ultimate determination of success or failure of the HEZ program. Outcome metrics which reflect population health will include hospitalization rates and emergency department visit rates (for all causes and for specific conditions) and measures of chronic disease control (taken from national standards).

Several of these metrics are being reported quarterly as a part of Performance Tracking and Management. Some of the above metrics are still under development.

The HEZ program will undergo external evaluation, which is expected to begin in 2014, as the solicitation for this vendor is the in the final stages of development and is expected to be released in the first quarter of the year. The external evaluation will independently review and evaluate the quantitative data described above. In addition, the external evaluation contractor will collect qualitative data by surveys, focus groups, and key informant interviews with HEZ residents, patients, providers, administrators and staff. This will provide important insights into the levels of awareness of and satisfaction with the HEZ from the perspective of these various kinds of stakeholders.

VI. Year Two - 2014 Plans

In year two, calendar year 2014, the HEZ Team in partnership with the HEZs will ensure that all start up activities are complete, operations are modified based on lessons learned, and ongoing oversight focuses on achievement of the stated objectives for each HEZ.

The program impact metrics will be explored and refined within each HEZ and across HEZs where disease reduction and interventions are similar. One such exploration will be to examine whether removing admissions for childbirth from the all-cause admission metric gives a clearer picture of potential HEZ impact. The HEZ team will also be working collaboratively with each of the Zones to encourage their collection of individual clinical outcome metrics, which will be based on national standards.

In addition to admissions, readmissions, and cost, another set of useful outcomes for HEZ impact assessment may be emergency department (ED) visit rates and emergency department costs. In Year Two of the program, CHRC and DHMH staff will assess the feasibility and value of adding these ED visit rate and ED cost metrics to the set of performance measures for HEZ tracking.

Cultural competency and Culturally and Linguistically Appropriate Services (CLAS) Standards training will be offered to the HEZ leadership and front line staff to aid in increasing diverse population's understanding and acceptability of services and messages provided.

Additional resources will be provided in the form of federal grants, data analyst experts, training and other support to strengthen each HEZ's capacity to revitalize public health with community partnerships at the local level.

An HEZ Conference is planned for the spring with funds from the Robert Wood Johnson Foundation (RWJF) for the purpose of bringing national experts to Maryland who can share their knowledge and experience implementing enterprise movements in communities with poverty.
At this Conference, the Maryland HEZs will have an opportunity to share their experiences and increase collaboration throughout the State.

VII. Appendices

A. Maryland Health Improvement and Disparities Reduction Act of 2012
B. 2012 Joint Chairmen's Report, Page 79, M00R01.03 – Maryland Community Health Commission – Health Enterprise Zones
C. HEZ Call for Proposals (October 2012)
D. Health Enterprise Zone Applications (19)

Chapter 3

(Senate Bill 234)

AN ACT concerning

Maryland Health Improvement and Disparities Reduction Act of 2012

FOR the purpose of requiring the Secretary of Health and Mental Hygiene to designate certain areas as Health Enterprise Zones in a certain manner; specifying the purpose of establishing Health Enterprise Zones; ~~requiring~~ authorizing the ~~Department~~ Secretary, in consultation with the Community Health Resources Commission, to adopt certain regulations; requiring the Secretary to consult with the Office of Minority Health and Health Disparities in implementing this Act; authorizing certain nonprofit community–based organizations or local government agencies to apply to the ~~Commission~~ Secretary on behalf of certain areas for designation as Health Enterprise Zones; establishing certain procedures and requirements in connection with the application process; requiring the Commission to make certain recommendations to the Secretary; requiring the Secretary to consider certain factors when designating areas as health enterprise zones and authorizing the Secretary to direct the Commission to conduct certain outreach efforts; requiring the Commission to report to certain committees of the General Assembly on certain information after certain applications are received by the Commission; authorizing the Secretary to limit the number of areas designated as Health Enterprise Zones; requiring the Commission and Secretary to give priority to applications in a certain manner; requiring the Commission to provide funding in accordance with the designation of the Secretary of a Health Enterprise Zone; authorizing certain licensed health care providers who practice in the Health Enterprise Zones to receive certain benefits, including certain grants; authorizing certain nonprofit community–based organizations or local government agencies to receive certain grants; establishing a Health Enterprise Zone Reserve Fund; requiring the Commission and the ~~Department~~ Secretary to submit certain annual reports; allowing a credit against the State income tax for certain health care providers who practice in Health Enterprise Zones under certain circumstances; ~~allowing certain nonprofit community–based organizations or local government agencies to assign certain tax credits~~ allowing a refundable State income tax credit in certain circumstances for certain health care providers who practice in, and hire certain health care providers to practice in, a Health Enterprise Zone; requiring the Department to certify to the Comptroller the applicability of the credit for each health care provider and the amount of each credit assigned; limiting the amount of the credits allowed for a fiscal year; requiring the Department, in consultation with the Comptroller, to adopt certain regulations; requiring a certain evaluation system to establish and incorporate a certain set of measures regarding racial

and ethnic variations in quality and outcomes and include certain information on certain actions taken relating to health disparities; requiring a certain community benefit report to include certain information relating to health disparities; requiring certain institutions of higher education to make a certain annual report to the Governor and the General Assembly relating to health disparities; requiring the Health Services Cost Review Commission and the Maryland Health Care Commission to conduct a certain study, develop certain regulations, and report to the Governor and General Assembly on or before a certain date; requiring the Maryland Health Quality and Cost Council to convene a certain workgroup and issue a certain report on or before a certain date; defining certain terms; providing for the application of certain provisions of this Act; providing for the termination of certain provisions of this Act; and generally relating to health improvement and the reduction of health disparities.

BY adding to
Article – Health – General
Section 20–904; and 20–1401 through ~~20–1406~~ 20–1407 to be under the new subtitle "Subtitle 14. Health Enterprise Zones"
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

BY adding to
Article – Tax – General
Section 10–731
Annotated Code of Maryland
(2010 Replacement Volume and 2011 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–134(c) and 19–303(c)
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

Preamble

WHEREAS, The State of Maryland has numerous advantages for its residents to enjoy good health care, such as the 3rd highest median household income, the 2nd highest number of primary care physicians per capita, the 10th lowest rate of smoking, and outstanding medical schools; and

WHEREAS, Despite these advantages, the State continues to lag behind other states on a number of key health indicators, such as ranking 43rd in infant mortality, 31st in early prenatal care, 28th in obesity prevalence, 31st in diabetes prevalence, 35th in cardiovascular deaths, 32nd in cancer deaths, and 33rd for geographic health disparities; and

WHEREAS, The State also demonstrates significant disparities in health care and health outcomes; and

WHEREAS, Examples of these disparities include a Black or African American death rate from HIV/AIDS that is 15 times higher than the White rate; an American Indian or Alaska Native end–stage kidney disease rate that is 3 times the White rate; an Asian or Pacific Islander death rate from tuberculosis that is 9 times higher than the White ~~rate, and~~ rate; a Hispanic rate of lack of health insurance that is 4.4 times the White rate; and a White rate of completion of advance directives that is 2 times the Minority rate; and

WHEREAS, Health disparities exist in urban, suburban, and rural communities in the State; and

WHEREAS, Communities where significant health disparities exist also often face shortages in the primary health care workforce, including nurses; and

WHEREAS, Health disparities are the result of modifiable health care system factors, community factors, and individual factors; and

WHEREAS, Key strategies for reducing and eliminating health disparities include collection and analysis of racial and ethnic data; inclusion of minority communities in health planning and outreach to those communities with health education and health services; cultural and linguistic health competency among service providers; diversity in the health care and public health workforce; access to primary care practitioners; and attention to the social determinants of health; and

WHEREAS, Health disparities present a serious fiscal challenge for our State and nation and result in significant costs; a 2009 report titled "The Economic Burden of Health and Equalities in the United States" released by the Joint Center for Political and Economic Studies found that between 2003 and 2006, the U.S. could have saved nearly $230 billion in direct medical care costs if racial and ethnic health disparities did not exist; and

WHEREAS, By 2045, over one–half of the U.S. population will be persons of color, and in order to reach health equity and stem the tide of rising health care costs, the State must take advantage of the tools provided by the federal Affordable Care Act to expand access, eliminate disparities, and make Maryland the healthiest state in the nation; and

WHEREAS, The Maryland Health Quality and Cost Council formed a workgroup to examine ways to reduce health disparities in the State; and

WHEREAS, The workgroup noted significant disparities between blacks and whites in Maryland in hospital admission rates measured by the federal Agency for Healthcare Research and Quality; and

WHEREAS, The workgroup found that these admission disparities were especially high for lung disease, cardiovascular disease, and diabetes; and

WHEREAS, The workgroup and the Maryland Health Quality and Cost Council recommended taking aggressive action to reduce health disparities in Maryland and improve the health of all Marylanders; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

SUBTITLE 14. HEALTH ENTERPRISE ZONES.

20–1401.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "AREA" MEANS A CONTIGUOUS GEOGRAPHIC AREA THAT:

(1) DEMONSTRATES MEASURABLE AND DOCUMENTED HEALTH DISPARITIES AND POOR HEALTH OUTCOMES; AND

(2) IS SMALL ENOUGH TO ALLOW FOR THE INCENTIVES OFFERED UNDER THIS SUBTITLE TO HAVE A SIGNIFICANT IMPACT ON IMPROVING HEALTH OUTCOMES AND REDUCING HEALTH DISPARITIES, INCLUDING RACIAL, ETHNIC, AND GEOGRAPHIC HEALTH DISPARITIES.

(C) "COMMISSION" MEANS THE COMMUNITY HEALTH RESOURCES COMMISSION.

(D) "FUND" MEANS THE HEALTH ENTERPRISE ZONE RESERVE FUND ESTABLISHED UNDER § 20–1406 OF THIS SUBTITLE.

~~(D)~~ (E) "HEALTH ENTERPRISE ZONE" MEANS A CONTIGUOUS GEOGRAPHIC AREA THAT:

(1) DEMONSTRATES MEASURABLE AND DOCUMENTED HEALTH DISPARITIES AND POOR HEALTH OUTCOMES;

(2) IS SMALL ENOUGH TO ALLOW FOR THE INCENTIVES OFFERED UNDER THIS SUBTITLE TO HAVE A SIGNIFICANT IMPACT ON IMPROVING HEALTH OUTCOMES AND REDUCING HEALTH DISPARITIES, INCLUDING RACIAL, ETHNIC, AND GEOGRAPHIC HEALTH DISPARITIES; AND

(3) IS DESIGNATED AS A HEALTH ENTERPRISE ZONE BY THE COMMISSION AND THE SECRETARY IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBTITLE.

~~(E)~~ (F) "HEALTH ENTERPRISE ZONE PRACTITIONER" MEANS A ~~LICENSED HEALTH CARE PROVIDER WHO PRACTICES AS A FAMILY PHYSICIAN, AN INTERNIST, A PEDIATRICIAN, AN OBSTETRICIAN, A GYNECOLOGIST, A GERIATRICIAN, A PSYCHIATRIST, A DENTIST, OR A PRIMARY CARE NURSE PRACTITIONER~~ HEALTH CARE PRACTITIONER WHO IS LICENSED OR CERTIFIED UNDER THE HEALTH OCCUPATIONS ARTICLE AND WHO PROVIDES:

(1) PRIMARY CARE, INCLUDING OBSTETRICS, GYNECOLOGICAL SERVICES, PEDIATRIC SERVICES, OR GERIATRIC SERVICES;

(2) BEHAVIORAL HEALTH SERVICES, INCLUDING MENTAL HEALTH OR ALCOHOL AND SUBSTANCE ABUSE SERVICES; OR

(3) DENTAL SERVICES.

20–1402.

(A) THE PURPOSE OF ESTABLISHING HEALTH ENTERPRISE ZONES IS TO TARGET STATE RESOURCES TO REDUCE HEALTH DISPARITIES, IMPROVE HEALTH OUTCOMES, AND REDUCE HEALTH COSTS AND HOSPITAL ADMISSIONS AND READMISSIONS IN SPECIFIC AREAS OF THE STATE.

(B) (1) THE ~~DEPARTMENT~~ SECRETARY, IN CONSULTATION WITH THE COMMISSION, ~~SHALL~~ MAY ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SUBTITLE AND TO SPECIFY ELIGIBILITY CRITERIA AND APPLICATION, APPROVAL, AND MONITORING PROCESSES FOR THE BENEFITS UNDER THIS SUBTITLE.

(2) THE SECRETARY SHALL CONSULT WITH THE OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES IN IMPLEMENTING THE PROVISIONS OF THIS SUBTITLE.

20–1403.

(A) IN ORDER FOR AN AREA TO RECEIVE DESIGNATION AS A HEALTH ENTERPRISE ZONE, A NONPROFIT COMMUNITY–BASED ORGANIZATION OR A LOCAL GOVERNMENT AGENCY SHALL APPLY TO THE ~~COMMISSION~~ SECRETARY ON BEHALF OF THE AREA TO RECEIVE DESIGNATION.

(B) THE APPLICATION SHALL BE IN THE FORM AND MANNER AND CONTAIN THE INFORMATION THAT THE COMMISSION AND THE SECRETARY REQUIRE.

(C) THE APPLICATION SHALL CONTAIN AN EFFECTIVE AND SUSTAINABLE PLAN TO REDUCE HEALTH DISPARITIES, REDUCE COSTS OR PRODUCE SAVINGS TO THE HEALTH CARE SYSTEM, AND IMPROVE HEALTH OUTCOMES, INCLUDING:

(1) A DESCRIPTION OF THE PLAN OF THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT AGENCY TO UTILIZE FUNDING AVAILABLE UNDER THIS SUBTITLE TO ADDRESS HEALTH CARE PROVIDER CAPACITY, IMPROVE HEALTH SERVICES DELIVERY, EFFECTUATE COMMUNITY IMPROVEMENTS, OR CONDUCT OUTREACH AND EDUCATION EFFORTS; AND

(2) A PROPOSAL TO USE FUNDING AVAILABLE UNDER THIS SUBTITLE TO PROVIDE FOR LOAN REPAYMENT INCENTIVES TO INDUCE HEALTH ENTERPRISE ZONE PRACTITIONERS TO PRACTICE IN THE AREA.

(D) THE APPLICATION MAY ALSO CONTAIN A PLAN TO UTILIZE OTHER BENEFITS, INCLUDING:

(1) TAX CREDITS AVAILABLE UNDER THIS SUBTITLE AND § 10–731 OF THE TAX – GENERAL ARTICLE TO ENCOURAGE HEALTH ENTERPRISE ZONE PRACTITIONERS TO ESTABLISH OR EXPAND HEALTH CARE PRACTICES IN THE AREA; ~~AND~~

(2) A PROPOSAL TO USE INNOVATIVE PUBLIC HEALTH STRATEGIES TO REDUCE HEALTH DISPARITIES IN THE AREA, SUCH AS THE USE OF COMMUNITY HEALTH WORKERS, HEALTH COACHES, REGISTERED DIETICIANS, OPTOMETRISTS, PEER LEARNING, AND COMMUNITY–BASED DISEASE MANAGEMENT ACTIVITIES, THAT COULD BE SUPPORTED BY GRANTS AWARDED UNDER THIS SUBTITLE; AND

~~(2)~~ (3) A PROPOSAL TO USE OTHER INCENTIVES OR MECHANISMS TO ADDRESS HEALTH DISPARITIES THAT FOCUS ON WAYS TO EXPAND ACCESS TO CARE, EXPAND ACCESS TO FRESH PRODUCE THROUGH

GROCERY STORES AND FARMER'S MARKETS, PROMOTE HIRING, AND REDUCE COSTS TO THE HEALTH CARE SYSTEM.

20–1404.

(A) THE COMMISSION SHALL MAKE RECOMMENDATIONS TO THE SECRETARY ON THE DESIGNATION OF HEALTH ENTERPRISE ZONES UNDER THIS SUBTITLE.

(B) (1) THE SECRETARY SHALL DESIGNATE AREAS AS HEALTH ENTERPRISE ZONES IN ACCORDANCE WITH THIS SUBTITLE.

(2) THE SECRETARY SHALL CONSIDER GEOGRAPHIC DIVERSITY, AMONG OTHER FACTORS, WHEN DESIGNATING AREAS AS HEALTH ENTERPRISE ZONES AND MAY DIRECT THE COMMISSION TO CONDUCT OUTREACH EFFORTS TO FACILITATE A GEOGRAPHICALLY DIVERSE POOL OF APPLICANTS, INCLUDING PROMOTING APPLICATIONS FROM RURAL AREAS.

(3) AFTER RECEIVING ALL APPLICATIONS SUBMITTED TO THE COMMISSION, THE COMMISSION SHALL REPORT, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE ON THE NAMES OF APPLICANTS AND GEOGRAPHIC AREAS IN WHICH APPLICANTS ARE LOCATED.

(C) THE SECRETARY MAY LIMIT THE NUMBER OF AREAS DESIGNATED AS HEALTH ENTERPRISE ZONES IN ACCORDANCE WITH THE STATE BUDGET.

(D) THE COMMISSION AND THE SECRETARY SHALL GIVE PRIORITY TO APPLICATIONS THAT DEMONSTRATE THE FOLLOWING:

(1) SUPPORT FROM AND PARTICIPATION OF KEY STAKEHOLDERS IN THE PUBLIC AND PRIVATE SECTORS, INCLUDING RESIDENTS OF THE AREA AND LOCAL GOVERNMENT;

(2) A PLAN FOR LONG–TERM FUNDING AND SUSTAINABILITY;

(3) INCLUSION OF SUPPORTING FUNDS FROM THE PRIVATE SECTOR;

(4) ~~THE SUPPORT~~ INTEGRATION WITH THE STATE HEALTH IMPROVEMENT PROCESS AND THE GOALS SET OUT IN THE STRATEGIC PLAN OF THE LOCAL HEALTH IMPROVEMENT COALITION;

(5) A PLAN FOR EVALUATION OF THE IMPACT OF DESIGNATION OF THE PROPOSED AREA AS A HEALTH ENTERPRISE ZONE; AND

(6) OTHER FACTORS THAT THE COMMISSION AND THE SECRETARY DETERMINE ARE APPROPRIATE TO DEMONSTRATE A COMMITMENT TO REDUCE DISPARITIES AND IMPROVE HEALTH OUTCOMES.

(E) THE DECISION OF THE SECRETARY TO DESIGNATE AN AREA AS A HEALTH ENTERPRISE ZONE IS FINAL.

20–1405.

(A) HEALTH ENTERPRISE ZONE PRACTITIONERS THAT PRACTICE IN A HEALTH ENTERPRISE ZONE MAY RECEIVE:

(1) TAX CREDITS AGAINST THE STATE INCOME TAX AS PROVIDED IN § 10–731 OF THE TAX – GENERAL ARTICLE;

(2) LOAN REPAYMENT ASSISTANCE, AS PROVIDED FOR IN THE APPLICATION FOR DESIGNATION FOR THE HEALTH ENTERPRISE ZONE AND APPROVED BY THE SECRETARY AND THE COMMISSION UNDER THIS SUBTITLE;

(3) PRIORITY TO ENTER THE MARYLAND PATIENT CENTERED MEDICAL HOME PROGRAM, IF THE HEALTH ENTERPRISE ZONE PRACTITIONER MEETS THE STANDARDS DEVELOPED BY THE MARYLAND HEALTH CARE COMMISSION FOR ENTRY INTO THE PROGRAM; AND

(4) PRIORITY FOR THE RECEIPT OF ANY STATE FUNDING AVAILABLE FOR ELECTRONIC HEALTH RECORDS, IF FEASIBLE AND IF OTHER STANDARDS FOR RECEIPT OF THE FUNDING ARE MET.

(B) A NONPROFIT COMMUNITY–BASED ORGANIZATION OR A LOCAL GOVERNMENT AGENCY THAT APPLIES ON BEHALF OF AN AREA FOR DESIGNATION AS A HEALTH ENTERPRISE ZONE MAY RECEIVE GRANTS, AS DETERMINED BY THE COMMISSION AND THE SECRETARY, TO IMPLEMENT ACTIONS OUTLINED IN THE ORGANIZATION'S OR AGENCY'S APPLICATION TO IMPROVE HEALTH OUTCOMES AND REDUCE HEALTH DISPARITIES IN THE HEALTH ENTERPRISE ZONE.

(C) (1) A HEALTH ENTERPRISE ZONE PRACTITIONER MAY APPLY TO THE SECRETARY FOR A GRANT TO DEFRAY THE COSTS OF CAPITAL OR LEASEHOLD IMPROVEMENTS TO, OR MEDICAL OR DENTAL EQUIPMENT TO BE USED IN, A HEALTH ENTERPRISE ZONE.

(2) TO QUALIFY FOR A GRANT UNDER PARAGRAPH (1) OF THIS SUBSECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER SHALL:

(I) OWN OR LEASE THE HEALTH CARE FACILITY; AND

(II) PROVIDE HEALTH CARE FROM THAT FACILITY.

(3) (I) A GRANT TO DEFRAY THE COST OF MEDICAL OR DENTAL EQUIPMENT MAY NOT EXCEED THE LESSER OF $25,000 OR 50% OF THE COST OF THE EQUIPMENT.

(II) GRANTS FOR CAPITAL OR LEASEHOLD IMPROVEMENTS SHALL BE FOR THE PURPOSES OF IMPROVING OR EXPANDING THE DELIVERY OF HEALTH CARE IN THE HEALTH ENTERPRISE ZONE.

20–1406.

(A) THERE IS A HEALTH ENTERPRISE ZONE RESERVE FUND.

(B) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(C) (1) THE STATE TREASURER SHALL INVEST THE MONEY OF THE FUND IN THE SAME MANNER AS OTHER STATE MONEY MAY BE INVESTED.

(2) ANY INVESTMENT EARNINGS OF THE FUND SHALL BE CREDITED TO THE GENERAL FUND OF THE STATE.

(D) THE MONEY IN THE FUND SHALL BE USED FOR:

(1) ANY ACTIVITY AUTHORIZED UNDER THIS SUBTITLE; AND

(2) THE STATE INCOME TAX CREDIT AUTHORIZED UNDER § 10–731 OF THE TAX – GENERAL ARTICLE.

(E) THE COMMISSION SHALL ADMINISTER THE FUND AND PROVIDE FUNDING IN ACCORDANCE WITH THE DESIGNATION BY THE SECRETARY OF A HEALTH ENTERPRISE ZONE UNDER THIS SUBTITLE.

20–1407.

ON OR BEFORE DECEMBER 15 OF EACH YEAR, THE COMMISSION AND THE ~~DEPARTMENT~~ SECRETARY SHALL SUBMIT TO THE GOVERNOR AND, IN

ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY, A REPORT THAT INCLUDES:

(1) THE NUMBER AND TYPES OF INCENTIVES GRANTED IN EACH HEALTH ENTERPRISE ZONE;

(2) ~~ANY EVIDENCE~~ EVIDENCE OF THE ~~SUCCESS~~ IMPACT OF THE TAX AND LOAN REPAYMENT INCENTIVES IN ATTRACTING HEALTH ENTERPRISE ZONE PRACTITIONERS TO HEALTH ENTERPRISE ZONES;

(3) ~~ANY EVIDENCE~~ EVIDENCE OF THE ~~SUCCESS~~ IMPACT OF THE INCENTIVES OFFERED IN HEALTH ENTERPRISE ZONES IN REDUCING HEALTH DISPARITIES AND IMPROVING HEALTH OUTCOMES; AND

(4) ~~ANY EVIDENCE~~ EVIDENCE OF THE ~~SUCCESS~~ PROGRESS IN REDUCING HEALTH COSTS AND HOSPITAL ADMISSIONS AND READMISSIONS IN HEALTH ENTERPRISE ZONES.

Article – Tax – General

10–731.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(3) "FUND" MEANS THE HEALTH ENTERPRISE ZONE RESERVE FUND ESTABLISHED UNDER § 20–1406 OF THE HEALTH – GENERAL ARTICLE.

~~(3)~~ (4) "HEALTH ENTERPRISE ZONE" HAS THE MEANING STATED IN § 20–1401 OF THE HEALTH – GENERAL ARTICLE.

~~(4)~~ (5) "HEALTH ENTERPRISE ZONE PRACTITIONER" HAS THE MEANING STATED IN § 20–1401 OF THE HEALTH – GENERAL ARTICLE.

(6) "QUALIFIED EMPLOYEE" MEANS A HEALTH ENTERPRISE ZONE PRACTITIONER, COMMUNITY HEALTH WORKER, OR INTERPRETER WHO:

(I) PROVIDES DIRECT SUPPORT TO A HEALTH ENTERPRISE ZONE PRACTITIONER; AND

(II) EXPANDS ACCESS TO SERVICES IN A HEALTH ENTERPRISE ZONE.

(7) (I) "QUALIFIED POSITION" MEANS A QUALIFIED EMPLOYEE POSITION THAT:

1. PAYS AT LEAST 150% OF THE FEDERAL MINIMUM WAGE;

2. IS FULL TIME AND OF INDEFINITE DURATION;

3. IS LOCATED IN A HEALTH ENTERPRISE ZONE;

4. IS NEWLY CREATED AS A RESULT OF THE ESTABLISHMENT OF, OR EXPANSION OF SERVICES IN, A HEALTH ENTERPRISE ZONE; AND

5. IS FILLED.

(II) "QUALIFIED POSITION" DOES NOT INCLUDE A POSITION THAT IS FILLED FOR A PERIOD OF LESS THAN 12 MONTHS.

(B) A HEALTH ENTERPRISE ZONE PRACTITIONER WHO PRACTICES HEALTH CARE IN A HEALTH ENTERPRISE ZONE MAY BE ELIGIBLE FOR A TAX CREDIT AGAINST THE STATE INCOME TAX IN ACCORDANCE WITH A PROPOSAL APPROVED BY THE SECRETARY OF HEALTH AND MENTAL HYGIENE, IF THE INDIVIDUAL:

(1) DEMONSTRATES COMPETENCY IN CULTURAL, LINGUISTIC, AND HEALTH LITERACY IN A MANNER DETERMINED BY THE DEPARTMENT;

(2) ACCEPTS AND PROVIDES CARE FOR PATIENTS ENROLLED IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND FOR UNINSURED PATIENTS; AND

(3) MEETS ANY OTHER CRITERIA ESTABLISHED BY THE DEPARTMENT.

(C) (1) A NONPROFIT COMMUNITY–BASED ORGANIZATION OR A LOCAL GOVERNMENT AGENCY ~~MAY SUBMIT~~ THAT SUBMITS A PROPOSAL TO THE DEPARTMENT AND THE COMMUNITY HEALTH RESOURCES COMMISSION UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE ~~REQUESTING AN ALLOCATION OF TAX CREDITS AGAINST THE STATE INCOME TAX FOR USE BY~~ MAY ALSO SUBMIT TO THE DEPARTMENT A REQUEST FOR

CERTIFICATION OF ELIGIBILITY FOR CERTAIN INCOME TAX CREDITS ON BEHALF OF A HEALTH ENTERPRISE ZONE ~~PRACTITIONERS~~ PRACTITIONER PRACTICING OR SEEKING TO PRACTICE IN A HEALTH ENTERPRISE ZONE.

(2) THE PROPOSAL SHALL MEET THE REQUIREMENTS SPECIFIED UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE.

(D) ~~IF THE DEPARTMENT APPROVES A PROPOSAL SUBMITTED UNDER THIS SECTION AND UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE, THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT AGENCY THAT SUBMITTED THE PROPOSAL MAY ASSIGN THE TAX CREDIT AMOUNTS ALLOCATED TO THE HEALTH ENTERPRISE ZONE FOR A TAXABLE YEAR TO HEALTH ENTERPRISE ZONE PRACTITIONERS THAT ESTABLISH, EXPAND, OR MAINTAIN HEALTH CARE PRACTICES IN THE HEALTH ENTERPRISE ZONE DURING THE TAXABLE YEAR AND MEET THE REQUIREMENTS OF THIS SECTION.~~

~~(E) A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CLAIM A CREDIT AGAINST THE STATE INCOME TAX IN AN AMOUNT EQUAL TO THE AMOUNT OF THE TAX CREDIT ASSIGNED BY THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT AGENCY, AS CERTIFIED BY THE DEPARTMENT, FOR THE TAXABLE YEAR~~

(1) IF THE DEPARTMENT APPROVES A REQUEST FOR CERTIFICATION SUBMITTED UNDER THIS SECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CLAIM A CREDIT AGAINST THE STATE INCOME TAX IN AN AMOUNT EQUAL TO 100% OF THE AMOUNT OF THE STATE INCOME TAX EXPECTED TO BE DUE FROM THE HEALTH ENTERPRISE ZONE PRACTITIONER FROM INCOME TO BE DERIVED FROM PRACTICE IN THE HEALTH ENTERPRISE ZONE, AS CERTIFIED BY THE DEPARTMENT FOR THE TAXABLE YEAR.

(2) (I) IN ADDITION TO THE STATE INCOME TAX CREDIT PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CLAIM A REFUNDABLE CREDIT OF $10,000 AGAINST THE STATE INCOME TAX FOR HIRING FOR A QUALIFIED POSITION IN THE HEALTH ENTERPRISE ZONE, AS CERTIFIED BY THE DEPARTMENT FOR THE TAXABLE YEAR.

(II) TO BE ELIGIBLE FOR THE CREDIT PROVIDED UNDER THIS PARAGRAPH, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY CREATE ONE OR MORE QUALIFIED POSITIONS DURING ANY 24–MONTH PERIOD.

(III) THE CREDIT EARNED UNDER THIS PARAGRAPH SHALL BE TAKEN OVER A 24–MONTH PERIOD, WITH ONE–HALF FOR THE CREDIT AMOUNT ALLOWED EACH YEAR BEGINNING WITH THE FIRST TAXABLE YEAR IN WHICH THE CREDIT IS CERTIFIED.

(IV) IF THE QUALIFIED POSITION IS FILLED FOR A PERIOD OF LESS THAN 24 MONTHS, THE TAX CREDIT SHALL BE RECAPTURED AS FOLLOWS:

1. THE TAX CREDIT SHALL BE RECOMPUTED AND REDUCED ON A PRORATED BASIS, BASED ON THE PERIOD OF TIME THE POSITION WAS FILLED, AS DETERMINED BY THE DEPARTMENT AND REPORTED TO THE COMPTROLLER; AND

2. THE HEALTH ENTERPRISE ZONE PRACTITIONER WHO RECEIVED THE TAX CREDIT SHALL REPAY ANY AMOUNT OF THE CREDIT THAT MAY HAVE ALREADY BEEN REFUNDED TO THE PRACTITIONER THAT EXCEEDS THE AMOUNT RECOMPUTED BY THE DEPARTMENT IN ACCORDANCE WITH ITEM 1 OF THIS SUBPARAGRAPH.

(3) (I) TO BE CERTIFIED AS ELIGIBLE FOR THE CREDITS PROVIDED UNDER THIS SECTION, A HEALTH ENTERPRISE ZONE PRACTITIONER MAY APPLY FOR CERTIFICATION THROUGH THE NONPROFIT COMMUNITY–BASED ORGANIZATION OR LOCAL GOVERNMENT THAT SUBMITS AN APPROVED PROPOSAL UNDER TITLE 20, SUBTITLE 14 OF THE HEALTH – GENERAL ARTICLE.

(II) 1. ELIGIBILITY FOR THE CERTIFICATION FOR THE CREDITS PROVIDED UNDER THIS SECTION IS LIMITED BY AVAILABILITY OF BUDGETED FUNDS FOR THAT PURPOSE, AS DETERMINED BY THE DEPARTMENT.

2. CERTIFICATES OF ELIGIBILITY SHALL BE SUBJECT TO APPROVAL BY THE DEPARTMENT ON A FIRST–COME, FIRST–SERVED BASIS, AS DETERMINED BY THE DEPARTMENT IN ITS SOLE DISCRETION.

~~(F)~~ (E) THE DEPARTMENT SHALL CERTIFY TO THE COMPTROLLER THE APPLICABILITY OF THE CREDIT PROVIDED UNDER THIS SECTION FOR EACH HEALTH ENTERPRISE ZONE PRACTITIONER AND THE AMOUNT OF EACH CREDIT ASSIGNED TO A HEALTH ENTERPRISE ZONE PRACTITIONER, FOR EACH TAXABLE YEAR.

~~(G)~~ (F) **THE CREDITS ALLOWED UNDER THIS SECTION FOR A FISCAL YEAR MAY NOT EXCEED THE AMOUNT PROVIDED FOR IN THE STATE BUDGET FOR THAT FISCAL YEAR.**

~~(H)~~ (G) **THE DEPARTMENT, IN CONSULTATION WITH THE COMPTROLLER, SHALL ADOPT REGULATIONS TO IMPLEMENT THE TAX CREDIT UNDER THIS SECTION.**

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health – General

19–134.

(c) (1) The Commission shall:

(i) Establish and implement a system to comparatively evaluate the quality of care and performance of categories of health benefit plans as determined by the Commission on an objective basis; and

(ii) Annually publish the summary findings of the evaluation.

(2) The purpose of the evaluation system established under this subsection is to assist carriers to improve care by establishing a common set of quality and performance measurements and disseminating the findings to carriers and other interested parties.

(3) The system, where appropriate, shall:

(i) Solicit performance information from enrollees of health benefit plans; **[**and**]**

(ii) **[**On or before October 1, 2007, to the extent feasible, incorporate racial and ethnic variations**]** **ESTABLISH AND INCORPORATE A STANDARD SET OF MEASURES REGARDING RACIAL AND ETHNIC VARIATIONS IN QUALITY AND OUTCOMES; AND**

(III) INCLUDE INFORMATION ON THE ACTIONS TAKEN BY CARRIERS TO TRACK AND REDUCE HEALTH DISPARITIES, INCLUDING WHETHER THE HEALTH BENEFIT PLAN PROVIDES CULTURALLY APPROPRIATE EDUCATIONAL MATERIALS FOR ITS MEMBERS.

(4) (i) The Commission shall adopt regulations to establish the system of evaluation provided under this subsection.

(ii) Before adopting regulations to implement an evaluation system under this subsection, the Commission shall consider recommendations of nationally recognized organizations that are involved in quality of care and performance measurement.

(III) IN IMPLEMENTING PARAGRAPH (3)(II) AND (III) OF THIS SUBSECTION, THE COMMISSION SHALL CONSULT WITH APPROPRIATE STAKEHOLDERS, INCLUDING AT LEAST ONE REPRESENTATIVE OF A CARRIER THAT DOES BUSINESS PREDOMINANTLY IN THE STATE AND A CARRIER THAT DOES BUSINESS IN THE STATE AND NATIONALLY, TO DETERMINE NATIONAL STANDARDS FOR EVALUATING THE EFFECTIVENESS OF CARRIERS IN ADDRESSING HEALTH DISPARITIES AND TO FULFILL THE PURPOSES OF PARAGRAPH (3)(II) AND (III) OF THIS SUBSECTION IN A MANNER THAT CAN BE EASILY REPLICATED IN OTHER STATES.

(5) The Commission may contract with a private, nonprofit entity to implement the system required under this subsection provided that the entity is not an insurer.

(6) The annual evaluation summary required under paragraph (1) of this subsection shall include to the extent feasible information on racial and ethnic variations.

19–303.

(c) (1) Each nonprofit hospital shall submit an annual community benefit report to the Health Services Cost Review Commission detailing the community benefits provided by the hospital during the preceding year.

(2) The community benefit report shall include:

(i) The mission statement of the hospital;

(ii) A list of the initiatives that were undertaken by the hospital;

(iii) The cost to the hospital of each community benefit initiative;

(iv) The objectives of each community benefit initiative;

(v) A description of efforts taken to evaluate the effectiveness of each community benefit initiative; **[**and**]**

(vi) A description of gaps in the availability of specialist providers to serve the uninsured in the hospital**; AND**

(VII) A DESCRIPTION OF THE HOSPITAL'S EFFORTS TO TRACK AND REDUCE HEALTH DISPARITIES IN THE COMMUNITY THAT THE HOSPITAL SERVES~~, IN THE FORM SET BY THE DEPARTMENT BY REGULATION~~.

20–904.

(A) ON OR BEFORE DECEMBER 1 OF EACH YEAR, EACH INSTITUTION OF HIGHER EDUCATION IN THE STATE THAT ~~INCLUDES IN THE CURRICULUM COURSES~~ OFFERS A PROGRAM NECESSARY FOR THE LICENSING OF HEALTH CARE PROFESSIONALS IN THE STATE SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON THE ACTIONS TAKEN BY THE INSTITUTION TO REDUCE HEALTH DISPARITIES.

(B) THE ~~DEPARTMENT~~ SECRETARY MAY SET STANDARDS FOR THE FORM OF THE REPORT REQUIRED UNDER THIS SECTION.

SECTION 3. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission and the Maryland Health Care Commission shall:

(1) Study the feasibility of including racial and ethnic performance data tracking in quality incentive programs;

(2) In coordination with the evaluation of the Maryland Patient Centered Medical Home, develop recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes;

~~(2)~~ (3) Report to the General Assembly on or before January 1, 2013, data by race and ethnicity in quality incentive programs where feasible and recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes; and

~~(3)~~ (4) Submit a report on or before January 1, 2013, to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly that explains when data cannot be reported by race and ethnicity and describes any necessary changes to overcome those limitations.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(1) ~~the~~ The Maryland Health Quality and Cost Council shall:

~~(1)~~ (i) Convene a workgroup to examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and

the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors; ~~and~~

(ii) Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and

(iii) Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency and health literacy training.

(2) The workgroup established under this section may include representatives from:

(i) The Maryland Health Care Commission;

(ii) The Maryland Office of Minority Health and Health Disparities;

(iii) Academic centers of health literacy and academic centers for health disparities research;

(iv) The Department of Health and Mental Hygiene;

(v) Health Occupations Boards in the State;

(vi) A wide range of health care professionals and providers;

(vii) Experts on health disparities and health literacy;

(viii) Accreditation entities, including the National Committee for Quality Assurance and URAC;

(ix) Members of the Maryland Patient Centered Medical Home Program Learning Collaborative; and

(x) The Maryland Advisory Council on Mental Hygiene/Cultural Competence Advisory Group.

(3) The academic centers of health literacy and the academic centers for health disparities research shall assist the Maryland Health Care Commission and the Department of Health and Mental Hygiene in staffing and leading the workgroup.

~~(2)~~ (4) ~~Submit~~ The workgroup shall submit a report to the ~~Governor and, in accordance with § 2–1246 of the State Government Article, the~~

~~General Assembly~~ Maryland Quality and Cost Council on or before ~~January~~ December 1, 2013, on its findings and recommendations.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall be applicable to all taxable years beginning after December 31, 2012, but before January 1, 2016.

SECTION 6. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect July 1, 2012. It shall remain effective for a period of 4 years and, at the end of June 30, 2016, with no further action required by the General Assembly, Section 1 of this Act shall be abrogated and of no further force and effect.

SECTION 7. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect on October 1, 2012.

SECTION 8. AND BE IT FURTHER ENACTED, That, except as provided in Sections 6 and 7 of this Act, this Act shall take effect July 1, 2012.

Approved by the Governor, April 10, 2012.

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

AUG 1 5 2012

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
House Health and Government
Operations Committee
241 House Office Building
Annapolis, MD 21401-1991

RE: 2012 Joint Chairmen's Report, Page 79, M00R01.03- Maryland Community Health Resources Commission – Health Enterprise Zones

Dear Chairmen Kasemeyer, Middleton, Conway and Hammen:

Pursuant to page 79 of the Joint Chairmen's Report of 2012, the Department of Health and Mental Hygiene respectfully submits this report on the implementation of provisions of Senate Bill 234 of the Acts of 2012 relating to Health Enterprise Zones. Specifically, the Joint Chairmen's Report requested that the report contain specifics as to the criteria used in selecting Health Enterprise Zones, how funding is to be allocated, and what outcome measures and/or measurement system will be developed to monitor the progress in the Health Enterprise Zones, as well as other details about the funding. The Fiscal 2013 budget restricts $3.75 million until the report is submitted, and gives the committees 45 days to review and comment on the report.

This report responds to this requirement, and contains general information about our plan for implementation of Senate Bill 234.

I. Introduction

a. Overview of the Maryland Health Improvement and Disparities Reduction Act of 2012

The Maryland Health Improvement and Disparities Reduction Act of 2012 (Senate Bill 234/Chapter 3 of 2012) seeks to combat unacceptable health disparities and improve health in

underserved communities. The legislation created a framework for the establishment of Health Enterprise Zones (HEZs) in Maryland.

The purpose of establishing HEZs is to target State resources to:

- Reduce health disparities among racial and ethnic groups and geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce healthcare costs and hospital admissions and readmissions.

The legislation enables local governments and non-profit community-based organizations to submit a plan for addressing disparities and improving health outcomes in their communities. Approved HEZs can receive funding for innovative strategies to reduce disparities and improve health outcomes, as well as for tax and capital incentives to attract needed health care providers to the HEZ. The FY 2013 budget provides for $4 million for HEZs.

b. Restricted Funds and Requested Report

Page 79, M00R01.03, of the 2012 Joint Chairmen's Report requests the Community Health Resources Commission to submit a report to the House Health and Government Operations Committee, the Senate Finance Committee, and the budget committees detailing how the funding for HEZs will be spent. $3.75 million in funding is made contingent on the receipt of the report.

This report will describe the process that the Maryland Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission (CHRC) used to develop our approach to implementation for HEZs, as well as provide details about our approach to implementation.

II. Process Used to Develop Approach to Implementation

An internal steering committee led by Lieutenant Governor Anthony Brown and Secretary Sharfstein, and comprised of DHMH and CHRC staff, has been established to lead implementation of the HEZs. This committee received guidance from the Health Disparities Collaborative, with more than 175 Marylanders participating in 5 committees.

On June 15, DHMH and the CHRC published the following drafts on the HEZ website, http://dhmh.maryland.gov/healthenterprisezones, for public comment:

- Threshold eligibility criteria for HEZ applicants;
- Additional benefits that could be provided by the State to assist HEZ awardees; and
- Principles that will be used to review HEZ applications.

The official public comment period ended July 20. We received more than 150 comments from Marylanders across the state. These comments led to a range of changes in the proposals. The summary of our responses to comments is included as **Attachment 4**.

In addition, we are holding public forums to educate the public about the HEZ implementation process. Events have been held in Charles County, Baltimore City, and Montgomery County. Events are also being planned for Prince George's County, the Eastern Shore, and Western Maryland.

III. Approach To Implementation

a. General Threshold Eligibility Criteria

DHMH and CHRC are proposing that HEZ applicants meet basic threshold eligibility criteria, as set out in **Attachment 1**. These general threshold eligibility criteria aim to cast a wide net and allow many communities to apply to become an HEZ.

The selection process will be the point at which more stringent criteria are used and communities have the opportunity to further demonstrate the existence of health disparities and poor health outcomes in their communities. It is expected that communities with large racial and ethnic minority populations and rural communities that experience poor health and health disparities will be adequately represented in the set of communities that meet these proposed eligibility criteria.

b. Benefits Included in the Maryland Health Improvement and Disparities Reduction Act of 2012

HEZs are eligible to receive a wide range of benefits to address health disparities as approved in the HEZ plan, including funding for innovative public health strategies and other incentives or mechanisms to address health disparities and improve access to care. A summary of the benefits in various categories can be found in **Attachment 2.**

c. Principles for Review of Applications

Several principles were developed for the review of applications for HEZs. These principles will inform the Request for Proposals and reflect how the funding will be allocated. These Principles -- which cover the purpose, description of need, core disease targets and conditions, strategies, evaluations, and other key topics -- are set out in **Attachment 3**.

IV. Next Steps

Following review of comments from the General Assembly, DHMH and CHRC plan to release a Request for Proposals (RFP) for the HEZ Application Process. The RFP will be based on the threshold eligibility criteria and principles for review of HEZ applications contained in this report. The CHRC will use its process to fairly review the applications and make recommendations for awards to the DHMH Secretary.

On this timeline, HEZ awards will be made in December. It is anticipated that two to four HEZs will be selected, depending on the number of applications and their scale. We will provide the General Assembly with information on the specific grants when the awards are made. We greatly appreciate the support that the General Assembly has given for this exciting initiative.

We hope this information is useful. We respectfully request that the restricted funding be released. If you have any questions regarding this report, please contact Ms. Marie Grant, Director of the Office of Governmental Affairs, at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

John A. Hurson
Chair, Community Health Resources Commission

Enclosures - 4

cc: The Honorable Anthony G. Brown
Carlessia Hussein, RN, DrPH
Mark Luckner
Marie L. Grant, J.D.
Frances Phillips, RN, MHA

Attachment 1

HEZ Threshold Eligibility Criteria

In general, the below table summarizes HEZ threshold eligibility criteria that an applicant should demonstrate. Potential applicants will also be allowed to use an alternative approach, as outlined after the table.

HEZ Eligibility Criteria	Rationale	Data Source
1. An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes).	The law requires that an HEZ be a contiguous geographic area. In addition, there needs to be a cohesive sense of place held by residents and community leaders, who will actively participate in the governance of the HEZ project. Zip codes were selected because of the data available to measure need and outcomes (ex. utilization rates).	MD Department of Planning zip code maps
2. An HEZ must have a resident population of at least 5,000 people.	The HEZ population should be large enough to model community change for application statewide. An upper limit was not placed on the HEZ population size to allow applicants flexibility to determine what population size is appropriate for their selected interventions.	2010 Census, population by zip code tabulation areas
3. An HEZ must demonstrate economic disadvantage by having either: a) a Medicaid enrollment rate above the median value for all Maryland zip codes, or b) a WIC participation rate above the median value for all Maryland zip codes. An HEZ made up of multiple zip codes must meet this criterion in each zip code if the values are known.	Medicaid enrollment data provides information on the number of low-income individuals in a community. WIC participation can be used to identify communities with a large number of low-income families and can capture high need populations that are ineligible for Medicaid. We expect this criterion to identify communities with disadvantaged racial/ethnic minority populations.	Medicaid enrollment data, Number of people enrolled per population, 2006-2010 Maryland WIC Program, Number of people enrolled per population, 2006-2010
4. An HEZ must demonstrate poor health outcomes by having either: a) a life expectancy below the median value for all Maryland zip codes, or b) a percentage of low birth weight infants above the median value for all Maryland zip codes. An HEZ made up of multiple zip codes must meet this criterion in each zip code if the values are known.	Life expectancy is a meaningful measure of how health and wellbeing in a community compare to other areas of the state. This metric is easy for the public to interpret and data are available by zip code. Low birth weight is associated with infant mortality, which is an excellent indicator of the overall health of a population.	Maryland Vital Statistics, Life expectancy by zip code, 2006-2010 Maryland Vital Statistics, Low birth weight infants, age-adjusted, 2006-2010

DHMH and CHRC will permit applications to propose an alternative HEZ approach using sub-zip code geographic boundaries offered by an applicant, if:

- the proposal includes equivalent data to demonstrate ***both*** economic and health status eligibility,
- the area proposed is contiguous geographically, and
- the population in the proposed area is at least 5,000.

Attachment 2

Benefits for Health Enterprise Zones

Benefits Included in the Maryland Health Improvement and Disparities Reduction Act of 2012
HEZs are eligible to receive benefits to address health disparities as approved in the HEZ plan, including funding for innovative public health strategies and other incentives or mechanisms to address health disparities and improve access to care.

Examples of funding for innovative public health strategies and other incentives could include the following suggestions received during the public comment period, if requested in an approved application and linked to targeted diseases and outcomes:

- Internship and volunteer programs for students in an HEZ;
- Discounted gym memberships for families as a benefit of an HEZ;
- Funding for improvements to the built environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
- Grants to integrate behavioral health care into existing primary care practices in an HEZ;
- Funding for better health information technology tools for providers in an HEZ; and
- Funding for resources to enhance provider capacity to serve non-English speakers in an HEZ.

As is provided in the enabling legislation, practitioners that provide primary care, behavioral health services, or dental services in an approved HEZ are eligible for:

- Tax credits against the State income tax, in accordance with the approved HEZ plan;
- Loan repayment assistance, in accordance with the approved HEZ plan;
- Priority to enter the state's Patient Centered Medical Home Program, if the practitioner meets the standards developed by the Maryland Health Care Commission for entry into the Program;
- Priority for the receipt of any State funding available for electronic health records; if feasible and if other standards for receipt of the funding are met;
- Additional grant funding from the Community Health Resources Commission;
- Grants to defray the costs of capital or leasehold improvements for the purposes of improving or expanding the delivery of healthcare in the HEZ; and
- Grants to defray the costs of medical or dental equipment to be used in the HEZ, not to exceed the lesser of $25,000 or 50% of the cost of the equipment.

Additional Benefits for HEZs
In addition to the benefits listed above, DHMH plans to provide assistance and support to approved HEZs, including the following:

- General support for program planning, implementation, and evaluation;
- Working with awardees to provide access to DHMH data resources about approved HEZs;
- Invitations to participate in appropriate collaboratives and workgroups;
- Assistance in connecting to existing grant-writing resources; and

- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations.

DHMH can also provide assistance with benefits that do not need to be budgeted for, but that should be specifically requested by an HEZ in an approved application. These benefits include working with federal agencies to enable an HEZ to be considered for new FQHC sites, working to promote incentives for care to take place in the appropriate venue in the HEZ, and assisting in identifying funding opportunities for cultural competency trainings.

Attachment 3

Principles for Review of Applications for HEZs

The following are proposed principles for the review of applications for HEZs. These principles will inform the Request for Proposals and will be used in the final selection of the Health Enterprise Zones.

Principles

1. Purpose. The application must describe how the proposal will address the core statutory goal of Health Enterprise Zones of reducing health disparities, including racial/ethnic and geographic health disparities, in Maryland.

2. Description of need. The application should describe the health and health service needs of the population. Examples of metrics to describe community need include metrics of health status, risk factor prevalence, health un-insurance, primary care access (for example, Medically Underserved Area or Medically Underserved Population designations), and other health needs specific to the community. These metrics should be presented where possible by racial groups and by Hispanic ethnicity. The application should also discuss other factors that contribute to poor health in the community (such as education, employment, income, housing, physical environment, and other community factors that impact health).

3. Core disease targets and conditions. The application should identify specific diseases for improvement. Applications are encouraged to target at least one of the following conditions identified by the Health Disparities Workgroup of the Maryland Health Quality and Cost Council: cardiovascular disease, diabetes, and asthma. Applicants may address other major conditions where the community experiences poor health outcomes, such as behavioral health, dental health, birth outcomes, or related and co-morbid conditions.

4. Goals. The application should propose measurable goals for health improvement in the HEZ by January 2016. Goals should cover each of the following areas:

    a. Improved risk factor prevalence or health outcomes (SHIP or LHIP measures, or others);
    b. Expanded primary care workforce ;
    c. Increased community health workforce (including public health and outreach workers);
    d. Increased community resources for health (housing, built environment, food access, etc.);
    e. Reduced preventable emergency department visits and hospitalizations ; and
    f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

    The goals should reflect the disparities being addressed. For example, if the disparity being targeted is diabetes admissions for African-Americans, the goal should be stated as a specific value for diabetes admissions for African-Americans.

5. Strategies. The application should propose strategies and interventions to meet the goals. Investments in prevention, community outreach, and improved self-management of chronic disease are encouraged. The evidence and rationale for the strategies and interventions should be presented.

Examples of such strategies could include:

- A strategy to increase provider capacity by a specified percentage;
- A strategy to improve the quality of service delivery as indicated by tracking metrics such as those used by HEDIS ;
- A strategy to increase access to behavioral health and improve integration with primary care;
- A strategy to address community barriers to healthy lifestyles through public health involvement;
- A strategy to improve health outcomes through the use of community health workers;
- A plan to strengthen community and environmental policies to support good health in schools, day care, recreation centers, senior centers, and workplaces;
- A strategy to apply the Community-Centered Health Home model to the HEZ;
- A strategy to provide better access to healthy foods or facilities for physical activities; or
- A strategy to reach underserved racial and ethnic minority persons in the Health Enterprise Zone including approaches to increase capacity to reach non-English speakers.

Applicants are encouraged where possible to adopt strategies that are evidence-based, generally accepted as promising practices, or new/innovative ideas. Applicants are encouraged to bring health information technology (electronic medical records and health information exchange) and the patient-centered medical home model to their strategic approaches.

6. Cultural, linguistic and health literacy competence. The application should explain how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers, and issues of low health literacy in the population. The application should describe the efforts that will be undertaken to recruit a racially ethnically and linguistically diverse workforce for the HEZ.

7. Balance. The proposed strategies should be balanced between community-based approaches with primary care provider based incentives; it should combine grants for public health and community services with the provider credits and incentives that are available to HEZs.

8. Contributions from local partners. Explicit financial or in-kind contributions from local partners and stakeholders should be part of the strategic resource mix, in order to amplify the impact of the State-provided pilot funding and incentives.

9. Coalition. The applying coalition should include a diverse array of health and community partners, with specific roles and deep historical experience working in the HEZ. Efforts should be made to include members of the target populations and minority groups in planning and ongoing oversight of the program. The proposal should describe the coalition team and what assets, experience, knowledge, etc., it brings to the proposed HEZ. There should be a clear governance structure with a point of accountability. There should be an advisory and oversight entity composed primarily of community members to provide advice and input to the coalition and the governing body.

10. Work-plan. The application should include a detailed list of program activities, measurable outputs, timelines, responsible entities and other logistics that enable tracking of effort; describe roles of the listed partners, include interim milestones and deliverables; and support appropriate data collection

and reporting. Funding levels to partners should be appropriate to their responsibilities in the work-plan.

11. Program management and guidance. The application should include a plan for periodic reporting to the State regarding progress and challenges on implementation of the HEZ work-plan and interim values for the evaluation metrics. Applicants should propose a plan of periodic reporting that meets any criteria in the Request for Proposals issued by the CHRC and that contains periodic reporting requirements that make sense given the core disease targets and conditions of the HEZ as well as the goals of the HEZ.

12. Sustainability. The application should describe a plan for sustainability and acquisition of resources beyond State funding, including partnership with entities in the health care system that have the financial incentive for better outcomes. The application should include a specific plan for developing and implementing a short-term and long-term sustainability strategy. Investments from insurers who stand to gain from cost savings in the HEZ are a potential component of a sustainability plan.

13. Internal evaluation and progress monitoring. The application should propose a draft internal evaluation plan (to be finalized with DHMH and CHRC input after award) which tracks progress in meeting the health goals within the HEZ. This is separate from the external program evaluation that will be performed statewide and funded separately. As discussed in 4 above, the draft internal evaluation should include goals in each of these areas:

    a. Improved risk factor prevalence or health outcomes (SHIP or LHIP measures, or others);
    b. Expanded primary care workforce ;
    c. Increased community health workforce (including public health and outreach workers);
    d. Increased community resources for health (housing, built environment, food access, etc.);
    e. Reduced preventable emergency department visits and hospitalizations ; and
    f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

    In addition, the evaluation plan should propose assessing the process used to achieve these goals. For example, the plan should track the use of proposed incentives, the implementation of the plan on cultural competency, the broad-based participation of the community coalition, and the status of progress on sustainability.

    Data collection and monitoring should be an ongoing effort, so that productivity metrics, program implementation milestones, and values for the goal outcome metrics can be monitored at baseline and throughout the HEZ lifespan. Data collection and monitoring budget is expected to range between 5% and 10% of the total HEZ budget.

Attachment 4

Responses to Public Comment on Implementation of Health Enterprise Zones

Threshold Eligibility, Benefits, and Principles for Review of Applications

Background

On June 15, the Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission (CHRC) released draft threshold eligibility criteria for health enterprise zones (HEZs), draft benefits for approved HEZs, and draft principles for the review of applications for HEZs for public comment. The public comment period closed July 20. DHMH and CHRC received over 150 comments on these three topics. Below is a summary of how DHMH and CHRC responded to the comments. For additional information on specific comments, please email hez@dhmh.state.md.us.

Threshold Eligibility for HEZs

We received numerous comments related to eligibility criteria for the HEZs, summarized below. Generally, these comments addressed one of three topics:

1. The geographic unit of measurement/data that should be used to determine eligibility;
2. The selection of an appropriate cutoff to determine eligibility; or
3. Different or additional criteria that should be applied to determine eligibility.

We appreciated all of the comments and have made several changes as a result.

To understand where we did not make changes, it will be helpful to recognize that the purpose of the eligibility criteria is solely to consider areas eligible to be designated a HEZ. The specific criteria for eligibility have no bearing on whether an organization will be selected; it is the application review that determines selection. As we originally stated, "the selection process will be the point at which more stringent criteria are used and communities have the opportunity to further demonstrate the existence of health disparities and poor health outcomes in their communities."

Selection of the Appropriate Geographic Unit of Measurement/Data to Determine Eligibility

Several commentators suggested that in place of zip codes, it would be better to use census tracts or other units, such as Public Use Microdata Sample Areas (PUMAs), census tracts, community statistical areas (CSAs), or urban renewal zone designations. Several commentators also suggested that the initial screening could be done using zip code level data, but that the subsequent evaluation of applications should involve explicit criteria, and could involve different levels of geographic detail and different ("more descriptive") data such as census tracts.

Response: The Department selected zip codes as the unit of analysis so that as much of the state could be included as possible, with as complete and uniform a set of data as possible. We looked at other potential units of analysis, and noted significant limitations for all of them:

- We determined, based on a review of the literature, that average life expectancy should only be calculated for geographic units containing at least 5,000 individuals. Of the 1,406 census tracts

in Maryland in the 2010 census, 1,012 census tracts have a population less than 5,000. However, these smaller census tracts contain 3.3 million (57%) of the state's 5.8 million people.

- There are no standardized state-wide data sources or designations for any of the other geographic units (PUMAs, CSAs, Urban Renewal Zones).
- People recognize zip codes and identify them readily, unlike many other geographic units.
- There are data readily available for calculations of many measures using zip codes and zip code tabulation areas (ZCTAs). Significantly, health outcomes data from the Health Services Cost Review Commission (HSCRC) are only available at the zip code or county level.

The Department recognizes that zip codes have many limitations, as pointed out by several commentators. The Department agrees with the comments that suggested that applications could address geographic units at a sub-zip code level. Therefore, the Department is providing the following guidance regarding the unit of measure for HEZ eligibility:

- The area proposed for an HEZ must be contiguous and have a population of at least 5000.
- Zip code boundaries will be the benchmark unit of measure for HEZ proposals for the reasons noted above.

An alternative HEZ approach using sub-zip code geographic boundaries will be considered, provided the proposal submits equivalent data to demonstrate both economic and health status eligibility.

1. Selection of Appropriate Cutoffs to Determine Eligibility

A few comments suggested cutoff points other than the median value of the four eligibility criteria. Some of these comments suggested lower cutoffs, which would have the effect of decreasing the number of eligible zip codes; a number also suggested cutoffs higher than the median value, which would have the effect of increasing the number of eligible zip codes.

Response: No specific rationale or evidence was presented to justify alternative cutoff points. The Department is comfortable that its proposal, which has the advantage of simplicity of calculation and interpretation, is appropriate as a screening measure.

By using the median value as the eligibility cutoff point for economic and health measures, the Department is intentionally adopting a permissive screen for HEZ proposals. A proposal representing a geographic area that does not meet the median cutoff would be required to have a special and compelling justification to be considered.

Selection of Different/Additional Criteria to Determine Eligibility

A number of commentators suggested additional or different criteria to determine eligibility, other than average life expectancy, percentage of low birth weight infants, Medicaid enrollment rate, or WIC participation rate. Some of the suggested criteria included:

- Social determinants of health
- Income
- Title I school status
- Unemployment
- Number of families up to X% of the poverty level who use emergency room for services
- Women with no prenatal care during pregnancy

- Asthma emergency room visits
- Child abuse and neglect cases
- Children who drop out of school before the 10th grade
- Environmental contaminants, industrial pollution and toxic exposures
- Obesity and overweight in youth and adults
- Chronic diseases
- HIV infection rates
- Competency in cultural, linguistic, and health literacy

There were also specific comments regarding the challenge of applying criteria uniformly for both urban and rural areas. Several comments suggested that applicants should be free to add their own criteria to demonstrate disadvantage.

Response: These are all important metrics of health and economic well-being. In setting eligibility criteria, we looked for a few basic criteria where data would be available for the entire state, with the idea to cast a wide net. Once the basic criteria are met, the focus shifts to the application. The above metrics are more appropriate for inclusion in specific applications, where organizations will make the case about the challenges in their specific areas and their solutions.

Benefits for Health Enterprise Zones

The Maryland Health Improvement and Disparities Reduction Act of 2012 provides that Health Enterprise Zones (HEZs) are eligible to receive benefits to address health disparities as approved in the HEZ plan, including funding for innovative public health strategies and other incentives or mechanisms to address health disparities and improve access to care. Practitioners in an HEZ are also eligible for a variety of incentives if included in an approved HEZ plan, as well as other incentives specifically provided for in the legislation.

DHMH posted for comment questions relating to the benefits that the State could provide to an approved HEZ. Specifically, DHMH requested comments on the following questions:

1. What other types of benefits could the state provide in a HEZ?
2. What specific existing programs, i.e. public health grant programs, might be prioritized for applicants in a HEZ?

DHMH requested that comments take into account fiscal and legal parameters when responding, as well as the overall mission of the HEZ program.

DHMH received a number of thoughtful comments regarding benefits that would be helpful to be provided in an HEZ.

The comments can be divided into five categories:

1. Benefits that DHMH will provide to approved HEZs that do not need to be budgeted for in specific applications;

2. Benefits that DHMH will provide, on request, to approved HEZs that do not need to be budgeted for in specific applications;
3. Benefits that DHMH and the CHRC will provide to approved HEZs as budgeted for in an approved application;
4. Benefits that approved HEZs may work with other local entities to achieve; and
5. Benefits that are outside the scope of the HEZ program.

A description of the comments, by each category, is below.

1. ***Benefits that DHMH will Provide to Approved Health Enterprise Zones And That Do Not Need to Requested or Budgeted For***

Some of the benefits that were suggested through public comment are benefits that DHMH plans to provide to approved HEZs automatically. These benefits do not need to be budgeted for in an application and do not need to be specifically identified in an application.

These benefits include:

- General support for program planning, implementation, and evaluation;
- Working with awardees to provide access to DHMH data resources about approved HEZs;
- Invitations to participate in appropriate collaboratives and workgroups;
- Assistance in connecting to existing grant-writing resources; and
- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations.

2. ***Benefits that the State will Provide to Approved Health Enterprise Zones That Do Not Need to Be Budgeted For, But Need to Be Requested in An Application***

Several comments suggested benefits that DHMH can offer to HEZs that do not need to be budgeted for, but that would need to be specifically requested by an HEZ in an approved application. These benefits include working with federal agencies to enable an HEZ to be considered for new FQHC sites, working to promote incentives for care to take place in the appropriate venue in the HEZ, and assisting in identifying outside funding opportunities for cultural competency trainings (the application can also budget for such trainings).

3. ***Benefits that Can Be Provided As Part of An Approved Application, and Must Be Requested and Budgeted For***

Many of the comments suggested benefits that an HEZ could pursue as part of an approved application, but that should be requested in as well as budgeted for in the HEZ application. These benefits could be part of an approved funding package for an approved HEZ, if funding for these types of expenses was part of the application and linked to the applicable targeted diseases and outcomes.

Examples of these benefits that can be requested in and budgeted for in an application include:

- Internship and volunteer programs for students in an HEZ;

- Discounted gym memberships for families as a benefit of an HEZ;
- Funding for improvements to the built environment in an HEZ;
- Grants to integrate behavioral health care into existing primary care practices in an HEZ;
- Funding for better health information technology tools for providers in an HEZ; and
- Funding for resources to enhance provider capacity to serve non-English speaking individuals in an HEZ.

4. *Benefits That Approved HEZs May Work with Other Local Entities to Achieve*

Some benefits suggested in comments are not benefits that DHMH can offer, but may be benefits that an approved HEZ could work with other local entities on achieving. Examples of these types of benefits could include access to school buildings for education and health screenings and use of municipality-owned land for community gardens. In such cases, the applicants should engage the school or municipality during the application process and include the plan as part of the application.

5. *Benefits That DHMH Cannot Provide As Part of The Program*

Some suggested benefits that were provided during the public comment period are outside of the scope of the program as envisioned by Senate Bill 234. Benefits that cannot be provided by DHMH as part of the program, whether for fiscal, administrative, or legal reasons, include:

- Forgiving the costs of an employer's share of workers compensation or unemployment insurance;
- Increasing Medicaid reimbursement for particular providers as part of the HEZ program; and
- Providing enhanced medical liability protections for mid-level practitioners and community health workers.

Principles for Review of Applications of Health Enterprise Zones

The principles for review of applications for HEZs were drafted to capture values that would lead to use of innovative and promising public health practices, focus on reducing health disparities, support existing and stimulate new partnerships within communities, and ensure a results and outcome orientation.

The comments received regarding the principles for review fell in 6 categories. A majority of the comments were accepted and integrated into the draft.

The following is a brief summary of how comments were incorporated into the principles for review of applications:

- in the *NEED* section race, income, ethnicity, MUA and MUP were added;

- in the *TARGETS* section the title was changed to add conditions that will include dental, behavioral, and co-morbidities, as eligible to be addressed;

- in the *GOALS* section clarification was provided to include public health and outreach workers and social determinants of health;

- in the *STRATEGY* section the use of HEDIS measures, specifically mentioning behavioral health, applying a 'Community-Centered Health Home' model to the HEZ, and adopt models that are Promising Practices, new or innovative and evidence-based; integrate Information technology, health information exchange and patient-centered medical home to HEZ strategic approaches;

- in the *CULTURAL COMPETENCY* section promote cultural and linguistic competency in the provider workforce;

- in the *COALITION* section include members of the target populations in planning and ongoing oversight, involve and partner with existing organizations with history in the community, place greater emphasis on the Coalition as an entity that can keep the HEZ responsive to the community and keep the partners connected to each other;

- in the *EVALUATION* section clarification on evaluation expectations was asked along with adequate resources to do evaluation, and concern was raised about HEZ goals whose metrics cannot show change for many months or years; and

- in the *DATA RESOURCES* section clarification is provided regarding the internal evaluation by the HEZ organization and an external evaluation conducted by the State including the need for an evaluation budget between 5 and 10 percent of the base award.

STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman – Mark Luckner, Executive Director

Health Enterprise Zones

Call for Proposals

October 5, 2012

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I. Executive Summary

The state of Maryland has numerous advantages for its residents to enjoy good health care, such as the 3rd highest median household income; the 2nd highest number of primary care physicians per capita; the 10th lowest rate of smoking; and outstanding medical schools. Despite these advantages, Maryland continues to lag behind other states on a number of key health indicators, such as ranking 43rd in infant mortality, 31st in early prenatal care, 28th in obesity prevalence, 31st in diabetes prevalence, 35th in cardiovascular deaths, 32nd in cancer deaths, and 33rd for geographic health disparities.

In recognition of these unacceptable disparities, Lieutenant Governor Anthony G. Brown, as Chair of the Maryland Health Quality and Cost Council, established the Health Disparities Work Group, led by Dean E. Albert Reece, M.D, Ph.D., M.B.A. of the University of Maryland School of Medicine. The Work Group issued its final report in January 2012, which provided several recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in Maryland's health care system. The Work Group developed bold recommendations, including the concept of utilizing enterprise zones typically used to drive economic development, and applied this principle in the field of public health and health disparities. The Work Group concluded that improvement in overall health in communities and reductions in health care costs may be achieved by saturating underserved communities with primary care providers and other essential health care services.

The recommendations of the Maryland Health Quality and Cost Council provided the structure for legislation, The Maryland Health Improvement and Disparities Reduction Act of 2012 (SB 234/Chapter 3 of 2012), which was approved by the Maryland General Assembly and signed into law on April 10 by the Governor. The Act combats continued health disparities and attempts to improve public health in underserved communities by creating the framework for the establishment of Health Enterprise Zones (HEZ), contiguous geographic areas that demonstrate measurable and documented health disparities and poor health outcomes and that are small enough for the incentives in this program to have a significant impact on improving health outcomes and reducing health disparities. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

The HEZ Initiative is a new, four-year pilot program, and the FY 2013 budget provides $4 million in new funding to the Community Health Resources Commission (CHRC) to support the activities of HEZs. Through this Call for Proposals, communities may apply for HEZ designation, which will enable access to a range of incentives which include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for available state electronic health record (EHR) grant funding; additional grant funding from the CHRC; and capital grant support. Applicants seeking HEZ designation may draw upon any or all of these incentives when developing their

intervention strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the area. The application for HEZ designation will be a combination of **both** demonstrated need and intervention strategies to improve health outcomes in the potential HEZ.

The HEZ Initiative will be jointly administered by the Maryland Department of Health & Mental Hygiene (DHMH) and the CHRC. The Commission is issuing this HEZ Call for Proposals, will evaluate applications requesting HEZ designation, and will provide recommendations to the DHMH Secretary. Final HEZ designation decisions will be made by the Secretary by the end of calendar year 2012. It is anticipated that the state will award between two to four Zones in this first year of the program.

An internal steering committee led by DHMH Secretary Joshua M. Sharfstein, M.D., comprised of DHMH, Lt. Governor, and CHRC staff, was established to help guide implementation of the HEZ Initiative. The committee received guidance and input from several external sources including the Health Disparities Collaborative, which included more than 175 Marylanders participating in five committees.

In addition, a public comment period was launched in the summer of 2012, and the following three documents were distributed in draft form to solicit public feedback:
1. Threshold eligibility criteria for communities seeking HEZ designation;
2. Additional benefits that could be provided by the state to assist HEZ awardees; and
3. Principles that will be used to review HEZ applications.

The committee received more than 150 comments which led to a range of changes in the implementation plan and are summarized in a Joint Chairmen's Report submitted in August to the Maryland General Assembly (this report is available at http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx). In addition, public forums were held earlier this year in Baltimore City, Montgomery, Prince George's, and Charles Counties, the Eastern Shore, and western Maryland. The public comment period and these public forums informed the development of this Call for Proposals.

Key Dates	
October 11, 2:30 PM	Proposal Question & Answer Conference Call Dial-In Number: (866) 233-3852 Participant Access Code: 267478
October 19, 5:00 p.m.	Initial Letters of Interest are due to the CHRC
November 13, 12:00 p.m.	HEZ Proposals due to the CHRC
December 11	Select applicants invited to present at CHRC meeting
December 21	DHMH Secretary makes HEZ designations

Overview of the CHRC
The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly when it approved the *Community Health Care Access and Safety Net Act of 2005* legislation to expand access to health care for low-income Marylanders and underserved communities in the state and bolster Maryland's health care safety net infrastructure. The CHRC is a quasi-independent commission operating within the DHMH, and its 11 members are appointed by the Governor. In creating the Commission, the Maryland General Assembly recognized the need for having an independent commission that focused on strengthening the state's diverse network of community health centers and safety net providers and addressed service delivery gaps in Maryland's dynamic health care marketplace.

Over the last seven years, the Commission has awarded 110 grants totaling approximately $26.3 million, supporting programs in every jurisdiction of the state. These 110 programs have collectively served more than 105,000 underserved Marylanders. The CHRC has awarded grants to help reduce infant mortality; expand access to substance use treatment; integrate behavioral health services in primary care settings; increase access to dental care; boost primary care capacity; and invest in health information technology for safety net providers. Program sustainability is a top priority of the Commission, and CHRC grantees have used initial grant funds to leverage more than $10 million in additional federal and private funding sources to support their programs.

II. Information for Health Enterprise Zone Applicants

The designation of HEZ status will enable access to a range of incentives to support strategies to address health disparities, to expand access, and to help attract needed health care practitioners into the HEZ. Incentives and benefits include state income tax credits; hiring tax credits; loan repayment assistance; priority entrance into the state's Patient Centered Medical Home Program; priority for state EHR grant funding; additional grant funding from the CHRC; and capital grant support. These benefits and incentives are described in greater detail on page six. The purpose of the HEZ Initiative is to target state resources to:

- Reduce health disparities among racial and ethnic minority populations, and among geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions and re-admissions.

HEZ applicants are expected to submit applications which demonstrate the needs of the community, provide a comprehensive plan to address these needs, and achieve the overall policy goals of the HEZ Initiative. Eligible applicants should develop strategies using the benefits and incentives available to designated HEZs described in this Call for Proposals.

Community Eligibility
An HEZ is a community or a cluster of contiguous communities that are comprised of one or more zip codes. In order to be designated an HEZ, the proposed zip code(s) within a potential HEZ area must meet <u>each</u> of the following four criteria:

1. An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes);
2. An HEZ must have a resident population of at least 5,000 people;
3. An HEZ must demonstrate economic disadvantage by having either:
   a) a Medicaid enrollment rate above the median value for all Maryland zip codes; or
   b) a WIC participation rate above the median value for all Maryland zip codes.
4. An HEZ must demonstrate poor health outcomes by having either:
   a) a life expectancy below the median value for all Maryland zip codes, or
   b) a percentage of low birth weight infants above the median value for all Maryland zip codes.

A proposed HEZ made up of multiple zip codes must meet these criteria in each zip code if the values are known. ***Applicants are permitted to propose an alternative approach in eligibility determinations, using sub-zip code geographic bounds*** *(e.g. Census Tracts, Public Use Microdata Areas),* ***if the following criteria are met****:*

1. The area proposed is contiguous geographically;
2. The population in the proposed area is at least 5,000; and
3. The zip code(s) where the sub-zip code geographic bounds are located must meet the criteria for demonstrating economic disadvantage and poor health outcomes.

Data regarding the economic disadvantage and poor health outcomes, by zip code, has been compiled by DHMH and is available at: http://eh.dhmh.md.gov/hez/index.html. ***Applicants seeking designation status for sub-zip code geographic bounds will be required to provide data confirming eligibility for economic disadvantage and poor health outcomes.***

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it ready, and not wait until October 19. The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website. The full grant application is due to the CHRC no later than 12:00 p.m., November 13, 2012. For a more detailed description of the LOI, please see page 11 of this Call for Proposals.

Organizations Eligible to Apply for HEZ Designation on Behalf of a Community

An applicant for this Call for Proposals must be either a local government entity or a non-profit community-based organization. Applications should be submitted by one organization, the Coordinating Organization (local government entity or local non-profit entity), on behalf of a coalition of key community stakeholders and proposed HEZ geographic area. The community coalition should include a combination of health and community partners with specific roles and demonstrated historical experience working in the proposed zone. Applicants will be required to provide evidence validating that genuine efforts were made to include members of the target populations and minority groups in the HEZ application, and in the planning and program implementation, post-designation award.

Health Care Provider/Practices Eligibility
Individual health care providers and practices providing services within a Zone are eligible to receive state tax credits against their income, loan repayment assistance, funding for electronic health records, capital improvements and equipment in accordance with the HEZ Initiative and regulations to be proposed and adopted regarding tax credits. In addition, providers and practices may only receive incentives and benefits under the HEZ Initiative for the duration of their service/employment in a designated HEZ.

HEZ Benefits and Incentives
The HEZ Initiative provides a range of benefits and incentives to address health disparities and expand access to health care services. These benefits and incentives are available to non-profit organizations, local government entities, and eligible health care providers to achieve the HEZ's program goals at the community level. Following are examples of benefits and incentives that HEZ applicants may include in their application. If these benefits and incentives are included, then their cost must be included in the overall budget request of the HEZ application. Successful applicants will finalize the specific benefits and incentives utilized in the Zone in a post-designation conference.

- Tax credits against the State income tax: State income tax credits are available to eligible health care providers as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a credit against the state income tax in an amount equal to 100% of the amount of the state income tax derived from income received from practice in the HEZ. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Hiring Tax credits: Hiring tax credits are available to eligible health care provider practices as part of an overall HEZ strategy to increase health care capacity and access to services. An eligible practitioner may claim a refundable credit of $10,000 against the state income tax for hiring a qualified position in the Health Enterprise Zone. Based on the language of the HEZ Act, tax credits are available for calendar years 2013, 2014, and 2015. Tax credits may become available for calendar year 2016, pending legislative approval and budget appropriation.

- Loan repayment assistance: Loan repayment assistance is available to eligible health care providers for qualified education loan repayments.

- Priority to enter the state's Patient Centered Medical Home Program (PCMH): Priority entry into Maryland's PCMH program may be available to eligible health care providers and practices who meet the standards developed by the Maryland Health Care Commission for entry into the PCMH Program.

- Grant funds for electronic health records: Grants for obtaining and/or implementing electronic health records systems are available to eligible health care providers and

practices.

- Grants to defray the costs of capital or leasehold improvements**:** Grants for capital/leasehold improvements are available to eligible health care providers and practices to improve or expand capacity for the delivery of primary healthcare, behavioral, or dental services in the HEZ.

- Grants to defray the costs of medical or dental equipment**:** Grants for medical or dental equipment are available to eligible health care providers and practices for equipment which must be used to provide medical or dental services in the HEZ. Grants are not to exceed the lesser of $25,000 or 50% of the cost of the equipment. Providers/Practitioners must leave working medical and dental equipment in the designated Zone for continued community use, should the providers/practitioners choose to leave the Zone.

- Grant funding for innovative public health strategies: Grant funding is available to non-profit organizations and local government entities to facilitate innovative public health strategies and other incentives to help address the goals of the HEZ Initiative. Examples of fundable innovative public health strategies could include (but are not limited to) the following:
  a) Internship and volunteer programs for students in an HEZ;
  b) Funding for improvements to the environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
  c) Grants to integrate behavioral health care into existing primary care practices in an HEZ;
  d) Funding for better health information technology tools for providers in an HEZ; and
  e) Funding for resources to enhance provider capacity to serve non-English speakers in an HEZ.

In addition to these incentives and benefits, CHRC and DHMH will provide the following types of assistance and support to HEZ designees, which do not need to be included in the application's budget.

- General support for program planning, implementation, and evaluation;
- Working with HEZ grantees and coalition members to provide access to DHMH data resources for approved HEZs;
- Invitation to participate in appropriate collaboratives and work groups;
- Assistance in connecting to existing grant-writing resources;
- Opportunity to apply for J-1 Visa Waiver primary care placements in HEZ sites that are located in federally designated Health Professional Shortage Areas and Medically Underserved Areas or Populations; and
- Priority assistance in achieving Health Information Exchange connectivity at the individual practice level.

Program Duration

HEZ designation will be for a four-year period and applications for HEZ designation should reflect a four-year period of activities. Designations made by the Secretary will be for the duration of the four-year program. Applicants should submit a detailed work-plan and evaluation plan with specific activities, objectives, milestones, and deliverables for each year of

the potential four-year program. In order to receive funding in years two, three, and four of the designation, HEZ Coordinating Organizations will need to meet the terms and conditions of the designation award, namely submitting the required reporting documents on a quarterly basis. In addition, Coordinating Organizations must demonstrate progress in terms of meeting performance measures developed by the Coordinating Organization and CHRC. HEZs that fail to comply with the reporting requirements or do not demonstrate performance in year one may be subject to revocation of designation status, and would no longer have access to benefits and incentives under the HEZ Act. The CHRC retains the right to "claw-back" funds distributed to the Zones or revoke the designation award if the Coordinating Organization is not compliant under the terms and conditions of the designation or does not meet performance measures during implementation.

Program Budget and Use of Funds

HEZ funding requests should be between $500,000 and $2 million per year for the duration of the four-year program. Annual budgets should be based on the calendar year (January – December). The Secretary and the CHRC, post-designation decisions (in January 2013), will meet with grantees to finalize the distribution of benefits and incentives to each designated Zone.

Overall or Global Budget

Applicants will be required to submit an overall or global budget requested, per year, for the duration of the four-year program. The global budget should include the total dollar amount allocated to **each** of the above benefit and incentive areas in the budget, per year. (see Appendix Item F). For example, if the HEZ applicant is requesting a total of $1 million in year one (calendar year 2013), the sum of each incentive or benefit requested should total $1 million. Please refer to Appendix Item G for a sample global budget. In the global budget, applicants are not expected to include/list the specific/actual provider names or practices that will receive each of the incentives or benefits. The global budget simply requires sub-totals for each incentive or benefit utilized in the Zone for each year of the program duration. In the months following the HEZ designation, the Coordinating Organizations will work to identify the individual providers and practices that will receive these benefits and incentives, and the CHRC will work with the Coordinating Organization to develop a mechanism to distribute these benefits and incentives.

Grant Program Budget (by Implementing Organization)

In addition to submitting the global budget, applicants may also be required to submit in their HEZ application a program-specific budget, if they request CHRC grant funding for innovative public health strategies. Applicants are required to provide the total grant funding amount requested for **each** participating partner organization that may receive CHRC grant funding and an accompanying line-item budget, by organization, showing precisely how each organization will utilize CHRC grant funding. Please refer to Appendix Item I for a sample line-item budget. In addition to the Grant Program Budget form, applicants must also provide an accompanying budget justification which details how each line item of grant funding will support the overall objectives of the HEZ. Funding amounts to partners should be appropriate to their responsibilities in the implementation of the HEZ programs and strategies. Applicants are expected at the time of the application to indicate in their application which organizations are committed to partnering in the implementation of the program's strategies by providing either an executed Memorandum of Understanding or Letter of Commitment.

Depending on the distribution mechanism agreed upon by the HEZ Coordinating Organization and CHRC, grant funding and certain incentives will be made directly by the CHRC to the partnering organization or providers who will be implementing the program and/or receiving the benefit. Coalition organizations and providers receiving funding under the HEZ program are expected to work with the CHRC and Coordinating Organizations to ensure all HEZ program reporting and evaluation guidelines are followed.

Incentives and benefits must be used for the purposes indicated in the HEZ Call for Proposals. As required in previous CHRC Call for Proposals, grant funds for innovative public health strategies may be used for program staff salaries and fringe benefits, consultant fees, data collection and analysis, in-state program-related travel, conference calls and meetings, and office supplies and expenses. Indirect costs are limited to 10% of the total grant funds requested (not 10% of the overall HEZ budget). If the services in an application will be delivered by a contractor agency or sub-grantee, and not directly by the applicant, the applicant may not take a fee for passing through the funds to the contractor agency. Funding under the HEZ program may not be used to support clinical trials, for lobbying, or for political activity.

III. Review Principles

Applications will be evaluated by a Review Committee, which will be comprised of experts in the fields of public health, health disparities, chronic diseases, social determinants of health and program management, and economic development. Individuals volunteering on the Review Committee may not be involved in any of the HEZ applications. The Review Committee will be asked to review and score each application on the following 13 review criteria:

1. Purpose. The application addresses the core statutory goals of the HEZ Initiative of reducing health disparities, including racial/ethnic and geographic health disparities, in Maryland.

2. Description of need. The application demonstrates the health and health services needs of the proposed HEZ resident population. The application demonstrates that the needs of the community exceed existing health resources and that the community's health and socio-economic outcomes are worse than/below the State's average and/or comparable communities. Applicants are permitted to draw on the data submitted in the Letter of Interest (the economic disadvantage or poor health outcomes) for threshold eligibility consideration or draw on other data metrics or factors demonstrating the need of the proposed Zone.

3. Core disease targets and conditions. The application identifies at least one or more specific diseases and/or conditions for improvement, and the data provided in the description of need supports the targeted disease(s) and/or conditions(s).

4. Goals. The applicant provides goals for health improvement by January 2016 in the HEZ that are achievable and measurable. The goals reflect the disparities being addressed (in terms of racial, ethnic and/or geographic) and reflect each of the following areas:
   a. Improved risk factor prevalence or health outcomes (Maryland State Health Improvement Process or Local Health Improvement Coalition measures, or others);
   b. Expanded primary care workforce ;

c. Increased community health workforce (including public health and outreach workers);
d. Increased community resources for health (housing, built environment, food access, etc.);
e. Reduced preventable emergency department visits and hospitalizations; and
f. Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

5. Strategies. The strategies and interventions proposed in the application have a high degree of achieving success or achieving the goals stated in the application.

6. Cultural, linguistic and health literacy competence. The application explains how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers and issues of low health literacy in the target population. The application describes the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

7. Balance. The proposed strategies are balanced between community-based approaches and primary care provider-based incentives. The strategies combine grants for public health and community services with the provider credits and incentives to expand health care capacity/services.

8. Contributions from local partners. Explicit financial or in-kind contributions from local partners and stakeholders are part of the strategic resource mix in order to amplify the impact of the State-provided pilot funding and incentives.

9. Coalition. The application demonstrates that the coalition includes a diverse array of health and community partners, with specific roles and historical experience working in the HEZ. A potential coalition could be led by the Coordinating Organization (the entity submitting the HEZ application and ultimately responsible for reporting requirements and Zone performance) and be comprised of participating partners that are delivering services in the Zone and community advisory groups involved in assisting overall implementation of the activities in the Zone. The application demonstrates inclusion of members of the target populations and minority groups in planning and ongoing oversight of the program. The application describes the coalition team members and participating partners and what assets, experience, knowledge, etc., are brought to the HEZ. There should be a clear governance structure of the coalition with a point of accountability for the Coordinating Organization and each key coalition member. There should be an advisory and oversight entity composed primarily of community members or residents of the designated Zone to provide advice and input to the coalition and the Coordinating Organization. This advisory/oversight entity should reflect experience in serving minority communities or populations.

10. Work-plan. The application provides a detailed work-plan that provides a clear understanding of how the program will be implemented over a four-year period and includes a detailed list of program activities, measurable outcomes, timelines, responsible entities and other logistics that enable tracking of effort; describes roles of the listed partners; includes interim milestones and deliverables; and supports appropriate data collection and reporting. See Appendix E for a sample work-plan.

11. Program management and guidance. The application provides a plan for quarterly reporting to the CHRC regarding progress and challenges regarding implementation of the HEZ work-plan and interim values for the evaluation metrics. The application includes a plan of quarterly reporting that meets the criteria in this Call for Proposal (see section V. Evaluation and Implementation, page 18) and that make sense given the core disease targets and conditions of the HEZ as well as the goals of the HEZ.

12. Sustainability. The application provides a feasible short-term and long-term sustainability strategy and acquisition of resources beyond state funding. Explicit financial or in-kind contributions from local partners and stakeholders should be part of the strategic resource mix and can be described here either as pledges or potential contributions to be pursued by the Coordinating Organization. Investments from insurers who stand to gain from cost savings in the HEZ are a potential component of a sustainability plan.

13. Internal evaluation and progress monitoring. The application provides a draft internal evaluation plan which tracks its progress in meeting each of the goals within the HEZ. The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to allow assessment of the deployment of the interventions in the work-plan.

A Review Committee will evaluate applications on these review principles and will provide the CHRC with recommendations for selected organizations to present their applications before the full Community Health Resources Commission. Applicants not invited to present will be notified that they are not eligible to receive HEZ designation in this Call for Proposal opportunity. Recommendations by the CHRC to the Secretary will be based upon the recommendations of the Review Committee and presentations before the Commission. The Secretary will issue final HEZ designation awards in late December, 2012.

IV. Submitting an Application for Health Enterprise Zone Designation

The HEZ designation application has three steps:
Step 1: Submit a Letter of Interest, due no later than October 19, 2012, 5:00 p.m.
Step 2: Submit full Application, due no later than November 13, 2012, 12:00 p.m.
Step 3: Present Applications before the CHRC, December 11 (invited applicants only)

Step 1: Letter of Interest
The Letter of Interest should include the following items:
1. Name of the applicant organization (the Coordinating Organization);
2. Name, title, address, telephone number, and e-mail for the Chief Executive Officer and the proposed program director (if different) of the Coordinating Organization;
3. Documentation that shows the Coordinating Organization is either a community-based non-profit organization or local government entity;
4. Name of organizations partnering in the coalition;
5. A description of the location/geographic area of the proposed Health Enterprise Zone (i.e., community/neighborhood names); and

6. HEZ Eligibility Worksheet (Appendix Item A).

Letters of Interest are due to the CHRC no later than 5:00 p.m., October 19, 2012, but will be accepted and reviewed on a **rolling basis**. Applicants are encouraged to submit the Letter of Interest as soon as it is ready, and not wait until October 19. Letters of Interest should be submitted as a PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Letter of Interest, Date.

The CHRC will review the Letters of Interest and Eligibility Worksheets (see Appendix Item A) as soon as is possible, certify each applicant's eligibility, and contact eligible applicants to submit the full application, hopefully within 48 hours of submission of LOI. Once eligibility is certified and applicants are notified, LOIs will be posted on the HEZ website.

Only applicants whose proposed HEZ meets the eligibility criteria (see page 4) will be invited to proceed in submitting a full application (Step 2). CHRC staff will review the Letters of Interest, certify applicants' eligibility, and will invite eligible applicants to submit a formal application for HEZ designation. The CHRC will notify applicants of their eligibility as soon as is possible, hopefully within a 48-hour period of submission of the Letter of Interest.

Step 2: Submission of Applications

Following are guidelines and the requested structure of the HEZ application. The overall length of the HEZ application should be no more than 25 pages and will contain Standard Forms located in the Appendices of this Call for Proposals and narrative written sections. The HEZ application should be structured using these topic headings and forms, in the following order:

Topic Heading and Forms	Narrative versus Standard Form	Included in Page Limit
Table of Contents	Narrative	Not included
1. Grant Application Cover Sheet	Standard Form – CFP Appendix Item B	Not included
2. Contractual Obligations, Assurances, and Certifications	Standard Form – CFP Appendix Item C	Not included
3. Program Summary	Narrative	Included
4. Program Purpose	Narrative	Included
5. HEZ Geographic Description (HEZ map)	Narrative	Included (map not included)
6. Community Needs Assessment	Narrative	Included
7. Core Disease(s) and Condition(s) Targeted	Narrative	Included
8. Goals	Narrative	Included
9. Strategy to Address Health Disparities	Narrative	Included
10. Use of Incentives and Benefits	Narrative	Included

11. Cultural, linguistic and health literacy competency	Narrative	Included
12. Applicant Organization and Key Personnel	Narrative	Included
13. Coalition Organizations and Governance	Narrative	Included
14. Work-plan	Standard Form – CFP Appendix Items D and E	Not included
15. Evaluation Plan	Narrative	Included
16. Sustainability Plan	Narrative	Included
17. Program Budget and Justification	Standard Form – CFP Appendix Items F - I	Not included
18. Financial Audit		Not included
Appendices		Not included

The suggested content of each of these sections is provided below. Appendices should be limited to only the material necessary to support the application.

1. Grant Application Cover Sheet: The form should be completed and signed by the program director(s) and either the chief executive officer or the individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on behalf of the applicant organization. This form is attached as Appendix Item B and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

2. Contractual Obligations, Assurances, and Certifications**:** The agreement should be completed and signed by either the Chief Executive Officer or the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant organization. This document is attached as Appendix Item C and also can be accessed at the Maryland Community Health Resources website (http://dhmh.maryland.gov/mchrc/ - click on "Forms" on the left hand side menu) and the DHMH HEZ website (http://dhmh.maryland.gov/healthenterprisezones/).

3. Program Summary: The program summary is a concise, one-page overview of the proposed HEZ community(ies), the community needs, and the overall strategies that will be implemented to achieve the HEZ program's goals.

4. Program Purpose: The application should describe how the activities in the application will address the core goals of HEZ Initiative.

5. HEZ Geographic Description: The application should provide a brief description of the geographic location of the proposed HEZ, including the zip code(s) or sub-zip code geographic units that will be part of the HEZ. Applications should provide names of the community(ies) or

neighborhood(s) that are participating as part of the HEZ and any other relevant details that help to describe the physical location of the proposed HEZ. Applications should include a map of the proposed HEZ area that delineates the geographic units that are the boundaries of the zone (i.e., zip code, Census Tracts, etc). This can be the same map provided as part of the Letter of Interest.

6. Community Needs Assessment: The application should describe the health and health service needs of the population in the proposed HEZ. Examples of metrics to describe community need include (but are not limited to) indicators of health status, risk factor prevalence, health insurance status, primary care access, Medically Underserved Area or Medically Underserved Population designations, and other needs that impact the health of the community. This data should be presented, where possible, by racial groups and by Hispanic ethnicity. The application should also discuss other socio-economic factors that contribute to poor health in the community, such as data regarding education, employment, income, housing, physical environment, and other community factors that impact health.

7. Core Disease Targets and Conditions. Based upon the community need, the application should identify specific disease(s) and/or condition(s) that will be targeted for improvement. Applications are encouraged to target at least one of the following conditions identified by the Health Disparities Workgroup of the Maryland Health Quality and Cost Council: cardiovascular disease, diabetes, and asthma. Applications may address other major conditions where the community experiences poor health outcomes, such as behavioral health, dental health, birth outcomes, or related co-morbid conditions.

8. Goals: The application should propose ***measurable*** goals for health improvement in the HEZ by January 2016. The goals should reflect the disparities being addressed. Each goal should be included in the work-plan (see item 16, page 17). Goals should cover each of the following areas:

- Improved risk factor prevalence or health outcomes (e.g., SHIP or LHIP measures, or others);
- Expanded primary care workforce;
- Increased community health workforce (including public health and outreach workers);
- Increased community resources for health (e.g., housing, built environment, food access, etc.);
- Reduced preventable emergency department visits and hospitalizations; and
- Reduced unnecessary costs in health care (costs that would not have accrued if preventive services and adequate primary care had been provided).

9. Strategies. The application should provide a clear description of each strategy, including the key programmatic components, implementation steps, and partnering organizations who will assist in the implementation of the proposed strategy. The application should reference the key action steps included in the work-plan (see item 16, page 17). The evidence and rationale for each of the strategies and interventions should be presented. Examples of potential strategies could include:

- A strategy to increase provider capacity by a specified percentage;
- A strategy to improve the quality of service delivery as indicated by HEDIS measures;
- A strategy to address community barriers to healthy lifestyles;
- A strategy to improve health outcomes through the use of community health workers;

- A plan to strengthen community and environmental policies to support good health in schools, day care, recreation centers, senior centers, and workplaces;
- A strategy to provide better access to healthy foods or facilities for physical activities;
- A strategy to engage underserved racial and ethnic minority persons in the Health Enterprise Zone;
- A strategy to improve the built environment in an HEZ, including improvements intended to increase access to recreation, healthy food, and quality housing;
- A strategy to integrate behavioral health care into existing primary care practices in an HEZ;
- A strategy to improve health information technology tools for providers in an HEZ; and
- A strategy to enhance provider capacity to serve non-English speakers in an HEZ.

Applicants are encouraged where possible to adopt strategies that are evidence-based, generally accepted as promising practices, or new/innovative ideas. Applicants are encouraged to bring health information technology (electronic medical records and health information exchange) and the patient-centered medical home model to their strategic approaches.

10. Use of Incentives and Benefits. The applications should describe which incentives and benefits will be utilized as part of its strategies. The proposed strategies should be balanced between community-based approaches and provider-based incentives, and it should combine grants for public health and community services with the provider credits and incentives that are available to HEZs. The application must include a proposal to use funding available under this Initiative to provide for loan repayment incentives to induce health enterprise zone practitioners to practice in the HEZ.

11. Cultural, linguistic and health literacy competency. The application should explain how the strategies will be implemented in a culturally competent manner and designed to be accessible to the target population. This includes addressing translation and interpretation issues for non-English speakers, and issues of low health literacy in the target population. The application should describe the efforts that will be undertaken to recruit a racially, ethnically, and linguistically diverse workforce for the HEZ.

12. Applicant Organization and Key Personnel: The application should provide a description of the Coordinating Organization (applicant organization) and the organization's capacity to implement and lead the HEZ program. This can include any relevant experience in leading a coalition of organizations, community-based work, and implementation of multi-year programs. The application should identify the program director and describe his/her role within the Coordinating Organization, qualifications to lead the program, and responsibilities in carrying out the program. The application should also identify other essential staff, their roles in the program, and their relevant qualifications. Résumés for all key personnel should be included as appendices, and do not count as part of the overall page limit of the application. The application should describe any positions for which the organization that will need to hire new/additional staff.

13. Coalition Governance and Participating Partners: The application should provide a list of all HEZ coalition members (this list may be included as an appendix item if needed [not included in

the overall page limit]). The application should describe the coalition team members and what assets, experience, knowledge, etc. each brings to the proposed HEZ. The application should also describe the roles and responsibilities (if any) of coalition members in the implementation of any of the proposed strategies and intervention. The application should describe the governance structure that will be used by the Coordinating Organization, which provides a point of accountability for each core coalition member and participating partner. The application should describe plans to include members of the target populations and minority groups in planning and ongoing oversight of the program.

14. Work-Plan (Chart): The application should include a work-plan for implementing the HEZ program across each goal and strategies. The work-plan is a comprehensive program management tool for HEZ performance (see Appendix E for a sample chart) that describes the key strategies, activities, and evaluation measures and links these with the overall goals of the HEZ. The work-plan should provide a "step-by-step" understanding of the key actions, the timing to implement these actions, and who (which participating partners or personnel) is responsible for implementing these actions. In addition, the work-plan will describe the time-specific milestones or deliverables that will be used to evaluate the success of the activities in the HEZ. The work-plan should be in a chart format which provides a clear understanding of how the program's goals will be achieved over the four-year program duration and should include the following components:

a. Goals;
b. Objectives;
c. Key program activities/action steps;
d. Data evaluation and measurement;
e. Responsible organization/entity; and
f. Timeline for implementation.

Some information presented in the other parts of the application, such as goals, specific strategies, activities, and the evaluation plan, will be repeated in the work-plan. A template (blank) work-plan chart and sample work-plan are included in this Call for Proposals (see Appendix Items D and E).

15. Evaluation Plan: The evaluation plan should include implementation and process metrics and performance measures with time-specific milestones and targets to assess the deployment of the interventions and strategies in the work-plan. Whereas the work-plan is in chart format (see Appendix D), the evaluation plan is in narrative (written prose) form. The primary purpose of the evaluation plan is to describe how the Coordinating Organization will measure the implementation and success of the proposed strategies on an ongoing basis to achieve the goals of the HEZ and report this information to the CHRC on a regular basis. This evaluation plan should include the specific activities/methods the Coordinating Organization (and sub-grantees/participating partners, where applicable) will undertake to capture needed information (e.g., health outcome data) and how the Coordinating Organization will evaluate the success of the activities within the HEZ on a regular basis. The evaluation plan should also include the health outcome metrics that will be tracked/reported to demonstrate that the HEZ is achieving its health improvement goals. Time-specific milestones for the health outcome metrics should be included. Methods for collecting the health outcome data within the HEZ or assembling data from external sources should be discussed. The metrics of reach (deployment) and impact

(health outcomes) should be analyzed in categories of race and ethnicity to assess the impact on minority health and health disparities.

In addition, the internal evaluation plan should describe how the Coordinating Organization plans to monitor the activities and progress of sub-grantees/participating partners in the implementation of specific program activities. This could include any information/data the Coordinating Organization will require from sub-grantees, how sub-grantees will be held accountable for program achievement, and how this information will be reported to the CHRC. The information gathered by the Coordinating Organization should be linked to specific milestones, data measures, and/or other metrics that evaluate the progress on key activities, objectives, and program goals. Applications should reference the data and evaluation measures included in the Work-Plan (see item 16, page 17).

Applications should show a budgeted line-item between 5% and 10% of the overall HEZ global budget for data collection and evaluation efforts. If the applicant organization plans to utilize external organizations or other tools/resources to assist to evaluation of the program, this should be described here (e.g., hiring an external organization to administer a survey or group interviews, purchasing software to capture particular data).

16. Sustainability: The application should describe a plan for sustainability and acquisition of resources beyond State funding, including partnership with entities in the health care system that have the financial incentive for better outcomes. The application should include a specific plan for developing and implementing a short-term and long-term sustainability strategy.

17. Program Budget and Justification (Standard form): The HEZ funding request should be between $500,000 to $2 million per year for the duration of the four-year program. All applicants must complete the Global Budget Form which provides the annual and total budget request by program benefit and incentive requested (see Appendix Item F for a template (blank) global budget form and Appendix Item G for a sample global budget form).

Applicants requesting CHRC grant funding for innovative health programs may also be required to complete a separate Grant Program Budget Form, which is a line-item budget for each organization that will be partnering in the implementation of the public health grant program (see Appendix Item H for a template (blank) organization program budget form and Appendix Item I for a sample organization program budget). For example, if the application requests CHRC grant support for the salaries of five community health workers to be hired by a participating partner, then the Line-Item Grant Budget Form is required in addition to the Global Budget.

The budget justification should detail what is included in each line-item and describe how each item will support the achievement of the program's goals and objectives. Funding levels to implementing organizations should be appropriate to their roles and responsibilities in the work-plan.

18. Financial Audits: Non-profit Coordinating Organizations must submit a copy of their most recent financial audit of the organization. As in previous CHRC Call for Proposals, financial audits are not required for local government entities.

Application Formatting
Applications should be approximately 20 to 25 pages single-spaced on standard 8 ½" x 11" paper with one-inch margins and using 12-point Times New Roman or Arial font. Tables and charts may use a 10-point font or larger. Please number pages. The hard copy of the application documents should be bound with prong report fasteners or clips. Please do not use spiral binding or three ring binders.

Applications are due to the CHRC no later than 12:00 p.m., November 13, 2012 by email **and** hand delivery, U.S. Postal Service, or private courier.

Electronic versions of applications should be submitted in one PDF or Word Document attachment, sent via email to dhmh.hez@maryland.gov. Please save file attachments using the following format: Organization Name, HEZ Proposal, Date.

In addition to electronic application submission, the following must be received by November 13, 2012, 12:00 p.m. to be considered a complete application package:

(1) One original application, labeled "original"; and

(2) Eight bound copies of the application.

Send hard copies of applications to:

Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Step 3: Presentation before the CHRC (invited applicants only)
A selected number of applicants will be invited to present their proposal at a Community Health Resources Commission meeting. This meeting will be held on December 11, Additional information regarding time and location of this meeting will be forthcoming. Invited applicants will be provided presentation instructions upon notification of invitation to present.

V. Program Evaluation and Implementation

The CHRC implements a robust system of grantee performance management that holds grantees accountable for performance and is designed to ensure that finite grant resources are utilized wisely and efficiently. The CHRC will work with each HEZ Coordinating Organization and its participating partners to develop standard and customized performance measures that will be reported by the grantees on a quarterly basis. These performance measures will reflect the four-year duration of the program and will be a combination of interim and longer-term measures.

Internal Evaluation
At the beginning of the grant period (January 2013), CHRC staff and the HEZ Coordinating Organization will meet to finalize the internal evaluation plans, which will be developed from the work-plan and proposed internal evaluation plan submitted in the original HEZ application. As part of this internal evaluation, HEZ Coordinating Organizations will be required to submit the following three deliverables on a quarterly basis. CHRC staff will make sample reports available to HEZ Coordinating Organizations after HEZ designations are made.

1. **Milestone & Deliverable Report (M&D)**. Quantitative report (excel file) which reports on a core set of common measures for all HEZ programs and specific measures that are unique to each HEZ program. These measures will be developed from the work-plan and proposed evaluation measures provided in the HEZ application. Grantees will be expected to provide baseline data/projections on evaluation measures and subsequent data will be compared to baseline data/projected outcomes;

2. **Narrative reports**. Qualitative report (word document) summarizing the status of implementation of key strategies of the HEZ proposal. The narrative reports should be based on the key time-specific milestones and deliverables in the M&D report (above), and the work-plan and proposed evaluation plan that were provided in the HEZ application. These reports provide details about each grant program including any major events or activities that took place as part of the implementation; any problems or barriers encountered during the reporting period and how these barriers were resolved or will be addressed; and details about why the grantee has not achieved program goals to date. Any successes or unexpected outcomes from the program activities should be highlighted in the narrative report; and

3. **Expenditure reports.** A line-item budget detail (excel file) showing exactly how HEZ resources were expended and utilized. Activities or expenditures by participating partners should be included. Recipients of HEZ funds are expected to retain all documentation of the use of grant funds and provide these to the CHRC upon request.

HEZ grantees will provide these reports throughout the program's four-year duration. Compliance will be required as a condition of receipt of funding in years two, three, and four of the program.

External Evaluation
Under the Maryland Health Improvement and Disparities Reduction Act, the CHRC and DHMH are required to submit an annual report to the Maryland General Assembly and Governor documenting the impact of the activities in the Health Enterprise Zones. To fulfill this reporting requirement, the CHRC will solicit proposals to contract with an outside entity to perform an independent, external evaluation of the program. This evaluator will not only analyze the periodic reports submitted by the HEZ Coordinating Organizations, but will also perform additional data collection and analysis to assess the impact of the activities of the HEZs on the outcomes specified in the Act and the proposals. The external evaluation activities will be coordinated and funded through the CHRC and DHMH, and, as such, do not need to be included as part of budget requests submitted by HEZ Coordinating Organizations. As a condition of receiving HEZ grant funds, however, HEZ grantees will be required to participate in this external evaluation. This may include the Coordinating Organization and participating partners assisting

with any data collection and information gathering required, such as participation in surveys, focus groups, site visits, meetings, and key informant interviews with the evaluators.

Program Implementation and Benefits Distribution

The HEZ program period will begin in January 2013, and reporting requirements will be organized around a calendar year. Once HEZ designations are made by the Secretary, CHRC staff and HEZ Coordinating Organizations will develop and finalize program budgets, internal evaluation plans, and periodic reports submitted to the CHRC. Once these documents are finalized, it is expected that the Coordinating Organization and partnering entities will begin implementing the HEZ strategies immediately. In addition, the HEZ Coordinating Organization and CHRC will determine the mechanics of distributing incentives or benefits. In some cases, the Coordinating Organization will receive funds from the CHRC to distribute the benefits to participating partners, and in other cases, the CHRC will distribute benefits directly to the individual participating partners.

Providers and practices who wish to receive benefits and incentives in the HEZ strategies (income and hiring tax credits, loan repayment assistance, EHR, capital and equipment funding) must apply to the Coordinating Organization. Within six months of designation (July 2013), the Coordinating Organization must evaluate the applications of providers and practices, certify their eligibility, and provide the CHRC with the specific/actual providers and practices that will receive the benefits and incentives budgeted for year one of the program. The CHRC and DHMH will distribute funding and incentives directly to each provider/practice.

Grant Modifications

HEZ Coordinating Organizations are permitted to request changes to their approved HEZ proposal/programs by submitting a formal Grant Modification Form (see Appendix Item H), and when required, an updated Global or Program Budget to the CHRC. Grantees may be asked to present their grant modification request before the CHRC.

VI. Inquiries and Other Information

Conference Call for Applicants

The program office will host a conference call for interested applicants to provide information on the HEZ program and assistance with the application process. This conference call, on **October 11, 2:30 p.m.,** is ***optional***. This call will be available on a first come, first serve basis. Multiple participants from the same organization are encouraged to use one phone line when calling into the conference call. The call in information is:

Dial-In Number: (866) 233-3852
Participant Access Code: 267478

Questions from Applicants

Applicants may also submit written questions at any time to dhmh.hez@maryland.gov.

COMMUNITY HEALTH RESOURCES COMMISSION
2012 Commissioners

John A. Hurson, Chairman
Nelson Sabatini, Vice Chairman
Dr. Charlene Dukes
Maria Harris-Tildon
Kendall D. Hunter
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Dr. Mark Li
Paula McLellan
Margaret Murray, M.P.A.

CHRC Staff and Contact Information

The Maryland Community Health Resources Commission is located at:

45 Calvert Street, Room 336
Annapolis, MD 21401
Fax: 410-626-0304
Website: http://dhmh.maryland.gov/mchrc/

CHRC Staff

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MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
Health Enterprise Zone Applications
Applicant
Allegany County Health Department
Anne Arundel Medical Center
Asian American Center of Frederick/ L.I.F.E. & Discovery, Inc.
Baltimore County Department of Health
Bon Secours Baltimore Health System
Calvert Memorial Hospital
Care for your Health
Cecil County Health Department
Charles County Department of Health
Dorchester County Health Department
GOSPEL/Allen Chapel AME
Laurel Regional Hospital/Dimensions Healthcare System
Lower Shore Clinic
MedChi - Chestertown
Primary Care Coalition of Montgomery County
Prince George's County Health Department
Sisters Together And Reaching - East Baltimore HEZ Collaborative
Somerset County Health Department
St. Mary's Hospital of St. Mary's County