



AUG 15 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



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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.

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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**.

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#### 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.



Joshua M. Sharfstein, M.D.  
Secretary

Sincerely,



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.

<b>HEZ Eligibility Criteria</b>	<b>Rationale</b>	<b>Data Source</b>
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@dnhm.state.md.us](mailto:hez@dnhm.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 10<sup>th</sup> 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.