



STATE OF MARYLAND

Community Health Resources Commission

201 W. Preston Street, Room 424 • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Dr. Samuel Lin, Chair

The Maryland Community Health Resources Commission

2006 Annual Report

October 13, 2006

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The Maryland Community Health Resources Commission 2006 Annual Report

On May 10, 2005, the Governor of Maryland, Robert L. Ehrlich, Jr., signed into law the *Community Health Care Access and Safety Net Act of 2005*. This legislation authorized the creation of the Maryland Community Health Resources Commission (the Commission). Through grants, community assessments, and technical assistance, the Commission will work to increase access to care for low-income families and under- and uninsured individuals in Maryland. The Commission will help communities develop more coordinated, integrated systems of community-based care, redirect non-emergency care from hospital emergency rooms to other providers in the community, and assist individuals in establishing a medical home. The cornerstone of these efforts will be “community health resources” that will be eligible to apply for and receive grants from the Commission.

While the Commission was authorized in May 2005, appointments were not confirmed until January 10, 2006.¹ The first formal meeting of the Commission was convened on March 6, 2006. Hence, this first annual report reflects seven months of active work by the Commission. During this short time, the Commission has made significant progress toward fulfilling its charge. This report highlights the strategies pursued by the Commission thus far.

Early in their deliberations, the commissioners came to consensus that the Commission’s top priority should be to take actions to allow the Commission to distribute grant funds to community health resources in accordance with its charge from the legislature. The Commission recognizes that its core task is to provide community health resources with financial support so these organizations may undertake activities that will improve the health care delivery system for Marylanders. Toward this end, the Commission has concentrated its efforts in the three areas discussed below.

Developing an Understanding of Maryland Health Issues. The Commission has made significant efforts to obtain information and input regarding Maryland’s health care needs from individuals and organizations throughout the state. During its first meeting the Commission

¹ See Appendix D for a list of commissioners.

invited several organizations to discuss their role in Maryland's health care safety net and to offer suggestions for grant programs. In addition, on June 16, 2006, the Commission convened a full-day policy retreat. The retreat began with remarks from S. Anthony McCann, Secretary of the Maryland Department of Health and Mental Hygiene, and included presentations that addressed a range of topics including the uninsured, health disparities, substance abuse, mental health, and rural health services. The question of how the funding it controls can be best leveraged to improve health services in Maryland is one the Commission has wrestled with since its inception.²

Establishing a Process for Awarding Grants. The Commission has developed a process for awarding grants that it will use for the grant cycle currently underway as well as for future cycles. During its first year of operation, the Commission plans to make two rounds of grant awards. The first grants, totaling \$3.5 million, will be directed to community health resources to increase access to care for low-income families and under- and uninsured individuals. The second round of grants, will build on experience gained during the first grant cycle and will address the Commission's legislative mandate to promote the creation of a unified data information system for community health resources.

In working to establish a grants program, the Commission released a Call for Proposals for its first round of grants and prepared regulations as directed by the legislation authorizing the Commission:

Call for Proposals: The Commission prepared a Call for Proposals for its first round of grants entitled *Aligning Community Health Resources: Improving Access to Care for Marylanders*.³ On August 11, 2006, the Commission released and distributed the Call for Proposals in draft form to over 300 interested parties. The draft was disseminated to allow prospective applicants ample time to come together, explore ideas, and develop quality proposals. On October 4, 2006 the Commission released the final version of the Call for Proposals pending regulation approval from the legislature's Administrative,

² See the Appendix for agendas and presentations from the Commission's retreat and other meetings.

³ The Call for Proposals can be found in Appendix E.

Executive and Legislative Review Committee (AELR). This final version included revisions to ensure consistency with the regulations submitted by the Commission to the AELR as discussed below.

Organizations throughout the state have enthusiastically responded to the Call for Proposals. By September 20, 2006 more than 70 prospective applicants had submitted letters of intent. Proposals are due to the Commission by October 20, 2006.

Regulations: The legislation directs Commission to develop the regulations under which it will operate. Regulations drafting was conducted coincident with the development of the Call for Proposals. The Commission distributed draft regulations to interested parties on September 8, 2006, with a request for comments by September 13, 2006. While this was not a formal comment period, it provided interested parties who have followed the Commission's deliberations an opportunity to provide input on the proposed regulations prior to their submission to AELR. On September 15, 2006, the Commission's ad hoc regulations committee met to review the comments and recommend final regulations to the full Commission. The comments received led to useful adjustments to the initial regulations. Following distribution of revised regulations, the full Commission held a public meeting via conference call on Monday, September 25, 2006. During that call, the Commission made final adjustments to the regulations and submitted them to AELR for approval on September 26.⁴ In keeping with the Commission's desire to move quickly, the regulations were submitted as "emergency." The approval of regulations is a key hurdle for the Commission, as approved regulations are a pre-condition for reviewing grant applications. The Commission hopes to receive AELR approval by late October 2006.

Executive Director Search. A lack of dedicated staff has been a challenge for the Commission since it began operating in spring 2006. The Maryland Department of Health and Mental Hygiene provided some staff support, and the Commission contracted for additional staff support from the Center for Health Program Development and Management at the University of

⁴ The regulations submitted to the AELR Committee are attached as Appendix C.

Maryland, Baltimore County. The Commission has made significant progress with these arrangements. However, the Commission sees the hiring of a dedicated, full-time staff as a priority. Toward this end, the Commission is actively engaged in recruiting and hiring an executive director. The Department of Health and Mental Hygiene's Office of Recruitment posted the position and received over 100 applications by the September 18, 2006 recruitment closing. Once the Office of Recruitment completes its initial review of applications, the Commission's ad hoc personnel committee will select applicants to interview. The Commission hopes to conduct interviews and select an executive director as soon as is practicable. Once the Executive Director is on board the Commission anticipates filling the other permanent staff positions.

Next Steps. The next several months will continue to be busy ones for the Commission. Some of the key milestones are:

October 20, 2006: Grant proposals are due in response to the Commission's Call for Proposals, *Aligning Community Health Resources: Improving Access to Care for Marylanders*.

November 2006: The Commission's Committee on Operational and Capital Funding will review proposals and recommend finalists to the full Commission. This timetable assumes approval of the Commission's regulations in late October.

December 2006-January 2007: The Commission will select proposals for funding and announce awards. As part of the selection process, the Commission may request that grantees modify their proposals and/or budgets prior to final approval of a grant.

February 2007: The Commission will begin distributing grant funds to successful applicants.

The past year has been an active learning experience for the Maryland Community Health Resources Commission. The Commission has made rapid and significant progress toward

fulfilling the charge of the legislation that authorized its creation. The Commission looks forward to continued progress in the coming years.

Appendix A

Meeting Minutes

**2nd MEETING OF THE
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION**

**April 3, 2006
Harper's Choice Community Center – Kahler Hall
5440 Old Tucker Row
Columbia, Maryland 21044**

Chairman Samuel Lin called the meeting to order at 3:33 PM. Commissioners Yvette J. Benjamin, Jude L. Boyer-Patrick, Alice Burton, Jorge E. Calderon, Kendall D. Hunter, Donald C. Roane, Karla R. Roskos, and Joseph P. Ross were also present. Commissioners John A. Hurson and Leon Kaplan were absent.

CHAIRMAN LIN'S COMMENTS

Chairman Lin announced an agenda change to allow Robyn Elliott, Director, DHMH Governmental Affairs to present a legislative update, then to proceed with the planned agenda.

LEGISLATIVE UPDATE

Robyn Elliott, Director, DHMH Governmental Affairs presented an update on the current Maryland General Assembly Session. Ms. Elliott noted that the Commission's FY 2007 budget is intact, including funding for staff positions. Ms. Elliott reported that House Bill 1118 will likely pass the General Assembly. This bill adds substance abuse to the areas for which the Commission can award grants. Legislation is pending to add \$7 Million for health care for legal immigrants. If these bills don't pass, the Commission may be asked to make these issues a priority for awarding grants.

MARCH 6, 2006 MEETING MINUTES

Commissioner Karla Roskos made and Commissioner Kendall Hunter seconded a motion to approve the March 6, 2006 meeting minutes. The motion passed by voice vote of the Commissioners.

BACKGROUND ON THE UNINSURED

Dr. Lin announced that the scheduled presentations: The Uninsured in Maryland (Findings from the HRSA State Planning Grant project), by Linda Bartnyska, Chief, Cost and Quality Analysis, Maryland Health Care Commission and Coverage and Access Programs for Uninsured Marylanders under 200% Federal Poverty Level by Stacey Davis, Office of Planning and Finance, Maryland Medicaid, DHMH would be deferred to a future date.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

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PUBLIC COMMENTS

These individuals presented comments on the definition of a “Community Health Resource”: Sandi Rowland, Allegany Health Right; Pegeen Townsend, Maryland Hospital Association, Salliann Alborn, Community Health Integrated Partnership and Maryland Community Health System, Martha Nathanson, Lifebridge Health, Linda J. Gilligan, Johns Hopkins Community Physicians, Inc., Krupa Shinde, Health Education Resource Organization, Inc (HERO), and Lori Doyle, Community Behavioral Association of Maryland.

Discussion followed with Ms. Rowland, Townsend, Dr. Alborn, Ms. Nathanson, Ms. Gilligan Ms. Shinde, and Ms. Doyle answering questions about the nature of community health centers and resources.

COMMISSION ADMINISTRATIVE ISSUES

Chairman Lin led a discussion on Commission administrative issues and asked that each commissioner volunteer to serve on two of the standing committees: Capital and Operational Funding – Commissioner Karla Roskos; Hospital and Community Health Resources relations – Commissioner Joseph Ross; Scholl-based Community Health Clinic Center Expansion – Commissioner Yvette Benjamin; and Data Information systems – Commissioner Kendall Hunter. . Jason Sapsin, Esq., Counsel to the Commission and Grace Zaczek, Commission staff will draft an outline of what activities the authorizing legislation requires.

NEXT MEETING DATE

Chairman Lin stated that the next Commission meeting is scheduled for Monday, May 1, 2006 from 1:30 PM to 6:30 PM in Columbia, Maryland. At Kahler Hall.

ADJOURNMENT

Chairman Lin declaring there was no further business for the Commission at this meeting, asked for a motion to adjourn. Vice-Chairman Burton made a motion to adjourn the meeting, which Commissioner Calderon seconded. Chairman Lin declared the meeting adjourned at 6:26 PM.

**3rd MEETING OF THE
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION**

**May 1, 2006
Harper's Choice Community Center – Kahler Hall
5440 Old Tucker Row
Columbia, Maryland 21044**

Chairman Samuel Lin called the meeting to order at 2:11 PM. Commissioners Jude L. Boyer-Patrick, Alice Burton, Jorge E. Calderon, Kendall D. Hunter, John A. Hurson, Leon Kaplan, and Karla R. Roskos were also present. Commissioners Yvette J. Benjamin, Donald C. Roane, and Joseph P. Ross were absent.

CHAIRMAN LIN'S COMMENTS

Chairman Lin announced that the Commission is considering an agreement with the University of Maryland, Baltimore County's Center for Health Program Development and Management to provide staff for the Commission.

**UNIVERSITY of MARYLAND, BALTIMORE COUNTY COMMISSION STAFFING
PROPOSAL**

John O'Brien, Director, Acute Care Policy at UMBC's Center for Health Program Development and Management presented a \$136,927 proposal for staffing the Commission for six months. Discussion followed with Vice-Chairman Burton noting Grace Zaczek, Director for DHMH's Office of Rural Health and Primary Care Services will act as the Commission's proposal contract monitor until the Commission's full time executive director can be hired. Commissioner Roskos stated that UMBC will not supplant DHMH staff for the Commission, but augment DHMH staff.

During the discussion, Commissioner John Hurson stated that the contract does not include responsibility to search for an executive director, which remains a Commission responsibility. Vice-Chairman Burton suggested forming an Ad Hoc Committee to conduct the search. Commissioners Hurson, Hunter, Kaplan and Roskos volunteered to serve on the Ad Hoc Committee with Commissioner Hurson chairing the committee.

Commissioner Hurson made a motion to accept UMBC's proposal and to approve the agreement's budget. Commissioner Hunter seconded the motion and it passed on voice vote of the Commissioners present.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

May 1, 2006

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April 3, 2006 MEETING MINUTES

Commissioner Kendal Hunter made and Vice Chairman Alice Burton seconded a motion to approve the April 3, 2006 meeting minutes. The motion passed by voice vote of the Commissioners. Commissioner Kaplan abstained in the vote as he was absent for the April 3rd meeting.

LEGISLATIVE UPDATE

Robyn Elliott, Director, DHMH Governmental Affairs presented an update on the recently concluded Maryland General Assembly Session. Ms. Elliott reported that House Bill 1118, sponsored by Delegate Hammen passed the General Assembly. This bill adds substance abuse treatment to the areas for which the Commission can award grants. Ms. Elliott reported that the Commission's FY 2007 budget is \$8.2 Million, including \$1.7 Million for the unified data system. Vice-Chairman Burton noted that this means the Commission has \$10.2 Million as of July 1, 2006 with the unspent funds from FY 2006.

Chairman Lin reported that he had received a letter from Delegate Hammen asking that the Commission consider a study on how to provide tort claims coverage for clinicians serving the low-income and uninsured. Vice-Chairman Burton suggested making such a study a priority for the Commission.

PUBLIC COMMENTS

Duane Taylor, Chief Operating Officer for Mid-Atlantic Association of Community Health Centers made a presentation on "Ideas to Further Increase Community Health Access" and "Creative Opportunities" for funding and future Commission activities.

COMMISSION VISION AND MISSION

Grace Zaczek led a discussion with the Commissioners on Vision and Mission statements for the Commission.

DEFINING COMMUNITY HEALTH RESOURCES AND GRANT MAKING

Commissioner Karla Roskos presented material and led a discussion on defining a "Community Health Resource," and other criteria for entities eligible for funding from the Commission. John O'Brien participated with the Commissioners in the discussion. Mr. O'Brien provided a tentative timeline and comments on strategies for developing grant regulations and application process and awards.

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

May 1, 2006

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NEXT MEETING DATE

Chairman Lin stated that the next Commission meeting is scheduled for Monday, June 5, 2006 from 1:30 PM to 6:30 PM. The location will be determined and announced at a later date.

ADJOURNMENT

Chairman Lin declaring there was no further business for the Commission at this meeting, asked for a motion to adjourn. Vice-Chairman Burton made a motion to adjourn the meeting, which Commissioner Calderon seconded. Chairman Lin declared the meeting adjourned at 5:37 PM.

4th Meeting of The

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

June 5, 2006

**UMBC Technology Center- Viewing Gallery
1450 South Rolling Road
Baltimore, MD 21227**

Vice-Chairman Alice Burton called the meeting to order at 1:30 PM. Commissioners Yvette Benjamin, Jorge E. Calderon, Kendall D. Hunter, John A. Hurson, Leon Kaplan, Donald C. Roane, Karla Ruhe Roskos, and Joseph P. Ross were also present. Chairman Samuel Lin and Commissioner Jude L. Boyer-Patrick were absent.

EXECUTIVE SESSION

May 1, 2006 Meeting Minutes

Commissioners Roane and Ross reported that the May 1, 2006 meeting minutes needed to reflect their absence. Vice-Chairman Burton asked for a motion to approve the May 1, 2006 meeting minutes, as amended. Commissioner Calderon made and Commissioner Hunter seconded the motion to approve the minutes. The motion was passed by a voice vote of the Commissioners present.

UPDATES

Commissioner Hurson presented an update on the progress of the Ad-hoc Personnel Committee. He presented three recommendations from the Committee based on information received from the Maryland Department of Budget and Management regarding the potential salary, application, and hiring processes for the Executive Director of the Commission. The first recommendation was to use the Executive Service Aids pay scale level ES-7 for the salary of the Executive Director. The second recommendation was to use the personnel office of the Department of Health and Mental Hygiene to create the job description, draft the application, and advertise for the Executive Director position. The final recommendation was for the Ad-hoc Committee to review the job applications, conduct initial interviews, recommend three to five applicants for a full Commission interview, and to schedule the full Commission interviews. Then, the full Commission would make the final selection for the position. The Commission discussed these recommendations, and Commissioner Hurson made a motion to approve the recommendations. Seconded by Commissioner Hunter. The motion was passed through a voice vote of the Commissioners present.

John O'Brien discussed the agenda and location of the June 16 Maryland Community Health Resources Commission retreat. The retreat will be held in the ITE building at the University of Maryland, Baltimore County.

REVIEW OF THE COMMISSION'S VISION AND MISSION

Grace Zaczek led a discussion with the Commissioners to review the Vision and Mission statements of the Commission. The Commission discussed and made several changes to these statements. Vice-Chairman Burton asked for a motion to approve the Commission's

Vision and Mission. Commissioner Roane made the motion to approve and Commissioner Roskos seconded the motion. The Vision and Mission statements were adopted through a voice vote of the Commissioners present.

DISCUSSION

John O'Brien presented material and led the Commission in a discussion of the following:

- **Defining a Community Health Resource**

The Commission was provided with an overview of legislatively defined Community Health Resources and discussed other criteria for certification as a Community Health Resource. The Commission's consensus was to define primary care to allow a broad pool of applicants for grant awards. They also agreed on a broader acceptance of sliding fee scales.

- **Weighing Legislative and Commission Funding Priorities**

The Commission identified two overarching themes for consideration in the Legislative grant making priorities: mental health/substance abuse issues and the reduction of ER use. The Commission also discussed their own grant making priorities in the following areas: Medicaid participation, sustainability, and sliding fee scales.

- **Size and Duration of Grant Awards**

The Commission discussed issues regarding the size and duration of grant awards. Medium and mixed funding awards were mentioned as preferable to larger awards, and there was general agreement that funding should not extend past three years. Renewable funding options were also mentioned.

Robyn Elliot presented material on the Financial Projections for the Commission.

NEXT MEETING DATE

Vice-Chairman Alice Burton stated that the next Commission meeting is scheduled for Friday, June 16, 2006 from 8:30 AM to 3:30 PM.

ADJOURNMENT

Vice-Chairman Burton asked for a motion to adjourn the meeting. Commissioner Hunter made a motion to adjourn, which Commissioner Roskos seconded. Vice-Chairman Burton declared the meeting adjourned at 4:59 PM.

5th Meeting of The

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

July 10, 2006

UMBC Technology Center- Viewing Gallery

1450 South Rolling Road

Baltimore, MD 21227

Chairman Samuel Lin called the meeting to order at 1:35 PM. Vice-Chairman Alice Burton and Commissioners Yvette Benjamin, Kendall D. Hunter, Leon Kaplan, Karla Ruhe Roskos, and Joseph P. Ross were also present. Commissioners John A. Hurson, Jude L. Boyer-Patrick, and Donald C. Roane were absent. Commissioner Jorge E. Calderon was excused.

UNIFIED DATA INFORMATION SYSTEM PRESENTATIONS

The Commission was provided with informational presentations on Unified Data Information Systems from two organizations. In the first presentation, Rosemary Ferdinand, RN PhD and Kevin McCarter of *Deloitte Consulting LLP* presented the Commission with an overview of healthcare system inter-operability. The second presentation was given by Janet Marchibroda and Emily Welebob of the *eHealth Initiative*. This presentation provided the Commission with an overview of e-health trends at the national and state levels.

June 5, 2006 MEETING MINUTES

Chairman asked for a motion to approve the June 5, 2006 meeting minutes. Commissioner Roskos made and Commissioner Kaplan seconded the motion to approve the minutes. The motion was passed through a voice vote of the Commissioners present.

UPDATES

Commissioner Kaplan expressed concern about the Commission's progress in recruiting an executive director. Grace Zaczek reported that the Department of Health and Mental Hygiene's Human Resource Office provided the Ad Hoc Committee with sample job descriptions for the executive director position, and the Department has not received any further feedback or guidance to move forward from the Committee. There was agreement among the Commissioners present that the Executive Director recruitment is an urgent issue.

DISCUSSION

- **Grant Approval Process and Timeline**

John O'Brien presented material involving the grant approval process and a tentative timeline for awarding grants. He provided the Commission with a schematic diagram and an outline of the steps involved in grant approval. The Commission discussed this material, and made suggestions for elements to be included in the Letter of Intent. There was a consensus among the

Commissioners that determination of a grantee's eligibility as a Community Health Resource must be made by the full Commission. The Commission also asked John O'Brien to modify the timeline for awarding grants because an issue was raised by counsel about processing applications before regulations are finalized.

- **Sliding Fee Scales for Community Health Resources**

John O'Brien also presented information on sliding fee scales and asked the Commission to vote on the elements that will be required of grantees. After discussing this information, the Commission felt that the following elements must be included in a sliding fee scale: documentation of sliding fee policy, process of notifying patients of the policy, minimum provision of discounts to all patients below 200% of the Federal Poverty Level, nominal or no charges to all patients below 100% of the Federal Poverty Level, and language to ensure that discounts are all inclusive and no additional fees may be charged. A discounted or free service to all patients is an acceptable sliding fee scale. The Commission also felt that sliding fee regulations should be as general as possible. Commissioner Ross made and Commissioner Roskos seconded a motion to approve these sliding fee requirements for certification as a Community Health Resource. The motion was approved through a voice vote of the Commissioners present.

- **Grant Application Elements**

Cynthia Woodcock provided the Commission with an overview presentation of grant program announcements, grant application elements, and application scoring criteria. John O'Brien asked the Commission to decide on an indirect cost rate for grant application budgets. Vice-Chairman Burton made and Commissioner Ross seconded a motion to approve a 10% indirect cost rate on the condition that this percentage is acceptable to the State. The motion passed with a voice vote of the present Commissioners. The Commission also discussed and came to a consensus on general application scoring priorities

- **Size and Duration of Grant Awards**

John O'Brien made the following suggestions to the Commission regarding the size and duration of grant awards for the first round of funding: applicants may apply for single year grants of any amount up to \$100,000 or multi-year grants, not to exceed three years, for amounts between \$250,000 and \$500,000. There was a general acceptance of these suggestions among the Commissioners. The Commission also discussed the idea of providing more than one funding cycle per year. The Commission suggested that \$3.5 million in funding be awarded in the first cycle.

NEXT MEETING DATE

Chairman Lin announced that the next Commission meeting is scheduled for Monday, August 7, 2006.

ADJOURNMENT

Chairman Lin asked for a motion to adjourn the meeting. Commissioner Kaplan made a motion to adjourn, which Vice-Chairman Burton seconded. Chairman Lin declared the meeting adjourned at 5:25 PM.

6th Meeting of The

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

August 7, 2006

UMBC Technology Center- Viewing Gallery
1450 South Rolling Road
Baltimore, MD 21227

Chairman Samuel Lin called the meeting to order at 1:35 PM. Vice-Chairman Alice Burton and Commissioners Yvette Benjamin, Leon Kaplan, John A. Hurson, Karla Ruhe Roskos, Jorge E. Calderon, Donald C. Roane and Joseph P. Ross also present. Commissioners, Jude L. Boyer-Patrick, and Kendall D. Hunter were absent.

The Commission then went into at 1:40 closed session pursuant to State Government Article § 10-508 (a)(7) to consult with counsel on a legal matter .

Motion Commissioner Roskos
Seconded Commissioner Ross
Motion Approved.

The Commission returned to Public Session at 2:05

July 10, 2006 MEETING MINUTES

Chairman asked for a motion to approve the July 10, 2006 meeting minutes. Commissioner Roskos made and Commissioner Roane seconded the motion to approve the minutes. The motion was passed through a voice vote of the Commissioners present.

UPDATES

Sam Lin updated the Commission on several activities of the past month. He detailed a meeting that was held with Bob Murray, Executive Director of the Health Services Cost Review Commission (HSCRC) in which they discussed how a reverse referral program might be developed that will complement efforts by the HSCRC to reduce emergency room use. He also provided an update of the meeting he had with Principal Deputy Secretary Mitchell where he detailed the progress of the Commission.

Commissioner Hurson provided an update of the activities of the ad-hoc personnel committee and the search for an executive director for the Commission. The Commission discussed several issues in relation to the Executive Director search including where to post the position and for how long to run the posting. There was a motion to give the ad-hoc committee discretion in finalizing the job posting and position description, and a budget of roughly \$10,000 for posting the position. Motion by Commissioner Ross, seconded by Commissioner Yvette Benjamin. The motion was passed through a voice vote of the Commissioners present.

MCHRC COMMITTEE ASSIGNMENTS

The Commission reviewed the assignments to the ad-hoc and standing Committees. The assignments are:

Standing Committees

Information Technology

Kendall Hunter, Chair
Yvette Benjamin
Jorge E. Calderon
John Hurson
Jude Boyer-Patrick
Donald Roane

Hospital and Community Relations

Joe Ross, Chair
Jorge Calderon
Leon Kaplan
Karla Roskos
Alice Burton
Sam Lin

School Based Health Centers

Yvette Benjamin, Chair
Jude Boyer-Patrick
Kendall Hunter
John Hurson
Donald Roane
Joe Ross

Capital and Operations Committee

Karla Roskos, Chair
Joe Ross
Don Roane
Leon Kaplan
Alice Burton
Sam Lin

Ad-hoc Committees

Personnel

John Hurson, Chair
Kendal Hunter
Leon Kaplan
Karla Roskos

Regulations

Sam Lin
Yvette Benjamin
Jude Boyer-Patrick
Alice Burton
Jorge Calderon

A motion was made to approve the committee assignments by Commissioner Benjamin, seconded by Commissioner Roskos. The motion was passed through a voice vote of the Commissioners present.

UNIFIED DATA INFORMATION SYSTEM

The Commission next heard a presentation from Rex Cowdry, Executive Director of the Maryland Health Care Commission (MHCC) and David Sharp of MHCC. On the Maryland Health Care Commission's initiatives and activities relating to electronic health records, electronic data exchange and how those activities relate to the MCHRC's charge to develop a unified data system.

TIMELINE FOR COMMISSION ACTIVITIES

The Commission was led by John O'Brien in a discussion of the timeline for Commission activities for the coming months. The Commission discussed that it was an aggressive, but doable timeline. Commissioner Hurson noted that to try to avoid potential problems from getting regulations approved by AELR in a timely fashion, it would be useful to build into the regulations an opportunity for public comment on the regulation prior to their submission to AELR.

CALL FOR PROPOSALS

MCHRC consultant John O'Brien then led the commissioners in a discussion of the draft grant application guidance that had been released to the Commissioners. Shortly after this discussion began at 3:34, the Commission went into closed session pursuant to State Government Article § 10-508 (a)(7) to consult with counsel on a legal matter. Motion to go into Closed Session by Commissioner Roskos, seconded by Commissioner Benjamin. The motion was passed through a voice vote of the Commissioners present.

*The Commission returned to public session at 4:10

The Commission continued discussion of the draft call for proposal guidance. The Commission decided that the guidance should be released to the public and interested parties on Friday August 11, following final review of changes by the Commissioners that would be due by close of business on Thursday August 10. Motion by Commissioner Burton, seconded by Commissioner Roskos. The motion was passed through a voice vote of the Commissioners present.

INTERESTED PARTIES LIST

The Commission then reviewed the interested parties list developed by staff. The interested parties list will be used, along with the Commission website, to distribute the Call for Proposals and updates and contain over 130 names/organizations. The Commissioner suggested that Maryland Area Health Education Centers, Medical professional schools, substance abuse treatment providers, and United Way organizations be added to the list.

ADJOURNMENT

Chairman Lin asked for a motion to adjourn the meeting. Commissioner Kaplan made a motion to adjourn, which Vice-Chairman Burton seconded. Chairman Lin declared the meeting adjourned at 4:55 PM.

Appendix B

Meeting Agendas and Documents

March 6, 2006 Meeting

Maryland Community Health Resources Commission

Monday March 6, 2006

1:30pm – 6:30pm

- 1:30 – 1:45 *Welcome and Introduction of Commissioners*
Chairman Sam Lin
- 1:45-2:20 *Remarks by Special Guests*
Delegate Peter Hammen
Chair, Health and Government Operations Committee
Michelle Gourdine, M.D.
Deputy Secretary,
Department of Health and Mental Hygiene
- 2:20-2:40 *Overview of Authorizing Legislation – HB 627, SB 775*
Robyn Elliott, Director, Governmental Affairs, DHMH
- 2:40-3:10 *Federally Qualified Health Centers and
National Health Service Corps – History and Lessons Learned*
Rear Admiral Donald Weaver, MD
Deputy Associate Administrator, Bureau of Primary Health Care
Health Resources and Services Administration
US Department of Health and Human Services
- 3:10-3:40 *Maryland's Non-Federally Qualified Health Centers*
Mr. Michael Spurrier
Executive Director
Frederick Community Action Agency
- 3:40-4:00 *Questions and Answers*
- 4:00-4:15 *Break*
- 4:15-4:45 *Medical Informatics and Health Information Technology*
Rear Admiral Carol Romano, PhD, RN
Chief Nurse Officer, US Public Health Service
Deputy Director, Department of Clinical Research Informatics
National Institutes of Health Clinical Center
National Institutes of Health
US Department of Health and Human Services
- 4:45-4:55 *Questions and Answers*

- 4:55-5:30 *Public Comments and Process for Future Public Comments*
- 5:30-6:10 Definition of “Community Health Resource” (D)
 (Maryland Code 19-2101)
 Commission-related Legislation (D)
 House Bill 1118 – Robyn Elliott
 Commission Authorities
- 6:10-6:30 *Commission Items for Discussion (D) or Action (A)*
 Standing Committee Appointments & Meeting Schedule (A)
 Capital and Operational Funding
 Hospital and Community Health Resources Relations
 School-based Community Health Clinic Center Expansion
 Data Information Systems
 Next Meeting (D)
- 6:30 *Adjournment*

**Instructions for Offering Public Comments at the April 3, 2006 Maryland
Community Health Resources Commission meeting.**

Please notify Mrs. Grace Zaczek by e-mail by Monday, March 20, 2006 of your intention to offer comments at the April 3, 2006 meeting. This request must be followed by a written summary of comments or issues to be presented to the Commission. This written material should be limited to two pages (8 1/2" x 11") double-spaced, with 50 copies submitted to Mrs. Zaczek by U.S. mail no later than a week (by Monday, March 27, 2006) before the Commission meeting.

Mrs. Zaczek may be reached at: zaczekg@dhmh.state.md.us 410-767-5301

**Office of Rural Health and Primary Care Services
201 West Preston Street, Room 424
Baltimore, MD 21201**

April 3, 2006 Meeting

Maryland Community Health Resources Commission

Monday April 3, 2006

2:30 pm – 6:30 pm

Kahler Hall

Columbia, Maryland

2:30 – 2:35

Call to Order

Approval – Meeting Minutes, March 6, 2006

2:35 – 2:40

Legislative Update – Robyn Elliott, Director, Office of Governmental Affairs, DHMH

2:40 – 3:25

Background on the Uninsured

- The Uninsured in Maryland (Findings from the HRSA State Planning Grant project), Linda Bartnyska, Chief, Cost and Quality Analysis, Maryland Health Care Commission
- Coverage and Access Programs for Uninsured Marylanders under 200% Federal Poverty Level, Stacey Davis, Office of Planning and Finance, Maryland Medicaid, DHMH

3:25 – 3:40

Break

3:40 – 4:40

Public Comments:

- Sandi Rowland, Allegany Health Right
- Pegeen Townsend, Maryland Hospital Association
- Salliann Alborn, Community Health Integrated Partnership and Maryland Community Health System
- Martha Nathanson, Lifebridge Health
- Linda J. Gilligan, Johns Hopkins Community Physicians, Inc.,
- Krupa Shinde, Health Education Resource Organization, Inc (HERO)
- Lori Doyle, Community Behavioral Association of Maryland.

4:40 – 4:55

Break

4:55– 6:30

Discussion

- Administrative issues and staffing
- Grant making process (Rolling agenda item for the next two meetings.)
- Goals for initial grants
- Defining Community Health Resources and other criteria for eligible entities
- Work plan for Commission and role for Subcommittees

- Next Meeting Date and Location: Monday, May 1, 2006 1:30 PM – 6:30 PM at Kahler Hall, 5440 Old Tucker Road, Columbia, Maryland

6:30 *Adjournment*

Instructions for Offering Public Comments at the May 1, 2006 Maryland Community Health Resources Commission meeting.

Please notify Mrs. Grace Zaczek by e-mail by Monday, April 17, 2006 of your intention to offer comments at the May 1, 2006 meeting. This request must be followed by a written summary of comments or issues to be presented to the Commission. This written material should be limited to two pages (8 ½” x 11”) double-spaced, with 50 copies submitted to Mrs. Zaczek by U.S. mail no later than a week (by Monday, April 24, 2006) before the Commission meeting.

Mrs. Zaczek may be reached at: zaczekg@dhmh.state.md.us 410-767-5301

**Office of Rural Health and Primary Care Services
201 West Preston Street, Room 424
Baltimore, MD 21201**

May 1, 2006 Meeting

AGENDA

Maryland Community Health Resources Commission

Monday May 1, 2006

2:30 pm – 6:30 pm

Kahler Hall

Columbia, Maryland

- 2:30 *Call to Order*
- 2:30 – 2:35 *Approval* – Meeting Minutes, April 3, 2006
- 2:35–3:05 *University of Maryland, Baltimore County Memorandum of Agreement* – John O’Brien, Director, Acute Care Policy, Center for Health Program Development and Management, University of Maryland, Baltimore County
- 3:05 – 3:10 *Legislative Update* – Robyn Elliott, Director, Office of Governmental Affairs, DHMH
- 3:10 – 3:15 *Public Comments:*
Duane Taylor, Chief Operating Officer, Mid-Atlantic Association of Community Health Centers
- 3:15 – 3:30 *Break*
- 3:30 – 5:00 *Discussion:*
- Commission Vision and Mission – Grace Zaczek
 - Defining Community Health Resources and other criteria for eligible entities – Commissioner Roskos
 - Grant making process, regulations and tentative timeline – John O’Brien
- 5:00 – 5:15 *Break*
- 5:15 – 6:30 *Continuation of Discussion*
- Grant making process, regulations and tentative timeline – John O’Brien
- 6:30 *Adjournment*
- Next Meeting Date and Location: Monday, June 5, 2006 1:30 PM – 6:30 PM at Kahler Hall, 5440 Old Tucker Road, Columbia, Maryland

Instructions for Offering Public Comments at the June 5, 2006 Maryland Community Health Resources Commission meeting.

Please notify Mrs. Grace Zaczek by e-mail by Monday, May 22, 2006 of your intention to offer comments at the June 5, 2006 meeting. This request must be followed by a written summary of comments or issues to be presented to the Commission. This written material should be limited to two pages (8 ½" x 11") double-spaced, with 50 copies submitted to Mrs. Zaczek by U.S. mail no later than a week (by Monday, May 29, 2006) before the Commission meeting.

Mrs. Zaczek may be reached at: zaczekg@dhmh.state.md.us 410-767-5301

**Office of Rural Health and Primary Care Services
201 West Preston Street, Room 424
Baltimore, MD 21201**

June 5, 2006 Meeting

AGENDA

Maryland Community Health Resources Commission

Monday June 5, 2006

2:00 pm – 5:00 pm

UMBC Technology Center

- 2:00 Call to Order
- 2:00 – 2:10 Review and approve - Meeting Minutes, May 1, 2006
- 2:10- 2:30 Updates
MCHRC June 16 retreat
Ad-hoc Personnel Committee progress
- 2:30–3:45 Review - *Grace Zaczek*
- Mission and Vision Statement
- Discussion- *John O'Brien*
- Criteria for Certification as a Community Health Resource *John O'Brien*
 - Weighing Legislative and Commission Funding Priorities.
- 3:45-4:00 *Break*
- 4:00- 5:00 Continue Discussion
- Size and duration of MCHRC grant awards
- 5:00 Adjourn

June 5, 2006 Meeting

Maryland Community Health Resources Commission Vision and Mission Statements

Vision:

All Maryland residents achieve optimal health status through access to an affordable, coordinated and integrated system of comprehensive primary and specialty care.

Mission:

To develop and implement strategies in an accountable manner, which improve availability and accessibility of comprehensive primary and specialty care services, for low-income, underinsured Marylanders regardless of their ability to pay.

June 16, 2006 Policy Retreat

**Maryland Community Health Resources Commission
Policy Retreat
President's Conference Room
4th Floor UMBC Information Technology Building
June 16, 2006**

The MCHRC is charged with awarding grants to organizations for the purpose of supporting access to primary care (and later specialty care) in Maryland. Toward that end, the purpose of the retreat is two fold:

- To provide the Commissioners with an overview of the health care landscape in Maryland, focusing on issues of access and uninsurance. In addition it will provide some general background on the role publicly funded programs play in providing (or not) financial access to low income populations in Maryland; and,
- To hear the thoughts of key policy makers in Maryland on what initiatives might provide the greatest benefit to improving access to care. It is assumed that Commissioners will be able to engage in discussion with these individuals to explore issues and opportunities. Also, since the format assumes discussion of policy issues and options the presenters should be senior enough to be able to comment on their organizations policy priorities.

Meeting Schedule

8:00-8:30 **Coffee**

8:30-8:45 **Greeting and Introductions**
Dr. Sam Lin, Chair
Maryland Community Health Resources Commission

8:45-9:30 **MCHRC Role in Improving Health Care in Maryland**
Anthony McCann Secretary
Maryland Department of Health and Mental Hygiene

9:30-10:30 **Panel Presentation: Overview of the Maryland Healthcare Landscape**
The Uninsured in Maryland, Who Are They and Where Do They Live?
Linda Bartnyska,
Maryland Health Care Commission
Health Disparities in Maryland
Dr. Carlessia Hussein
Office of Minority Health and Disparities
Public coverage
Stacey Davis
Office of Planning and Finance, DHMH

10:30-10:45 **Break**

PROGRAM PERSPECTIVES

10:45- 11:15 **Maryland Medicaid**

Paul Gurney
Deputy Secretary for Finance DHMH

11:15- 11:45 **Public Health/Local Health Officers**

Rodney Glotfelty, President
Maryland Association of County Health Officers.

11:45-12:15 **Immigrant Health Initiative**

Audrey Regan
Family Health Administration

12:15-1:30 **LUNCH**

1-30- 2:30 **Integrating Mental Health and Substance Abuse Treatment with
Primary Care**

Panel Presentation
Gail Jordan-Randolph,
Maryland Mental Hygiene Administration
Peter Luongo Ph.D.
Maryland Alcohol and Drug Abuse Administration

2:30- 2:45 **BREAK**

2:45- 3:15 **Rural Health Administration**

Doug Wilson
Maryland Rural Health Association

3:15- 3:30 **Summary/Adjourn**

Dr. Sam Lin, Chairman
Maryland Community Health Resources Commission

June 16, 2006 Policy Retreat

Maryland Community Health Resources Commission Policy Retreat Notes

June 16, 2006

President's Conference Room

4th Floor UMBC Information Technology Building

MCHRC Role in Improving Health Care in Maryland

Secretary Anthony McCann

Maryland Department of Health and Mental Hygiene

Secretary McCann outlined the following issues for the Commission to consider:

- Assuring progress/improving quality
- Health Disparities
- Public Health and the Role of Local Health Departments
- Mental Health Integration
- Relationship to the Medicaid Program

Panel Presentations: Overview of the Maryland Healthcare Landscape

The Uninsured in Maryland, Who Are They and Where do They Live?

Linda Bartnyska

Maryland Health Care Commission

Ms. Bartnyska provided an overview of the uninsured in Maryland using data from the Current Population Survey, the Small Area Health Insurance Estimates, and the Medical Expenditure Panel Survey. She noted characteristics of the uninsured in Maryland and compared Maryland to national averages.

Health Disparities in Maryland

Dr. Carlessia Hussein

Dr. David A. Mann

Office of Minority Health and Disparities

Dr. Hussein and Dr. Mann presented statistics to the Commission regarding the racial/ethnic composition of and health disparities in Maryland. Dr. Hussein also made the following suggestions to the Commission regarding its grant criteria:

- Address/quantify health service needs for ethnic/racial population groups
- Utilize measurable outcomes for each population group
- Partner with local community/minority groups in the program interventions
- Utilize best practices with each minority and population group
- Allocate at least 70% of budget to direct service delivery & require reporting
- Identify methods for collaborative work among partners

Public Coverage

Stacey Davis

Office of Planning and Finance, DHMH

Ms. Davis provided an overview of the coverage and services of Public Programs in Maryland, including the following: Maryland Medical Assistance Program, MCHIP, EID, Primary Adult Care Program, Pharmacy Assistance, Kidney Disease, Women's Breast and Cervical Cancer Health Program, Maryland Primary Care Program, Children's Medical Services, and other public safety net programs.

Program Perspectives

Maryland Medicaid

Paul Gurney

Deputy Secretary for Finance, DHMH

Mr. Gurney described four areas where the Commission could provide assistance to DHMH:

- Substance Abuse Hotline, which could reduce ER use for drug addiction care
- Crisis Beds for ER patients with dual diagnoses
- Outreach Programs to Pregnant Mothers
- Outreach Programs to improve child dental care and access

Public Health/Local Health Officers

Rodney Glotfelty

Maryland Association of County Health Officers

Mr. Glotfelty provided an overview of the functions and roles of public health departments and discussed some local grant initiative success stories in Garrett County. He also made the following suggestions to the Commission regarding grant awards:

- Local Health Departments should be recipients of funding awards
- Work with local health departments for programs to add infrastructure to initiate new services or expand existing networks to enroll more people
- Possible Program Initiatives: Adult Dental services, Prenatal Care, Continued Support for Pharmacy Assistance, Obesity, and Chronic Disease Prevention Programs

Immigrant Health Initiative

Audrey Reagan

Family Health Administration

Ms. Reagan provided the Commission with an overview of the Immigrant Health Initiative. She noted that the initiative focuses on pregnant women and children, and she described some of the programs that are available to this population. The following suggestions were made to the Commission regarding grant awards:

- Address Federal/Medicaid funding shifts in providing care to this population
- Funding for Interpreter services and programs to certify medical translators

Rural Health Administration

Doug Wilson

Maryland Rural Health Administration

Mr. Wilson provided an overview of the rural population in Maryland and the major health issues this population faces. Then, he made the following suggestions to the Commission regarding grant awards:

- Assistance to rural areas for Telemedicine
- Assistance for the development of Community Health Networks
- Assistance to enhance the human resource capacity of rural communities

- Assistance to improve access to dental, mental health, addiction, and specialty service.

**Integrating Mental Health and Substance Abuse Treatment with Primary Care
Maryland Alcohol and Drug Abuse Administration**

Dr. Peter Cohen, Medical Director (Substitute for Peter Luongo, Ph.D.)

Dr. Cohen reviewed the Maryland Alcohol and Drug Abuse Administration's annual report, *Outlook & Outcomes*, for the Commission and stressed the need for adequate screening in primary care for alcohol and drug abuse. He made the following recommendation to the Commission regarding grant awards:

- Funding for Buprenorphine Induction Centers (Set-up, physician education, and technical assistance)

Maryland Mental Hygiene Administration

Gail Jordan-Randolph

Dr. Jordan Randolph provided the Commission with an overview of the Mental Hygiene Administration and made the following requests for grant awards:

- Housing for the chronically mentally ill
- Funding for mental health training of case managers
- Facilitating mental health screening in managed care organizations
- Medical, somatic, and social services for transient youth.

Summary/Adjourn

Chairman Lin thanked the attendees for their time and adjourned the meeting at 3:33 PM.

July 10, 2006 Meeting

AGENDA

Maryland Community Health Resources Commission

Monday July 10, 2006

1:30 pm – 5:00 pm

UMBC Technology Center

Public Session

- 1:30 Call to Order
Review and Approve meeting minutes June 5, 2006 meeting
- 1:35-2:30 Presentations on issues related to Unified Data Information System
- Rosemary Ferdinand, RN PhD
Kevin McCarter
Deloitte Consulting LLP
 - Janet Marchibroda
Emily Welebob,
eHealth Initiative
- 2:30-3:00 Sliding Fee Scales for Community Health Resources
John O'Brien
- 3:00-3:45 Application Elements
Cynthia Woodcock
- 3:45-4:15 Grant Approval Process and Timeline
John O'Brien
- 4:15-4:45 Grant Monitoring and Evaluation
Cynthia Woodcock

July 10, 2006 Meeting

MEMO

To: Maryland Community Health Resources Commission
From: Laura Spicer
Date: July 5, 2006
Re: Sliding Fee Scales

This is an overview of research conducted on sliding fee scales and policies for ten organizations that span federal, state, and local levels. Miguel McInnis of the Mid-Atlantic Association of Community Health Centers and Salliann Alborn of Maryland Community Health Systems were contacted for the sliding fee protocol that their organizations use. The protocol of the Department of Health and Human Services and several local providers were also researched. In addition to these sources, several fee scales from the Department of Health and Mental Hygiene were also obtained.

Sliding Fee Scale Summary

General Rules

- Discount must be offered to all patients who meet eligibility criteria
- Eligibility criteria must be developed from the Federal Poverty Guidelines, based on family size and income
- Sliding scale policy must be updated annually (As FPG is updated annually)
- Discounts apply to any amount due from patients
- Discounts need to be all inclusive, covering visits, procedures, etc.

Fee Scale

- Discounts to **all patients below 200% FPL**
- Patients between 101-200% FPL receive a discount
- Patients below 100% FPL receive a 100% discount, however most organizations require a nominal fee (Nominal fee varies, but \$10 seems to be the most common fee for medical services. Other organizations varied from \$2-\$20 for medical services. Only one fee chart for dental services was found, and the organization charged a \$40 minimum fee).
- Ryan White HIV patients are eligible for the sliding fee scale and an annual payment cap (cap is set at a % of patient's annual income)

Determining Eligibility for Discounts

- The collection of family size and income information from all patients must be a part of the usual registration process
- Patients who decline to offer this information are ineligible for a discount

- Grace periods are given to patients without the required documentation (A standard time frame for the grace period was not found, but several organizations allow patients 2 weeks and one allows 30 days).
- Discounts are granted to patients on their initial visit based on self-reporting (Documentation is not required)
- Discount application form is separate from registration form
- Discount application form is completed on initial registration and is updated at least once per year

Required Documentation for Discounts

- Documentation is required for discounts after the initial visits
- **Proof of Income** (If Employed) One of the Following:
 - 1040
 - W2
 - 2 recent pay stubs
 - Written statement by employer
- **Proof of Income** (If Unemployed) One of the Following:
 - Public Assistance check stub/copy
 - Social Security check stub or letter of award
 - Certification Letter from Medical Assistance or Department of Social Services
 - Completed zero income form
 - Written statement from friend or relative with whom patient lives (if other forms not available)
 - Letter of reference from a 501 (c)(3) organization, such as a church (if other forms not available)
- **Proof of Address** One of the following:
 - Driver's license
 - MVA ID,
 - Any document (envelope) recently addressed to patient such as a utility bill
 - A written statement by relative or friend with whom patient lives
- **Proof of Address** (Immigrants) One of the Following:
 - Form 1551
 - Form 194

Recertifying Clients for Discount

- Patients are re-certified at least once per year, some organizations require re-certification every 6 months

Postage of Discount Policy

- Postage of discount policy in a visible location is generally required, such as at the cashier's desk, in the waiting room, or in the lobby.

Additional Features

- Maryland CHC's are encouraged to develop handouts or brochures for distribution about their discount programs
- Maryland CHC's are encouraged to do their financial screening, billing, and collection of co-payment in a culturally appropriate manner
- Maryland CHC discount policies should be written in all languages relevant to target population
- Several providers post their sliding scales and guideline information for patients on their websites
- Many NHSC sites offer discounts to families above 200% FPL

The following documents are attached to this memo:

- An Outline of the Available Protocol for Each Organization
- Two Sample Sliding Fee Application Forms
- A Sample Sliding Fee Notice (for Postage in a provider's office)

Appendix A

Outline of Sliding Fee Protocol by Organization

I. Organization A

Guideline Summary

- CHC's must provide services to all patients, regardless of ability to pay
- CHC's must offer discounts to patients who meet eligibility criteria based on family size and income
- Eligibility criteria are developed using the Federal Poverty Guidelines (updated annually)
- Bureau of Primary Health Care sets upper and lower parameters for patient eligibility
- CHC's design their own sliding scale policies within these parameters
- These sliding scale policies must be updated annually
- Discounts must be offered to all patients below 200% FPL, patients above 200% must pay full charge
- Patients 101%-200% FPL receive a % discount (% at CHC's discretion)
- Patients below 100% FPL receive a 100% discount, but nominal fee is charged
- Discounts apply to any amounts due from patients, including deductibles/co-insurance for insured patients

Determining Eligibility for Discounts

- CHC's must collect income/family size information from all patients as part of the Usual registration process
- Patients who decline to provide this information are not eligible for a discount
- Patients without required documentation can be given a grace period to turn it in
- Discounts may be granted on initial visit based on self-reporting
- CHC's are encouraged to develop handouts/brochures about the discount program

Discount Eligibility Application

- Discount Eligibility Form is separate from Patient Registration Form
- Form must be completed upon initial registration & updated annually
- Form should include language that explains application of information
- Include a statement of confidentiality
- Define family size on form (such as listing names/birthdates/ages)
- Family size is self-defined & does not have to be restricted to those listed as dependents on IRS forms
- Define income on application
- Require patient signature

- Require staff signature
- Include a statement of consequence for providing false information

Other Protocol

- Billing/collection of co-payment and financial screening must be done in a culturally appropriate manner to assure that these administrative steps do not present a barrier to care
- Discounts need to be all inclusive and include visits, procedures, lab, radiology, and pharmacy
- Discount policies must be posted (lobby/cashier's desk, etc)
- Discount policies should be written in all languages relevant to target population

II. Organization B

Sliding Scale Information

- Available on website
- Required proof of income if employed (one of the following): 1040 or W-2, two recent pay stubs, or written statement by employer
- Required proof of income if unemployed (one of the following): public assistance check stub or copy, unemployment check stub or copy, Social Security check stub or letter of award, certification letter from Medical Assistance or DSS, or written statement by friend or relative with whom patient lives
- Required proof of address (one of the following): driver's license, MVA ID, any document (envelope) recently addressed to patient such as a utility bill, or a written statement by relative or friend with whom patient lives
- Required proof of address for immigrants (documented/undocumented): Form 1551 Or 1151, Form 194

III. Organization C

Sliding Scale Information

- Available on website
- Required proof of income (one of the following): 2 current pay stubs, 1 unemployment stub, letter from employer, award/benefit letter, 1040, Pharmacy Assistance Card, completed zero income form, if none of the above are available, a letter of reference from an organization, such as a church
- \$10 nominal fee for those below 100% FPL

IV. Organization D

Sliding Scale Information

-
- Available on website
- Offers discounted medical services fees up to 90% for qualified patients
- Required proof of income (one of the following): 1040, 2 current pay stubs, 1 unemployment stub, letter from employer, award/benefit letter, completed zero income form, Pharmacy Assistance, letter of reference from any 501(c)3 organization if other sources unavailable

V. National Health Services Corps

Guideline Summary

- Practices employing NHSC clinicians have some flexibility in designing discount schedules
- NHSC sites must assure patients below 100% FPL pay a nominal or no fee
- Patients between 100-200 % FPL are discounted
- Many NHSC sites offer discounts to families above 200% FPL
- NHSC sites should use the HHS Federal Poverty Guidelines that are issued annually when designing discounts

Determining Eligibility for Discounts

- Discount policy should include: procedure for qualifying for discounted fees, how discounts will be determined, what documentation is required for discount, and re-certifying clients for the discount. Most practices recertify patients at least once per year
- Preferable to accept patient's word on income during the initial visit and require verification on future visits
- Verification of income typically includes tax returns or current pay stubs
- Eligibility may also be based on current participation in certain federal/state public assistance programs, such as SSI, TANF, Free or Reduced School Lunch, and other public assistance programs
- NHSC does not require the extension of the discount to Medicare, Medicaid, or SCHIP recipients. Clinics that do offer discounts to these patients must apply the policy uniformly to all patients

Other Protocol

- NHSC requires all sites to post notice of discount in a clearly visible location, such as front office or waiting room. Sites do not have to post details of policy.
- At least one staff member must know how to collect the necessary documentation and determine the discount percentage.

VI. Organization E

Sliding Scale Information

- Available on website with a “cost calculator” for services/procedures
- Required Proof of income (one of the following): school id/class schedule, college financial award letter, two current pay stubs, unemployment letter, two recent bank statements, notarized letter from parent or caretaker, other household income from partner or spouse, or a recent W-2
- Adolescents living at home may report their personal income only
- Scale based on weekly income/ # of people supported by that income
- Allows a grace period to turn in documentation

VII. Organization F

Sliding Scale Information

- Must provide services to all patients, regardless of ability to pay
- Must offer discounts to patients who meet eligibility criteria based on gross household income
- Sliding fee scales determine payment for low-income, uninsured, and underinsured patients
- Sliding fee scale also determines cap for out-of-pocket-HIV-related medical expenses for Ryan White patients
- Ryan White patients do not have to pay for services once they reach their annual payment cap
- Discount eligibility criteria is based on the Federal Poverty Guidelines
- Sliding fee scales are updated annually (As FPG is updated annually)
- Discount applies to all services, but only HIV patients receive a Ryan White payment cap
- Discount application form is given to all new patients
- Primary care patient information is re-certified annually
- HIV patient information is re-certified every 6 months
- Patients are allowed a 30 day grace period for Proof of Income documentation
- Required Proof of Income documentation (one of the following): W2, pay stubs, letter of salary from employer, public assistance award letters, unemployment letter, Social Security award letter, verification of no income form, child support/alimony statements
- Patients below 100% FPL pay a \$5 nominal fee

Appendix B

Example Discount Application Form People's Community Health Centers Application Form (Available on Web)

Fee Determination Data Sheet

Date of Intake _____ Renewal Date _____ Renewal Date _____

Patient Name _____

Name of wage earners in household _____

Billing Address _____

City _____ State _____ Zip Code _____

Phone Numbers: Home _____ Office _____ Cell _____

Place of employment _____

Driver's License No. _____ SS# _____

Occupation/Trade _____ No. of Family Members _____

Combined Annual Income _____ Age _____ Race _____ Sex _____

Documents provided by patient to prove income _____

The Financial Counselor has explained to me my financial responsibility. My percentage of discount from People's full fee is ___% based on my current income and family size. My one year period of eligibility starts on . I will need to be redetermined for this program on my anniversary date which is ___. I understand I must bring in more current documentation at the point of my annual anniversary.

I understand that the fee on People's Laboratory fee schedule has already been discounted by People's reference Lab and will not be discounted any further. Lab fees will be paid in full by me before lab specimens are drawn.

Patient / Guardian Signature _____

Financial Counselor Signature _____

Date Signed _____

Example 2 Sample Discount Application Form (From NHSC and Mid-Atlantic Association of Community Health Centers)

It is the policy of ABC Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon household income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at our office, but not those services which are purchased from outside, such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. Please inquire at the front desk if you have questions.

Number of persons living in your household: _____

Total household income: (complete one column)

Household Member Household Income (Complete one column)			
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Relatives			
Others			
Total			

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved and will be provided as may be requested.

Name (Print)

Signature Date

Office Use Only

Patient Name: _____

Discount: _____

Date of Service: _____

Approved By: _____

Appendix C

Sample Discount Fee Policy Signs (Posted in Provider's Office)

(Words to this effect are okay)

Notice to Patients:

This practice serves all patients regardless of ability to pay

**Discounts for essential services are offered depending upon
family size and income**

You may apply for a discount at the front desk

*** * ***

Aviso Para Los Pacientes:

**Este centro de salud atiende a todo paciente, sin importar su
capacidad de pago.**

**Descuentos por servicios esenciales son ofrecidos
dependiendo del acuerdo al tamaño de la familia y el sueldo.**

Puedo ud aplicar por un descuento en el mostrador del frente.

July 10, 2006 Meeting

**Maryland Community
Health Resources
Commission**

Memo

To: Maryland Community Health Resources Commission
From: Laura Spicer
Date: 7/05/2006
Re: Grant Application Guidelines

Introduction

Six grant applications from federal, state, and private organizations were reviewed to identify the information that these organizations require on their applications. At the federal level, the general application form for Public Health Services and two applications for the Health Resources and Services Administration (HRSA) were reviewed. At the state level, the Spinal Cord Injury Trust Fund from the Maryland Department of Health and Mental Hygiene was examined. Grant applications from two private organizations were also reviewed: the general application for the Horizon Foundation, a local non-profit organization, and the Robert Wood Johnson Foundation's Local Initiative Funding Partners grant, a national program. The categories of information that were required for each application were documented. This information is summarized in the following charts.

Comments

The federal applications provided a very standardized format for each section and detailed budget grids that may be useful. Some of their categories of information, relating to human subjects and the scientific method, may not be relevant to the purposes of the Commission.

The state application was less standardized, but it included an easy to follow format. Like the federal applications, it required some categories of information that may not be relevant, such as Human Subjects Informed Consent and Literature Reviews.

The Horizon Foundation's application was not as formal as the government applications, but it requested some pieces of information that may be useful. In the narrative, Horizon requires detailed information about the grantee

organization, including its history, mission/goals, programs/activities, and organizational structure. They also require a description of the target population of the grant and how this population will benefit from the grant, as well as a strategy for sustainability at the end of the grant period. Horizon was the only organization to request detailed information about the financial viability of the grantee, including the grantee's overall budget and revenues, its last audited financial report, and the organization's annual report.

The RWJ application was also less formal than the government applications, and it did not request a lot of detailed information in the narrative. They included a series of proposal questions related to the purpose of the grant. These questions included the following topics: health care improvement for vulnerable populations, engagement of local funders, collaboration with other organizations, and innovation. Questions are listed in the notes following the charts. RWJ also included a unique section in their budget, requesting the amount of matched support for each budget line.

Common Information

Most of the applications requested the following pieces of information:

Face/Cover Page: project title, project director, contact information, previous grants/funds received, time period for grant, and amount requested. Half of the applications also required tax identification.

Narrative: abstract/project summary, specific goals/aims/objectives of project, plan to implement these goals, timetable for implementation, description of key personnel, and grant specific information.

Budget: time frame, personnel (salary, fringe, etc), travel, consultants, equipment, indirect costs, other. Some required itemized information and justification for each budget line.

Most requested resume attachments for key personnel.

Other Information

Some applications requested unique pieces of information that might be useful:

Narrative: statement of rationale/need, relatedness of project to organization's mission statement, grantee organization information (history, goals, programs/activities, accomplishments, organizational structure), plan for sustainability after grant ends, description of target populations, and how target populations will benefit from project. RWJ included open ended, proposal related questions (as noted above).

Budget: Overall budget of grantee organization, overall revenues of grantee organization, other sources of funding for initiative, and matched support for initiative. Horizon also requested the following budget-related attachments: IRS documentation, most recent financial audit, and annual report.

Indirect Costs: The percentage allowed for indirect costs in grantee budgets varied by organization. The government applications were more stringent, allowing for indirect costs up to 8 %. The federal government, however, allowed room for negotiated indirect cost rates under certain circumstances. RWJ previously only allowed for 9% in indirect costs, but changed its policy on July 1, 2006 in order to keep pace with other grant making foundations. Under the new policy, RWJ

allows for 11% in indirect costs. RWJ indirect cost percentages do not include the amounts budgeted for equipment and consultant/contractual agreements. (Other private grant making foundations allow for 10-15 % in indirect costs.)

Grant Application Information

Face/Cover Sheet

Information Type	Federal Applications	State Application	Horizon Foundation Application	RWJ Foundation Application
Tax ID/Type of Org. Public (St, Fed, Local)	X	X		
Private Non-Profit	X	X		
For-Profit	X	X		
(Identify if Sm. Business, General, Woman Owned, Economic Disadvantage)	X			
Project Title/Grant Number	X	X	X	X
Applicant Contact Information	X	X	X	X
Project Director/Principle Investigator Information	X	X	X	X
Previous Grants/Funds Received		X	X	X
Time Period of Grant	X		X	X
Congressional District of Applicant	X			
Congressional Districts that will Benefit Financially	X			
Amount Requested for Proposed Period of Support	X		X	X

Budget Information

Information Type	Federal Applications	State Application	Horizon Foundation Application	RWJ Foundation Application
Specified Time Frame	X	X	X	X
Per Time Period of Grant	X	X		
Total Grant Period	X	X	X	X
Personnel	X	X	X	X
Salary/wages	X	X	X	X
Stipends	X	X		
Fringe	X	X	X	X
%Time/Effort on Project	X			
Hours/Week on Project	X			
Travel	X	X	X	X
Payroll Taxes			X	
Tuition Fees (Students)	X			
Consultants	X	X	X	X
Equipment	X	X	X	X
Itemized	X			
Supplies	X		X	
Itemized	X			
Contract/Consortium Costs	X			
Alterations/Renovations	X			
Patient Care Costs	X			
Rent/Utilities/Maintenance			X	X
Communications/Marketing			X	X
Meeting Expenses				X
Other	X	X	X	X
Itemized	X	X	X	
Indirect Costs	X	X		X
Total	X	X	X	X
Budget Justification	X	X		
By Line	X	X		
Organization's Overall Budget & Revenues	X		X	
Other Sources of Funding for Initiative (Itemized)	X		X	X
*See Note 1				

Narrative

Information Type	Federal Applications	State Application	Horizon Foundation Application	RWJ Foundation Application
Abstract/Summary		X	X	X
Organization Info			X	
Organization's History			X	
Mission & Goals			X	
Programs/Activities			X	
Accomplishments			X	
Organizational Structure			X	
Statement of Rationale/Need	X	X	X	
Relevance to Grant	X	X		
Relatedness to Org's Mission Statement	X		X	
Goals/Aims/Specific/Objectives	X	X	X	X
Research Methods/Design/Plan of Implementation	X	X	X	X
Target Populations			X	
Description			X	
# Served			X	
How they will Benefit			X	
Timetable for Plan	X	X	X	
Literature Review		X		
Key Personnel	X	X	X	
Role	X	X	X	
Position/Title	X		X	
Degree	X		X	
Field of Study	X		X	
Education/training	X		X	
Supporting Documentation		X	X	
Evaluation Plan			X	X
Description of Facilities/Equipment	X	X		
Grant Specific Information	X	X	X	X
Proposal Related Questions				X
* See Notes 2-3 for Specific Questions				
Strategy for Funding at End of Grant Period/Sustainability			X	X

Attachments

Information Type	Federal Applications	State Application	Horizon Foundation Application	RWJ Foundation Application
Letter of Nomination			X	X
Letter of Support from Partnering Organizations (If Any)			X	
IRS Documentation			X	
Organization's Annual Report (If Any)			X	
Overall Budget of Org			X	
Most Recent Financial Audit			X	
Resumes	X	X	X	
Preliminary Data		X		
Human Subjects Informed Consent Forms	X	X		

Notes

1. RWJF requested specific match support and other/in-kind support for each line of its budget.

2. A Robert Wood Johnson Foundation grant, Local Initiative Funding Partners, requested applicants to provide brief proposals in response to the following questions:
 - How would this project improve health or health care for people in your community made vulnerable by social factors?*
 - How have local funders been engaged in the development of this idea?*
 - How will collaboration with other organizations help to achieve the goals of your project?*
 - How is this project innovative?*
 - Is there any additional information you wish to share?*

3. Other applications asked for other forms of grant specific information, such as numbers of hospital beds.

August 7, 2006 Meeting

AGENDA

Maryland Community Health Resources Commission

Monday August 7, 2006

1:30 pm – 5:00 pm

UMBC Technology Center, 2nd Fl.

Executive Session

1:30-2:00 (est) Advice of counsel – “other Community Health Resources”

Public Session

- | | |
|-------------|---|
| 2:00 | Call to Order |
| 2:00 – 2:05 | Review and approve - Meeting Minutes, May 1, 2006 |
| 2:05- 2:15 | Updates
Finalize Committee Assignments
Ad-hoc Personnel Committee progress |
| 2:15–3:00 | Unified Information Systems Presentation
Maryland Health Care Commission
Rex Cowdry, MD and David Sharp |
| 3:00-3:30 | Review Revised MCHRC Timeline |
| 3:30-4:30 | Discuss Draft Grant Application Guidance |
| 4:30-5:00 | Review interested parties list |
| 5:00 | Adjourn |

August 7, 2006 Meeting

List of Interested Parties for Calls for Proposals

Local Health Departments		
Name	Title	Affiliation
Sue V. Raver MD	Health Officer	Allegany County Health Department
Frances B. Phillips RN, MHA	Health Officer	Anne Arundel County Health Department
Ronna Gothainer		Anne Arundel County Health Department
Joshua M. Sharfstein MD	Commissioner of Health	Baltimore City Health Department
Pierre N. Vigilance MD, MPH	Health Officer	Baltimore County Health Department
David L. Rogers, MD, MPH	Health Officer	Calvert County Health Department
Leland D. Spencer, MD	Health Officer	Caroline/Kent County Health Departments
Larry L. Leitch MPH	Health Officer	Carroll County Health Department
Virginia R. Bailey MD, MPH	Health Officer	Cecil County Health Department
Chinnadurai Devadason MD DPH	Health Officer	Charles/Queen Anne's County Health Departments
Roger L. Harrell MHA	Health Officer	Dorchester County Health Department
Barbara A. Brookmyer MD, MPH	Health Officer	Frederick County Health Department
Rodney B. Glotfelty RS, MPH	Health Officer	Garrett County
Andrew S. Bernstein MD, MPH	Health Officer	Harford County Health Department
Penny E. Borenstein MD, MPH	Health Officer	Howard County Health Department
Ulder J. Tillman MD	Health Officer	Montgomery County Health Department
Richard Helfrich	Deputy Health Officer	Montgomery County Health Department
Lois Kietur	Sr. Planning Specialist	Montgomery County Health Department
Kathleen Sheedy	Grants Program Manager	Montgomery County Health Department
Judith Covich	Nurse Administrator	Montgomery County Health Department

Gwendolyn T. Clerkley	Acting Health Officer	Prince George's County Health Department
Colleen K. Parrott RN, MSN	Health Officer	Somerset County Health Department
William B. Icenhower MD	Health Officer	St. Mary's County Health Department
Kathleen H. Foster RN, MS	Health Officer	Talbot County Health Department
William G. Christoffel MD, MPH	Health Officer	Washington County Health Department
Judith Sensenbrenner MD, MPH	Health Officer	Wicomico County Health Department
Deborah Goeller RN, MSN	Health Officer	Worcester County Health Department

Hospitals		
Name	Title	Affiliation
Denise Matricciani	Assistance Vice President	Maryland Hospital Association
Pegeen Townsend		Maryland Hospital Association
Ing-Jye Cheng		Maryland Hospital Association
William G. Robertson	President and CEO	Adventist Health Care
Martin L. Doordan	President and CEO	Anne Arundel Medical Center
Michael Franklin	President and CEO	Atlantic General Hospital
James R. Walker FACHE	President and CEO	Baltimore Washington Medical Center
Percy Allen II	CEO	Bon Secours Baltimore Health System
R. Lynn Rushing	CEO	Brook Lane Psychiatric Center
James J. Xinis	President and CEO	Calvert Memorial Hospital
Barbara Polak RN, MSN	Director, Ambulatory Care Services	Calvert Memorial Hospital
John M. Sernulka	President and CEO	Carroll Hospital Center
William R. Kirk Jr.	President and CEO	Chester River Hospital Center
Christine M. Stefanides RN, CHE	President and CEO	Civista Medical Center
John I. Galin MD	Director	Clinical Center National Institutes of Health
Dunlop Ecker	President and CEO	Dimensions Health Care System

Phillip B. Down	CEO	Doctor's Community Hospital
Paul E. Porter	President and CEO	Fort Washington Medical Center
Carl J. Shindelar	President and CEO	Franklin Square Hospital Center
Ken Coffey	Vice President, Chief Development Officer	Frederick Memorial Health Care System
Donald P. Battista	President and CEO	Garrett County Memorial Hospital
Lawrence M. Beck	President	Good Samaritan Hospital of Maryland
Laurence M. Merlis	President and CEO	Greater Baltimore Medical Center
Wynee E. Hawk RN, JD	Vice President, External Relations	Greater Baltimore Medical Center
Joseph M. Oddis	President and CEO	Harbor Hospital Center
Kevin J. Sexton	President and CEO	Holy Cross Hospital
Marlene Printz	Director	Holy Cross Hospital Health Ctr.
Victor A. Broccolino	President and CEO	Howard County General Hospital
Gregory F. Schaffer CHE	President	Johns Hopkins Bayview Medical Center
Ronald R. Peterson MHA	President	Johns Hopkins Health System
Gary Goldstein MD	President	Kennedy Krieger Institute
James Ross MBA	Executive Director	Kernan Hospital
Douglas Shepherd	President and CEO	Laurel Regional Hospital
Warren A. Green	President and CEO	Lifebridge Health
Martha Nathanson		Lifebridge Health
Sylvia Smith Johnson	President and CEO	Maryland General Hospital
Charles P. Pinkerman	CEO	The McCready Foundation
John P. McDaniel	CEO	MedStar Health
I. Vanessa Purnell	AVP Government Affairs	MedStar Health
Thomas C. Dowdell	Executive Director, Senior Vice President	Memorial Hospital and Medical Center of Cumberland
David Wallace	Executive Director	Mercy Health Clinic
Thomas R. Mullen	President and CEO	Mercy Medical Center
Peter W. Monge	President, CEO	Montgomery General Hospital
Lynne Myers	Vice President	Montgomery General Hospital
Sheldon J. Stein	President and CEO	Mount Washington Pediatric Health System
Eric G. Wexler	President	Northwest Hospital Center
R. Alan Newberry	President and CEO	Peninsula Regional Medical Center

Craig Juengling	President	Potomac Ridge Behavioral Health Institute
John A. O' Brien	President and CEO	Prince George's Hospital Center
Frances Pommett Jr.	Vice President, Executive Director	Sacred Heart Hospital
Bonnie Phipps	President	St. Agnes Health Care
John K. Tolmie	President and CEO	St. Joseph Medical Center
Fr. Joseph J. Rosetti PhD	President and CEO	Saint Luke Institute
Christine Wray	CEO	St. Mary's Hospital
Deborah A. Yancer	President , CEO	Shady Grove Adventist Hospital
Steven J. Sharfstein MD	President and CEO	Sheppard and Enoch Pratt Hospital
Jospeh P. Ross	President and CEO	Shore Health System
Neil M. Meltzer	President and COO	Sinai Hospital of Baltimore
Francis P. Chiaramonte MD, MPH	Chairman of the Board and CEO	Southern Maryland Hospital Center
Anna Maria Izquierdo-Porrera, MD	Medical Director	Spanish Catholic Center
Brian G. Gragnolati	President and CEO	Suburban Hospital Health Care System
Kenneth S. Lewis MD, JD	President and CEO	Union Hospital
Harrison J. Rider III	President	Union Memorial Hospital
Edmond F. Notebaert	President and CEO	University of Maryland Medical System
Donna Jacobs		University of Maryland Medical System
JoAnne Riley		University of Maryland Medical System
Kathy Kraft		Upper Chesapeake Health System
Lyle E. Sheldon	President and CEO	Upper Chesapeake Health System
Dennis Smith	Medical Director	V.A. MD Health Care System
Jere D. Stocks	President	Washington Adventist Hospital
James P. Hamill	President and CEO	Washington County Health System
Wendy Zimmerman	Nurse Coordinator	Washington County Hospital Association
Barry P. Ronan	President	Western Maryland Health System

Federally Qualified Health Centers and Look Alikes		
Name	Title	Affiliation
Jay Wolvovsky	Executive Director	Baltimore Medical Systems, Inc.
David Shippee	Executive Director	Chase Brexton Health Services
Wayne Howard	CEO	Choptank Community Health Systems
John Strube		Choptank Community Health Systems
Mark Langlais	Executive Director	Community Clinic, Inc.
Paula Brooks McClellan	CEO	Family Health Centers of Baltimore
Sarah Leonhard MD, JD	Executive Director	Greater Baden Medical Center
Jeff Singer		Health Care for the Homeless
Sylvia Jennings	Director	Owensville Primary Care (Look Alike)
Allen Bennett	Executive Director	Park West Medical Center
Patricia Cassatt	Executive Director	People's Community Health Center
Steve Galen	Executive Director	Primary Care Coalition of Mont. Co., Inc.
Sharon Zalewski	Director Center for Health Care Access	Primary Care Coalition of Mont. Co., Inc.
Joan Robbins	Director	Three Lower Counties Community Services, Inc.
Dennis Cherot	President	Total Health Care, Inc.
Sheila DeShong	Executive Director	Tri-State Community Health System
Kimberly Murdaugh	Executive Director	Walnut Street Community Health Center
Miguel McInnis MPH	CEO	Mid-Atlantic Association of Community Health Centers
Esther Lwanga		Mid-Atlantic Association of Community Health Centers
Duane Taylor		Mid-Atlantic Association of Community Health Centers
Salliann Alborn		Maryland Community Health System

Maryland Qualified Health Centers		
Name	Title	Affiliation
Don Bitzel	Site Administrator	East Baltimore Medical Center, Johns Hopkins

		Community Physicians
Rodney Taylor	Executive Director	GBMC Weinberg Community Health Center
Richard Williams MD	Medical Director	Harbor Family Care
Immaculata Ulu	Family Nurse Practitioner	Helene Fuld School of Nursing Community Health Center, Coppin State
Michael Crocetti MD	Medical Director	Johns Hopkins Bayview Children's Medical Practice
Hillary Sporney RN	Practice Administrator	Tindecu Health Center, Johns Hopkins Community Physicians
N/A		University of Maryland Family Medicine ASO
N/A		University of Maryland Pediatric Ambulatory Center

School-Based Health Centers		
Name	Title	Affiliation
Sharon Hobson		Baltimore City Health Department
Niccole Carroll		Baltimore Medical System
Alan Weisman		Maryland General Hospital (Baltimore City SBHC's)
Debbie Somerville		Baltimore County Public Schools
Sue Brenchley		Choptank Community Health Systems (Caroline County SBHC's)
Phyllis Naujakas		Cecil County Health Department
Kathleen Wise		Dorchester County Health Department
Marcy Austin		Magnolia Elementary School (Harford County SBHC's)
Donna Behrens	Executive Director	Maryland Assembly on School-Based Health Care
Anne Walker	Specialist, School-Based Health Centers	Maryland State Department of Education
Joan Glick		Montgomery County Department of Health and Human Services
Frances Caffé-Wright		School-Based Wellness Program, Prince George's County Health Department
Pat Papa		Prince George's County Public School System
Julia Strong		Talbot County Health Department
Wilbur Malloy	Clinic Director	The People's Community

		Wellness Ctr.
Susan Antol MS, RN	Director School Wellness Program	UMB, School of Nursing
Rhonda Reid		Washington County Health Department
Lisa Anderson RN BSN	Coordinator	Wicomico County Health Department

Wellmobile		
Name	Title	Affiliation
Bob Spector	Executive Director	Mobile Medical Care, Inc.
Rebecca Wiseman	Wellmobile Program Manager	UMB, School of Nursing

Universities/Professional Schools		
Name	Title	Affiliation
Bonita Jenkins	Acting Chair, Department of Nursing	Bowie State University
Dr. Bernardine Lacey	Acting Dean, School of Professional Studies	Bowie State University
Marcella Copes PhD, RN	Dean, Helene Fuld School of Nursing	Coppin State University
Dr. Mary Owens	Dean, Graduate Studies	Coppin State University
Michael Klag	Dean, Bloomberg School of Public Health	Johns Hopkins
David Hellmann MD	Vice Dean, Bayview Campus, School of Medicine	Johns Hopkins
Edward Miller MD	Dean and CEO, School of Medicine	Johns Hopkins
Linda Robertson	Vice President, Government Affairs and Community Relations, School of Medicine	Johns Hopkins
Jennifer Calhoun	Director, Strategic Initiatives, School of Nursing	Johns Hopkins
Martha Hill	Dean, School of Nursing	Johns Hopkins
Jane Shivnan	Interim Executive Director, Institute for Johns Hopkins Nursing	Johns Hopkins
Heather Barthel		Johns Hopkins
Kathy Guggino		Johns Hopkins
Sheila Higdon		Johns Hopkins
Tom Lewis		Johns Hopkins
Susan Battistoni	Chair, Department of Nursing	Salisbury University
Benjamin Mason	Special Assistant to President for Institutional Advancement	Sojourner-Douglass College
Charlotte Exner	Dean, College of Health Professionals	Towson University
Marilyn Halstead PhD, RN	Director, Grad. Program, School of Nursing	Towson University
Douglas Barnes DDS, MS	Professor and Director, General	UMB

	Medicine, Dental School	
Harold Goodman DMD	Executive Director, Community Programs, Dental School	UMB
Christian Stohler DMD	Dean, Dental School	UMB
Norman Tinanoff DDS, MS	Chair, Health Promotion and Policy, Dental School	UMB
Barbara Klein	Associate Vice President, Government and Community Affairs	UMB
Deborah Neels	Coordinator, Government Affairs	UMB
Malinda Orlin PhD	Dean, Graduate School	UMB
John Ashworth	Associate Dean, Hospital Networks, School of Medicine	UMB
Claudia Baquet MD, PhD	Associate Dean, Policy and Planning, School of Medicine	UMB
Donald Wilson MD	Dean and Vice President for Medical Affairs, School of Medicine	UMB
Patricia Morton PhD, RN	Assistant Dean, Masters Studies, School of Nursing	UMB
Susan Thomas	Assistant Dean, Doctoral Studies, School of Nursing	UMB
David Knapp	Dean, School of Pharmacy	UMB
Magaly Rodriguez de Bittner	Professor and Chairperson, School of Pharmacy	UMB
Angela Wilks	Associate Professor, School of Pharmacy	UMB
Bernard Carpenter	Executive Director, University Physicians, Inc.	UMB
William Tucker	Director, University Physicians, Inc.	UMB

AHEC's		
Name	Title	Affiliation
Claudia R. Baquet MD, PhD	AHEC Program Director	University of Maryland School of Medicine
Kim Williams	Executive Director	Baltimore AHEC
Jake Frego	Executive Director	Eastern Shore AHEC
Kery Hummel MS	Executive Director	Western Maryland AHEC

United Way of Central Maryland Affiliates		
Name	Title	Affiliation
Alice Harris	Executive Director	A.A. Co. Local Management Board
Jennifer Molloy	Execuitve Director	Arundel Lodge
Donna Fisher-Lewis	Chief Development Officer	Associated Black Charities

Harold A. Smith	Executive Director	Catholic Charities
Andrew Ross PhD, LCSW	President	The Children's Guild
Lorene Lake	Executive Director	The Chrysalis House
Wayne Horrell	President and CEO	Community Health Charities of Maryland
Janice Lockwood	Executive Director	Echo House
Stanley Levi LCSW-C	Executive Director	Family & Children's Services of Central MD
Ross Pologe	Executive Director	Fellowship of Lights
Roy Appletree	Executive Director	FIRN
David Goldman	Executive Director	First Step
Andrea Ingram LCSW-C	Executive Director	Grassroots Crisis Intervention Center
Naomi Benyowitz	Executive Director	Harbel Community Organization
Stephen Mood	Executive Director	Human Services Programs of Carroll Co.
Henry Posko	President and CEO	HUMANIM
Kathleen Curtin	Executive Director	Maryland Society for Sight
Audrey Leviton	Executive Director	PACT
Frank Miller	Chapter Executive	Red Cross of Central Maryland
Larry Walton	President and CEO	United Way of Central Maryland
Stanley Weinstein	Executive Director	Woodbourne Center

SAMHSA Grantees		
Name	Title	Affiliation
Eileen McGrath JD	Executive Vice President and CEO	The American Society of Addiction Medicine
Joseph Cupani	President	County Commissioners of Queen Anne's Co.
Thomas Durham PhD	Executive Director	Danya Institute
Patrick Bogan	Executive Director	Friends Research Institute
Karen Scott Griffin MS	Director of Administration	Gaudenzia Inc
Candace Kattar	Executive Director	Identity Inc.
Janice Walker	Executive Director	MD Coalition of Families for Children's Mental Health
Patricia Bonet	President	On Our Own of Maryland
Dale E. Meyer	President and CEO	People Encouraging People
Sylvia Quinton	Founder and CEO Executive Director	Strategic Community Services Suitland Family and Life Development
Janet Pfeffer		Talbot Partnership for Alcohol and Drug Abuse Prevention

Other Mental Health and Substance Abuse		
Name	Title	Affiliation
Brian Hepburn	Executive Director	Mental Hygiene Administration
Peter F. Luongo PhD	Director	Alcohol and Drug Abuse Administration

Lesa Diehl	Director, Core Service Agency	Allegany County
Frank Sullivan	Executive Director, Core Service Agency	Anne Arundel County
Sue Diehl	Int. President and CEO, Core Service Agency	Baltimore City
Robert Blankfeld	Bureau Chief, Core Service Agency	Baltimore County
Douglas Weems	Director, Core Service Agency	Calvert County
Joseph Newell	Executive Director, Core Service Agencies	Caroline, Dorchester, Kent, and Talbot Counties
Patti McQuade	Executive Director, Core Service Agency	Carroll County
Doug Sommers	Director, Core Service Agency	Cecil County
Mike Luginbill	Director, Core Service Agency	Charles County
Robert Pitcher	Executive Director, Core Service Agency	Frederick County
Fred Polce, Jr.	Director, Core Service Agency	Garrett County
Sharon Lipford	Director, Core Service Agency	Harford County
Donna Wells	Director, Core Service Agency	Howard County
Daryl Plevy	Chief, Behavioral Health Services	Montgomery County Health Department
L. Christina Waddler	Administrator, Core Service Agency	Prince George's County
Lisa Hartman	Director, Core Service Agency	Somerset County
Alexis Zoss	Director, Core Service Agency	St. Mary's County
Rick Rock	Director, Core Service Agency	Washington County
Cicely McElwain	Director, Core Service Agency	Wicomico County
Robin Travers	Director, Core Service Agency	Worcester County

Other		
Name	Title	Affiliation
Katherine Wojcik	Corporate and Foundations Relations Officer	Anne Arundel Medical Center Foundation
Michael Zampelli	Vice President	Antietam Health Services
Kathleen Westcoat		Baltimore Health Care Access
Linda Song	Clinic Director	Chinese Culture & Com. Service Center
Agnes Saenz	Managing Director	Community Ministry of Rockville
Andrew Brecher	Budget Analyst	Dept. of Budget and Management
Lori Brewster		DHMH
Ann Beauchamp		DHMH
Stacey Davis	Special Assistant	DHMH
Katherine Farrell		DHMH
Carlessia Hussein, PhD	Director, Cigarette Restitution Fund	DHMH
Russell Moy, MD	Director, Community and Public Health Administration	DHMH

Deborah Schwab		DHMH
Grace Zaczek		DHMH
Michael R. Spurrier	Executive Director	Frederick Community Action Agency
Krupa Shinde		HERO
Marie Grant		Maryland General Assembly
Yasmine Sursock-Khoury		Medbank of Maryland
Lori Doyle	Chief of Operations	Mosaic Community Services
Azad Ejaz	President	Muslim Community Center Clinic
Wilbur Malloy	Clinic Director	The People's Com. Wellness Center
Cesar Palacios	Clinic Director	Proyecto Salud
Anna Maria Izquierdo-Porrera	Director	Spanish Catholic Center
Kathleen A. McCormick	Vice President, Senior Scientist	Science Applications International Corporation
Ann Rasenberger		
Bernadette Watson		
Bianca Chang		
Carol J. Martin		
Debbie Fisher		
Ellen Clayton		
Jean Pasqualone		
Jill Utterback		
Kerry Topovski		
Lynn Slawson		
Mark Luckner		
Miny Binderman		
Nancy Forlifer		
Patrick McCracken		
Phyllis Matthai		
Sheila Higdon		
Tim Brown		
Sheilah O'Connor		

Appendix C

Regulations

**Code of Maryland Administrative
Regulations**

Title 10

Department of Health and Mental Hygiene

Subtitle 45

Maryland Community Health Resources Commission

Authority: Health-General Article, §§19-2107, 19-2109, and 19-2201,

Annotated Code of Maryland

Chapter .01 Purpose and Definitions.

.01 Purpose.

- A. The purpose of the Commission is, through community health resources, to:
 - (1) Increase access to health care services;
 - (2) Redirect non-emergency emergency room use to community health resources;
 - (3) Develop coordinated, integrated systems of community-based care; and
 - (4) Assist patients in establishing a medical home with a community health resource.
- B. A key objective of the Commission is to reduce health disparities in the State.

.02 Definitions.

A. In this subtitle, the following terms have the meanings indicated.

B. Terms Defined.

- (1) “Applicant” means a person that submits to the Commission, in a timely manner:
 - (a) A letter of intent to submit a grant application under this subtitle; or
 - (b) A grant application under this subtitle.
- (2) “Application” means a document:
 - (a) Prepared by an applicant in response to the Commission’s Call for Proposals; and
 - (b) Includes the elements specified in COMAR 10.45.06.03.
- (3) “Call for proposals” means a document issued by the Commission, that:
 - (a) Invites members of the public to develop and submit proposals for projects and programs for which grant funding under this subtitle is sought;
 - (b) Specifies the required content of a grant application and proposal; and
 - (c) Identifies selection criteria and funding priorities to be applied by the Commission in determining which proposals will be funded.

- (4) “Commission” means the Maryland Community Health Resources Commission.
- (5) “Commissioner” means a member of the Commission.
- (6) “Community health center” means a community-based health center that serves underserved populations and is grant-funded under §330(e) of the Public Health Service Act.
- (7) “Community health resource” means a person determined by the Commission to satisfy the criteria set forth in COMAR 10.45.05.02, .03, or .04.
- (8) “Department” means the Department of Health and Mental Hygiene.
- (9) “Federal poverty guidelines” means the poverty measure that is issued annually in the Federal Register by the U. S. Department of Health and Human Services and is used to determine eligibility for government programs.
- (10) “Federally qualified health center” has the meaning stated in Health-General Article, §24-1301(b), Annotated Code of Maryland.
- (11) “Federally qualified health center ‘look-alike’” means a community-based health center authorized under §1905(l)(2)(B)(iii) of the Social Security Act that meets the eligibility requirements for a grant under §330 of the Public Health Service Act (42 U.S.C. 254b), but is not a grantee.
- (12) "Fiscal year (FY)" has the meaning stated in COMAR 10.09.62.01B.
- (13) “Health care program for the homeless” means a community-based health center that serves homeless adults and children and is grant-funded under §330(h) of the Public Health Service Act (42 U.S.C. 254b(h)).
- (14) “Health center controlled operating network” means an entity funded or otherwise charged by the federal Health Resources and Services Administration (HRSA) to develop, operate, or enhance safety net provider networks so as to:

- (a) Improve health care access for the medically underserved;
- (b) Develop and operate safety net provider networks; and
- (c) Increase health centers' efficiency, revenue, and overall productivity.

(15) "Historic Maryland primary care provider" means a person that provided primary care services through the Maryland PrimaryCare program.

(16) "Local health department" has the meaning stated in COMAR 10.09.40.01.

(17) "Local nonprofit and community-owned health care program" means a collaboration of local public or private non-profit health care programs, or both, to provide or coordinate for low-income or uninsured individuals, free or reduced-cost health care services, such as:

- (a) County community action agencies established under the Economic Opportunity Act of 1964;

- (b) Partnerships of public or private nonprofit health care providers or programs providing case management or other care coordination services;

- (c) Private nonprofit programs that provide administrative, support, and coordination services to facilitate the provision of primary and specialty care services by volunteer practitioners; and

- (d) Community outreach programs sponsored by a local health department.

(18) "Maryland PrimaryCare program" means the State-funded initiative, governed by COMAR 10.51.01-.11, providing office-based primary care to qualifying low-income adults.

(19) "Migrant health center" means a community-based health center that is grant-funded under §330(g) of the Public Health Service Act (42 U.S.C. 254b(g)) and serves migratory and seasonal farm workers and their families in the State.

(20) "Outpatient mental health clinic" has the meaning stated in COMAR 10.21.17.02.

(21) “Person” has the meaning stated in Health-General Article, §1-101(h), Annotated Code of Maryland.

(22) “Primary care program for a public housing project” means a community-based health center that provides comprehensive primary care services to public housing residents and is grant-funded under §330(i) of the Public Health Service Act (42 U.S.C. 254b(i)).

(23) “Practitioner” has the meaning stated in COMAR 10.09.62.01B.

(24) “Provider” has the same meaning as “health care provider,” as stated in Health-General Article, §19-132, Annotated Code of Maryland.

(25) “Presiding officer” means:

- (a) The Chair of the Commission, or
- (b) In the Chair’s absence, the chair’s designee.

(26) “School-based health center” means a provider located on school grounds that the Secretary has designated a school-based health center as specified in COMAR 10.09.68.02.

(27) “Secretary” means the Secretary of the Maryland Department of Health and Mental Hygiene.

(28) “State” means the State of Maryland.

(29) “Substance abuse treatment provider” means a provider of substance abuse treatment services that is:

- (a) Located in the State; and
- (b) Certified in accordance with Health-General Article § 8-404, Annotated Code of Maryland.

(30) “Teaching clinic” means a provider in the State that is staffed in part by practitioners participating in accredited clinical training programs for health professionals, including but not limited to:

- (a) Physicians;
- (b) Nurses; and
- (c) Dentists.

(31) “Wellmobile” means a mobile health clinic in the Governor's Wellmobile Program, established under the Health-General Article, §§19-1301 to 19-1303, Annotated Code of Maryland, within the University of Maryland School of Nursing, which:

- (a) Delivers primary and preventive health care services to geographically underserved communities and uninsured individuals in the State; and
- (b) Provides principal training sites for the University of Maryland School of Nursing to expand student learning opportunities.

Chapter .02 Officers and Staff.

.01 Commission Chair.

A. The Chair is appointed by the Governor.

B. Duties. The Chair shall:

- (1) Except as provided in §B(6)(b) of this regulation, convene and preside over the meetings of the Commission;**
- (2) Call meetings of the Commission as necessary to accomplish the Commission’s purpose;**
- (3) Appoint the Commission’s Vice Chair;**
- (4) Appoint the chairs of the Commission’s standing and ad hoc committees;**

(5) **Appoint the members of the Commission’s committees; and**

(6) **At meetings of the Commission, either:**

(a) **Serve as the presiding officer; or**

(b) **Designate the Vice Chair or other Commissioner to preside over any**

Commission meeting the Chair is unable to attend.

.02 Commissioners.

The Commission consists of eleven members, appointed by the Governor, with the advice and consent of the Senate, in accordance with Health-General Article, §19-2103, Annotated Code of Maryland.

.03 Executive Director and Staff.

A. Executive Director. The Executive Director of the Commission:

(1) Is the chief administrative officer of the Commission;

(2) Is appointed by the Commission with the approval of the Governor;

(3) Serves at the pleasure of the Commission; and

(4) Shall, under the direction of the Commission, perform any duty or function that the

Commission requires, consistent with Health-General Article, §§19-2101-2201, Annotated Code of Maryland, and this subtitle.

B. Staff.

(1) The Commission may employ a staff in accordance with the State budget.

(2) The Commission, in consultation with the Secretary, shall determine appropriate job classifications and grades for all staff.

Chapter .03 Committees

.01 Standing Committees.

- A. The four standing committees of the Commission are:
- (1) The Committee on Capital and Operational Funding;
 - (2) The Committee on Hospital and Community Health Resources Relations;
 - (3) The Committee on School-based Community Health Clinic Center Expansion; and
 - (4) The Committee on Data Information Systems.

B. Committee Appointment. The Chair shall appoint Commissioners to serve on the standing committees annually, at the first regularly scheduled Commission meeting of each fiscal year.

C. Vacancies. The Chair may appoint Commissioners to fill vacancies on the Committees at any time.

.02 Ad Hoc Committees.

A. The Commission may establish one or more ad hoc committees to assist in performing duties of the Commission.

B. An ad hoc committee established pursuant to §A of this regulation shall:

- (1) Limit its activities to the purpose for which it was formed; and
- (2) Be dissolved when the purpose for which it was formed has been satisfied or abandoned by the Commission.

Chapter .04 Meetings

.01 Meetings - Procedure.

A. Meetings of the Commission and meetings of the standing committees specified in COMAR 10.45.03.01 shall be governed in accordance with:

- (1) Maryland's Open Meetings Act; and
- (2) Commonly accepted rules of parliamentary procedure as determined by the Chair.

B. Quorum.

- (1) A majority of the full authorized membership of the Commission is a quorum.
- (2) A quorum need not be present in order for the Commission to hold a meeting.
- (3) If less than a quorum is present at any meeting, the presiding officer shall defer matters submitted for a vote until a quorum is present.

C. Voting.

- (1) Each Commissioner shall be entitled to one vote on each matter submitted to a vote at the meeting.
- (2) Voting shall be in person or by proxy.
- (3) The Commission may not act on any matter unless at least six members in attendance concur.

D. Minutes. The Commission shall ensure that minutes of its public meetings are:

- (1) Recorded;
- (2) Presented to the Commission for approval; and
- (3) Made available for public inspection at the offices of the Commission during ordinary business hours.

.02 Frequency of Meetings.

A. Subject to §B of this regulation, public meetings of the Commission may be held for any authorized purpose, at a time and location determined by the Commission.

B. The Commission shall meet at least six times per year.

Chapter .05 Community Health Resources

.01 Qualification as Community Health Resource.

A. To qualify as a Community Health Resource, a person shall demonstrate that it meets the criteria set forth in Regulation .02, .03, or .04 of this chapter.

B. Regardless of the category of Community Health Resource category for which an applicant submits evidence of qualification, the Commission may determine that the applicant meets the criteria to qualify as a Community Health Resource under either Regulation 02, .03, or .04 of this chapter.

.02 Qualification under Health-General Article §19-2101(c)(1) – “Primary Health Care Services.”

A. Criteria. To qualify as a community health resource pursuant to this regulation and Health-General Article, §19-2101(c)(1), Annotated Code of Maryland, a person shall demonstrate that it:

(1) Is a nonprofit or for-profit health care center or program;

(2) Provides primary health care services:

(a) In accordance with a sliding scale fee schedule payment policy that is consistent with the guidelines set forth in Regulation .05 of this chapter;

(b) Without regard to an individual’s ability to pay; and

(c) Primarily to Maryland residents from service sites located within the State of Maryland; and

(3) Provides medical care to address a patient's general health needs including:

(a) Promotion and maintenance of the patient’s health;

(b) Treatment of illness;

(c) Prevention of disease;

(d) Maintenance of the patient’s health records; and

(e) Making referrals for medically necessary and appropriate specialty care services.

B. Submission Requirements. To demonstrate qualification as a community health resource under this regulation, a person shall submit, on or before the date and time specified by the Commission, the information and documentation that it meets the criteria set forth in §A of this regulation, including:

(1) A written statement, which includes the applicant's name and the address of all its service locations, and discusses how the applicant meets the requirements of §A of this regulation;

(2) A copy of the applicant's written procedures for consistent application of the applicant's policies concerning:

(a) Uncompensated care;

(b) Its sliding scale fee schedule that is consistent with the requirements of Regulation .05 of this chapter; and

(c) The applicant's payment policy documenting the applicant's policy of providing services regardless of a patient's ability to pay;

(3) A list of services offered by the applicant;

(4) A calculation of the proportion of patients served by the applicant who are Maryland residents;

(5) An explanation of how the services offered by the applicant are provided, specifying practitioners' licensure categories, such as physician, nurse-practitioner, or otherwise; and

(6) Upon the Commission's request, any additional information it requires to complete its determination.

C. The Commission shall determine that a person does not qualify as a community health resource pursuant to this regulation if:

(1) Unless COMAR 10.45.08.01D(4) applies, the person does not submit to the Commission, on or before the date and time specified by the Commission, the documentation required by §B of this regulation;

(2) The Commission requests additional information or materials pursuant to COMAR 10.45.08.01D(4); and:

(a) The person does not submit the information or materials requested by the Commission within the time allowed; or

(b) Additional information and material submitted by the person do not establish the person's qualification as a community health resource; or

(3) The Commission determines that the person does not meet the qualification criteria specified in §A of this regulation.

.03 Qualification under Health-General Article §19-2101(c)(2) – “Access Services.”

A. To qualify as a community health resource pursuant to this regulation and Health-General Article, §19-2101(c)(2), Annotated Code of Maryland, a person shall demonstrate that it:

(1) Is a nonprofit or for-profit health care center or program;

(2) Offers access services which:

(a) Directly assist low-income, uninsured, or underinsured individuals to gain access to reduced price clinical health care services; and

(b) May include, but are not limited to:

(i) Coordination of patients' health care;

(ii) Case management services; and

(iii) Transportation of patients to and from medical appointments;

(3) Offers access services, as described in §A(2) of this regulation:

(a) Without regard to an individual's ability to pay;

(b) In accordance with a sliding scale fee schedule that is consistent with the guidelines set forth in Regulation .05 of this chapter;

(c) Primarily to Maryland residents from service sites located within the State of Maryland.

B. Non-qualifying Services.

(1) Services not directly assisting patients to access clinical health care services are not access services and do not establish a person's qualification as a community health resource pursuant to this regulation and Health-General Article, §19-2101(c)(2), Annotated Code of Maryland.

(2) Examples of services that do not qualify as access services include, but are not limited to:

(a) Transportation to health fairs or wellness lectures;

(b) Mass mailings of health educational materials; or

(c) Promotional activities sponsored by health care providers.

C. To demonstrate qualification as a provider of access services, a person shall submit, on or before the date and time specified by the Commission, the information and documentation that it meets the criteria set forth in §A of this regulation, including:

(1) A written statement that includes the applicant's name and the addresses of all its service locations and discusses how the applicant meets the requirements of §A of this regulation;

(2) A copy of the applicant's written procedures for consistent application of the applicant's policies concerning its:

(a) Sliding scale fee schedule; and

(b) Provision of services regardless of a patient's ability to pay;

(3) A list of services offered by the applicant;

(4) A calculation of the proportion of patients served by the applicant who are Maryland residents; and

(5) Upon the Commission's request, any additional information it requires to complete its determination.

D. The Commission shall determine that a person does not qualify as a community health resource under this regulation if:

(1) Except when the Commission requests additional information or materials pursuant to COMAR 10.45.08.01D(4), the person does not submit to the Commission, on or before the date and time specified by the Commission, the documentation required by §C of this regulation;

(2) The Commission requests additional information or materials pursuant to COMAR 10.45.08.01D(4); and:

(a) The person does not submit the information or materials requested by the Commission within the time allowed; or

(b) Additional information and material submitted by the person do not establish the person's qualification as a community health resource; or

(3) The Commission determines that the person does not meet the qualification criteria specified in §A of this regulation.

.04 Qualification under Health-General Article, §19-2101(c)(2) – “Designee Services.”

A. To qualify as a community health resource designated pursuant to this regulation and Health-General Article §19-2101(c)(2), a person shall establish that it meets the definition in COMAR 10.45.01.02 of a:

- (1) Federally qualified health center;
- (2) Federally qualified health center "look-alike;"
- (3) Community health center;
- (4) Migrant health center;
- (5) Health care program for the homeless;
- (6) Primary care program for a public housing project;
- (7) Local nonprofit and community-owned health care program;
- (8) School-based health center;
- (9) Teaching clinic;
- (10) Wellmobile;
- (11) Health center controlled operating network;
- (12) Historic Maryland primary care provider;
- (13) Outpatient mental health clinic;
- (14) Local health department; or
- (15) Substance abuse treatment provider.

B. To demonstrate that it is a community health resource under this regulation a person shall submit, on or before the date and time specified by the Commission, documentation establishing that it meets the definitional criteria specified in COMAR 10.45.01.02 for a community health resource listed in §A of this regulation.

C. Except as provided in §D of this regulation, a person listed in §A of this regulation qualifies as a community health resource without regard to the sliding scale fee schedule requirements specified in Regulation .05 of this chapter.

D. The Commission shall determine that a person does not qualify as a community health resource under Regulation .04 of this chapter if :

(1) Except when the Commission requests additional information or materials to aid it in making a determination pursuant to COMAR 10.45.08.01D(4), the person does not submit to the Commission, on or before the date and time specified by the Commission, the documentation required by §B(2) of this regulation;

(2) The Commission requests additional information or materials pursuant to COMAR 10.45.08.01D(4) and:

(a) The person does not submit the information or materials requested by the Commission within the time allowed; or

(b) Additional information and material submitted by the person do not establish the person's qualification as a community health resource; or

(3) The Commission determines that the person does not meet the definition, as specified in COMAR 10.45.01.02, of a provider category listed in §A of this regulation.

.05 Sliding Scale Fee Schedule Guidelines.

A. Applicability. The Commission shall apply the sliding scale fee schedule criteria set forth in §B of this regulation to determine whether:

(1) An applicant meets the sliding scale fee schedule criterion to qualify as a community health resource under Regulations .02A(2) or .03A(3) of this chapter; and

(2) An application submitted by a community health resource addresses the selection criterion specified in COMAR 10.45.07.01I.

B. A community health resource shall offer primary health care services or access services to individuals whose annual family income is:

(1) Below 100 percent of the federal poverty guidelines:

(a) Free of charge; or

(b) For no more than a nominal fee;

(2) At least 100 percent of the FPL but less than 200 percent of the FPL:

(a) Free of charge; or

(b) At a reduced price.

C. A community health resource qualifying under Regulation .02 or .03 of this chapter may not require individuals with annual family income of less than 200 percent of the FPL to pay any charges for primary health care services or access services in addition to those specified in §B(1) or (2) of this regulation, as applicable;

D. Notice and Documentation. At each of its care sites in the State, a community health resource qualifying under Regulation .02 or .03 of this chapter shall:

(1) Provide notice to the public of its sliding scale fee schedule, including displaying a prominently-posted sign indicating that free or reduced-price care is available; and

(2) Collect documentation of income from individuals applying for reduced-price care pursuant to the community health resource's sliding scale fee schedule.

Chapter .06 Community Health Resource Grants

.01 Call for Proposals.

Beginning in FY 2007, the Commission shall issue to the public, at least once per year, and as budgeted resources permit, a Call for Proposals, which may include:

A. An explanation of the grants program;

B. A statement of the Commission's authority to make grant awards pursuant to Health-General Article, §19-2201(e), Annotated Code of Maryland and an indication of whether the object of the solicitation is to award:

(1) Operating grants to qualifying community health resources; or

(2) Funding for development, support, and monitoring of a unified data information system among primary and specialty care providers, hospitals, and other providers of services to community health resource members;

C. In addition to the statement required under §B of this regulation, a specific indication of the types of programs the Commission expects to fund and the amount of grant funds to be awarded;

D. Requirements relating to submission of community health resources qualifications, including a requirement that the materials necessary to establish an applicant's qualification as a community health resource pursuant to COMAR 10.45.05.02, .03, or .04 be submitted:

(1) As part of an applicant's letter of intent, pursuant to COMAR 10.45.06.02; or

(2) As part of an applicant's grant application, pursuant to COMAR 10.45.06.03.

E. Requirements applicable to letters of intent, if required, and grant applications, including:

(1) The content required for letters of intent under Regulation .02 of this chapter;

(2) The content required for grant applications under Regulation .03 of this chapter;

(3) Formatting guidelines; and

(4) The date and time for submission, the address to which they must be directed, and a specification of acceptable means of transmission;

F. Guidelines for preparing grant proposals, including requirements as to:

(1) The content of the proposal, consistent with Regulation .04 of this chapter;

(2) The proposal's structure and organization;

(3) Questions to be addressed in the proposal; and

(4) Formatting and page limit requirements.

G. An explanation of how grantees may use grant funds, consistent with COMAR 10.45.08.04;

H. Budget guidelines; and

I. To guide the applicant's preparation of the evaluation plan required by Regulation .04G of this chapter, an explanation of program monitoring and evaluation requirements.

.02 Letter of Intent.

A. The Commission may require that, as a condition of submitting a grant application, a person first respond to the Commission's Call for Proposals by submitting a letter of intent to the address and by the date and time specified in the Call for Proposals.

B. The Commission may, in its sole discretion, require that letters of intent include information and documentation sufficient to establish a person's qualification as a community health resource as specified in COMAR 10.45.05.02, .03, or .04.

C. If the Commission requires letters of intent pursuant to §A of this regulation, an applicant shall include in its letter of intent, in addition to any content that may be required by the Commission pursuant to §B of this regulation:

- (1) An identification of the type of grant, of those specified in the Call for Proposals pursuant to Regulation .01B of this chapter, for which the applicant intends to apply;
- (2) A succinct description, no more than 250 words in length, of the proposed project;
- (3) The estimated cost of the project and its expected duration;
- (4) The name and location of the applicant;
- (5) The name, title, address, telephone number, and e-mail address for the proposed project director; and
- (6) The name, affiliation, and e-mail address of the applicant's contact person or persons.

.03 Application

A. An application for a grant under this subtitle shall be submitted in the place and by the date and time specified in the Call for Proposals.

B. As specified in the Call for Proposals, an application for a grant under this subtitle may be required to include the following elements:

- (1) A transmittal letter:
 - (a) Specifying:
 - (i) The title of the proposal;
 - (ii) The name of the applicant;
 - (iii) The name of the project director; and
 - (iv) A statement that the applicant agrees that its submission of a proposal constitutes its acceptance of the terms of the grant program; and
 - (b) Signed by an individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on its behalf;
- (2) A grant application cover sheet, on a form provided by the Commission and signed

by:

- (a) The project director; and
 - (b) An individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on its behalf;
- (3) A statement of the applicant's contractual obligations, assurances, and certifications on a form provided by the Commission and signed by an individual legally authorized to execute contracts on behalf of the applicant;
- (4) The applicant's proposal, which includes the elements specified in Regulation .04 of this chapter; and
- (5) Any other information or documentation the Commission may require.

.04 Proposal Guidelines.

An applicant for a grant under this subtitle shall prepare and submit to the Commission a proposal that is consistent with the instructions and requirements specified in the Call for Proposals, which may include:

- A. Information about the applicant, including:
 - (1) The applicant's mission, programs, and service area;
 - (2) The applicant's organizational strengths and challenges;
 - (3) The applicant's organizational structure, including:
 - (a) An indication of the applicant's for-profit or nonprofit status; and
 - (b) If applicable, a copy of the applicant's IRS determination letter indicating tax-exempt status under 26 U.S.C. §501(c)(3) and a statement signed by an authorized official of the organization that this ruling remains in full force and effect;
 - (4) An identification of the applicant's provider type;

(5) The applicant's governance structure, including a list of the applicant's officers and governing body; and

(6) A description of the applicant's staffing pattern and a copy of its organizational chart.

B. A project summary;

C. A project description, including a specification of the payment policies proposed by the applicant;

D. A description of the target population;

E. A specification of the proposed service area of the project;

F. A discussion of the expected benefits of the project's success;

G. An evaluation plan; and

H. A work plan.

Chapter .07 Selection Criteria and Funding Priorities.

.01 Selection Criteria.

The Commission's criteria for selecting community health resources' grant proposals for funding under this subtitle are as follows:

A. Prospects for success of the proposed project, based on:

(1) Clear, feasible, and achievable goals and objectives;

(2) Reasonableness of work plan and budget; and

(3) Adequacy of:

(a) The project team's skills, competencies, commitment, and capacity to carry out the proposed work; and

(b) Organizational and community support;

B. Potential impact of the proposed project, based on the likelihood of it leading to:

- (1) Improved access to care and health outcomes for the target population by expanding:
 - (a) Existing services to make them available to a new population not previously served by the applicant; or
 - (b) The types of services offered to the applicant's established population;
 - (2) Expansion or replication within the community, in neighboring areas, or more broadly across the State; or
 - (3) Both;
- C. Community need for the proposed project; based on the:
- (1) Clarity and reliability of the proposal's quantitative and geographic identification and definition of the target population;
 - (2) Adequacy of the proposal's documentation of the target population's needs through qualitative and quantitative data such as demographics, insurance coverage rates, and service utilization statistics;
 - (3) Depth of the applicant's understanding of the community to be served; and
 - (4) Relevance of the proposed project to the community's identified needs.
- D. Sustainability of the proposed project, based on the likelihood that it will continue to provide benefits to the target population and the community beyond the duration of the proposed grant;
- E. Active engagement in the project by key participants, including relevant stakeholders, appropriate agencies and organizations, and community partners, based on their:
- (1) Participation in the project's planning and implementation process;
 - (2) Allocation of dedicated staff and other resources to the project; and
 - (3) Contributions of facilities and equipment;

F. Data collection in connection with the proposed project, based on the Commission's assessment of the project team's ability to:

(1) Both at baseline and as the project proceeds, measure and report progress in achieving project goals and objectives through quantitative measures, such as the number, demographics, characteristics, and service utilization of the target population; and

(2) Comply with the evaluation and monitoring requirements established by the Commission;

G. Organizational commitment, based on the applicant's:

(1) Commitment to improving access to care for the target population; and

(2) Ability to demonstrate that the proposed project will significantly contribute to this goal;

H. Financial viability and accountability, based on the:

(1) Applicant's financial soundness;

(2) Adequacy of the applicant's financial management systems; and

(3) Applicant's capacity to manage grant funds; and

I. The extent to which the applicant demonstrates use of a sliding scale fee schedule effectively to increase access to care for low-income uninsured and under-insured individuals in Maryland.

02. Funding Priorities.

In selecting community health resources' proposals to be funded under this subtitle, the Commission shall:

A. Consider geographic balance; and

B. Give priority to community health resources that:

- (1) In addition to normal business hours, operate during evening and weekend hours;
- (2) Have partnered with a hospital to establish a reverse referral program at the hospital;
- (3) Reduce the use of the hospital emergency department for non-emergency services;
- (4) Assist patients in establishing a medical home with a community health resource;
- (5) Coordinate and integrate the delivery of primary and specialty care services;
- (6) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;
- (7) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;
- (8) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and
- (9) Support the implementation of evidence-based clinical practices.

Chapter .08: Selection Process.

.01 Letters of Intent – Commission Review.

- A. The Commission may direct staff to review letters of intent and report to:
 - (1) The Committee on Capital and Operational Funding;
 - (2) The Commission; or
 - (3) Both.
- B. With respect to a letter of intent submitted after the submission deadline specified in the Call for Proposals, the Commission shall:
 - (1) Refuse delivery of the untimely letter of intent; or
 - (2) Return the untimely letter of intent to the sender without review.

C. The Commission shall review letters of intent properly submitted prior to the deadline specified in the Call for Proposals:

(1) To ensure that identifying information submitted by applicants is complete; and

(2) To determine the number and distribution of proposals likely to be submitted for each type of grant specified in the Call for Proposals;

D. If, pursuant to COMAR 10.45.08.02, the Call for Proposals requires applicants to submit evidence of their qualification as a community health resource with their letters of intent:

(1) The Commission shall determine, consistent with the criteria set forth in COMAR 10.45.05.02, .03, and .04, whether or not each applicant qualifies as a community health resource.

(2) The Commission shall notify each applicant determined to be a qualified community health resource:

(a) Of the result of the Commission's review, and

(b) That the applicant is eligible to submit a grant application in accordance with the requirements of the Call for Proposals.

(3) Except as provided in §D(4) of this regulation, the Commission shall notify each unsuccessful applicant for qualification as a community health resource:

(a) That the Commission has determined that the applicant does not qualify as a community health resource, and

(b) That the applicant is not eligible to submit a grant application in response to the Call for Proposals.

(4) If the Commission is unable to determine, from its review of qualification materials submitted by the applicant, whether or not the applicant qualifies as a community health

resource, the Commission may:

- (a) Request that the applicant submit additional materials supporting its application for qualification as a community health resource;
 - (b) Review the applicant's supplemental submission;
 - (c) Determine whether or not the applicant qualifies as a community health resource;
- and
- (d) Provide notice of its decision to the applicant, in accordance with §D(2)(b) or (3)(b) of this regulation, as appropriate.

.02 Application Review and Selection of Grantees.

A. With respect to a grant application submitted after the submission deadline specified in the Call for Proposals, the Commission shall:

- (1) Refuse delivery of the untimely application; or
- (2) Return the untimely application to the sender without review.

B. The Commission shall review grant applications that were properly submitted prior to the deadline specified in the Call for Proposals, in accordance with §C of this regulation.

C. Review Procedures.

- (1) The Commission may direct staff to:
 - (a) Initially review application materials;
 - (b) Conduct negotiations with successful applicants regarding program specifications and grant conditions;
 - (c) Report the results of staff's efforts performing the tasks assigned by the Commission pursuant to §C(1)(a) or (b) of this regulation to the:
 - (i) Commission; or

- (ii) Committee on Capital and Operational Funding; or
 - (d) Perform each of the tasks identified in §C(1)(a), (b), and (c) of this regulation.
- (2) The Commission may consider, in connection with its evaluation of grant proposals:
 - (a) Reports by:
 - (i) The Committee on Capital and Operational Funding;
 - (ii) Staff; or
 - (iii) Both; and
 - (b) Any application materials the Commission reviews directly;
- (3) The Commission shall consider, in connection with its evaluation of grant proposals, the degree to which a proposal:
 - (a) Effectively responds to the Call for Proposals;
 - (b) Meets the selection criteria specified in COMAR 10.45.07.01; and
 - (c) Addresses the funding priorities specified in COMAR 10.45.07.02.
- (4) If the Commission determines that none of the proposals received has sufficient merit to justify award of a grant under this subtitle, it shall notify all applicants of its decision not to award any grants in the present round of grant-making.
- (5) If the Commission determines, consistent with the criteria and priorities set forth in COMAR 10.45.07.01 and .02, that one or more of the proposals reviewed merits a grant award, it shall:
 - (a) To the extent adequate funding is available, select one or more applicant or applicants to receive funding pursuant to Regulation .03 of this chapter;
 - (b) Notify all applicants with applications pending before the Commission of the Commission's decision;

(c) With respect to applicants selected pursuant to §C(5)(a) of this regulation, include with the notice required by §C(5)(b) of this regulation:

(i) A specification of the amount or range of amounts the Commission expects to award to the grantee; and

(ii) An explanation of the negotiation process described in Regulation .03 of this chapter.

.03 Negotiation and Award

A. An applicant approved by the Commission for a grant award pursuant to Regulation .02 of this chapter shall, in collaboration with the Commission, develop grant specifications concerning:

- (1) Performance milestones;
- (2) Deliverables;
- (3) A grant disbursement schedule;
- (4) Monitoring and evaluation requirements;
- (5) Data requirements; and
- (6) The project's final budget.

B. Upon its approval of grant specifications proposed by the applicant pursuant to §A of this regulation, the Commission shall perfect the grant award according to the terms of the successful proposal, as modified by the specifications negotiated pursuant to §A of this regulation and agreed to by the Commission and the grantee.

C. In the event the Commission and an applicant selected pursuant to Regulation .02C(5) of this regulation are unable to agree on the specifications listed in §A of this regulation, either the Commission or the applicant may withdraw.

D. In the event of a withdrawal from negotiations pursuant to §C of this regulation, the Commission may, in its sole discretion, make an additional selection or selections, pursuant to Regulation .02C(5)(a) of this chapter, from applicants who submitted high-scoring proposals that were not chosen in the Commission’s original selection pursuant to Regulation .02C(5)(a) of this chapter.

.04 Use of Grant Funds.

A. A grantee under this subtitle may use grant funds for:

- (1) Salaries and employment benefits for project staff;
- (2) Subcontracting and consultant fees;
- (3) Data collection and analysis;
- (4) Project-related travel, conference calls, and meetings;
- (5) Office supplies, expenses, and other indirect costs as approved by the Commission;
- (6) A limited amount of essential equipment and minor infrastructure improvements

required by the project.

B. Funds from operating grants awarded under this subtitle may not be used for:

- (1) The purchase or lease of major equipment;
- (2) Construction projects;
- (3) Support of clinical trials;
- (4) Medical devices or drugs that have not received approval from the appropriate federal

agency; or

- (5) Lobbying or political activity.

C. Funds are not to be used in contravention of the Department’s “Standard Grant Agreement.”

.05 Formula for Disbursing Grants

A. The Commission shall disburse grant funds to grantees in accordance with the following formula:

(1) Unless it finds that special circumstances apply and the grant award so specifies, the Commission shall make an initial payment to a grantee of up to 20 percent of the total grant award;

(2) The Commission shall make progress payments to a grantee in accordance with a schedule of milestones:

(a) To which the Commission and the grantee have agreed; and

(b) Which provides that, by the time the grant period expires, the total disbursement of grant funds shall equal 100 percent of the amount awarded under this subtitle.

(3) Unless the Commission finds that special circumstances apply and the grant award so specifies, a single progress payment may not exceed 50 percent of the total funds awarded the grantee under this subtitle.

B. If the grantee fails to achieve any milestone, or fails to abide by the terms of the grant, the Commission may cancel the grant and withhold any or all funds not yet disbursed.

C. The Commission:

(1) By written agreement entered into with a grantee after the award of a grant under this subtitle, may modify any milestone or schedule of milestones;

(2) May conduct audits or otherwise inspect the records, premises, and operations of the grantee to determine whether grant funds are being administered:

(a) In a financially responsible manner;

(b) In accordance with the terms of the grant award; and

- (c) In accordance with the requirements of COMAR 10.45.08.04; and
- (3) May establish in the grant documents such other terms and conditions relating to grant funds as it considers reasonable and necessary.

Appendix D
Commission Membership List

Maryland Community Health Resources Commission Membership

Samuel Lin, Chair

Alice Burton, Vice-Chair

Yvette J. Benjamin

Judith L. Boyer-Patrick

Jorge E. Calderon

Kendall D. Hunter

John A. Hurson

Leon Kaplan

Donald C. Roane

Karla Ruhe Roskos

Joseph P. Ross

Appendix E

Revised Call for Proposals



STATE OF MARYLAND

Community Health Resources Commission

201 W. Preston Street, Room 424 • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Dr.

Samuel Lin, Chair

Aligning Community Health Resources: Improving Access to Care for Marylanders

Call for Proposals

October 4, 2006

Notice to Applicants

The Maryland Community Health Resources Commission is charged under Health Gen. §19-2109 and §19-2201 with promulgating regulations to operate its grants program. The Commission submitted regulations for review and approval by the legislature's Administrative, Executive and Legislative Review (AELR) Committee on September 26, 2006. A copy of those draft regulations is available on the Commission's website at <http://dhmh.state.md.us/mchrc/>. Final approval of the regulations is anticipated in fall 2006. Only the Commission's final regulations as adopted will determine the processes and criteria under which grants will be awarded.



Overview

On May 10, 2005, the Governor of Maryland, Robert L. Ehrlich, Jr., signed into law the *Community Health Care Access and Safety Net Act of 2005*. This legislation authorized the creation of the Maryland Community Health Resources Commission. Through grants, community assessments, and technical assistance, the Commission will work to increase access to care for low-income families and under- and uninsured individuals. The Commission will help communities develop more coordinated, integrated systems of community-based care, redirect non-emergency care from hospital emergency rooms to other providers in the community, and assist individuals in establishing a medical home. The cornerstone of these efforts will be community-based health care centers and programs, referred to in the legislation as “community health resources.”

Aligning Community Health Resources: Improving Access to Care for Marylanders is the new grants program of the Maryland Community Health Resources Commission. The program will award grants to community health resources serving Marylanders in Maryland. In this initial offering, the Commission encourages projects that will reduce non-emergency use of hospital emergency rooms by redirecting patients to community health resources for primary care. In addition, the Commission is seeking projects that will integrate mental health services with primary care services, substance abuse treatment, and social services to provide patients with a medical home leading to coordinated, comprehensive community-based care. The Commission will also consider proposals from community health resources for other projects that will improve access to care and/or promote service integration for low-income families and under- and uninsured populations in new and creative ways. The Commission anticipates awards totaling as much as \$3.5 million during this first round of grantmaking.

What is a Community Health Resource?



An organization can demonstrate that it is a community health resource in any of three ways:

➔ **As a Designated Community Health Resource.** The legislation and the Commission designated as community health resources the fourteen organization types listed below. All of these are eligible to apply for and receive grants from the Commission.

- Federally qualified health centers (FQHCs) and FQHC “look-alikes”
- Community health centers
- Migrant health centers
- Health care programs for the homeless
- Primary care programs for public housing projects
- Local nonprofit and community-owned health care programs
- School-based health centers
- Teaching clinics
- Wellmobiles
- Community health center-controlled operating networks
- Historic Maryland primary care providers
- Outpatient mental health clinics
- Local health departments
- Substance abuse treatment providers

Organizations not designated above may also qualify as a community health resource. To do so, organizations must demonstrate that they meet the Commission’s criteria for either a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource.

➔ **As a Primary Health Care Services Community Health Resource.** Organizations must demonstrate that they:

- Provide primary health care services
- Offer those services on a sliding scale fee schedule
- Serve individuals residing in Maryland

➔ **As an Access Services Community Health Resource.** Organizations must demonstrate that they:

- Assist individuals in gaining access to reduced price clinical health care services

- Offer their services on a sliding scale fee schedule
- Serve individuals residing in Maryland

Sliding Scale Fee Schedule Requirements

Organizations seeking to demonstrate that they are a Primary Health Care Services Community Health Resource or an Access Services Community Health Resource must offer a sliding scale fee schedule consistent with the following guidelines established by the Commission. An applicant organization's sliding scale fee schedule must provide discounts to individuals with a family income at or below 200 percent of the federal poverty level, with no more than a nominal charge for individuals with a family income at or below 100 percent of the federal poverty level. No additional fees may be charged, such as an enrollment fee. The availability of discounted fees must be publicly displayed, and discounted services must be available to all who meet the eligibility criteria. The organization must collect documentation on income from applicants. An organization that provides discounted or free care to all individuals who seek service, or to those with family income at or below 200 percent of the federal poverty level, complies with this requirement.

The Grants Program

Aligning Community Health Resources: Improving Access to Care for Marylanders seeks to award grants to community health resources in Maryland in three areas:

1. Redirecting Non-Emergency Use of Hospital Emergency Departments to Community Health Resources

Emergency room visits to Maryland hospitals increased 22 percent in five years to 2.2 million visits in 2004, far exceeding the 13 percent increase nationally during the same period. In 2001, 17 percent of visits to Maryland emergency departments were non-urgent; another 17 percent were urgent, but treatable in a primary care setting. Many of the 14 percent of Marylanders who lack health insurance coverage turn to emergency rooms when they require

routine medical care. The cost of the average emergency room visit has been estimated to be as much as six times the cost of a physician's office visit.

Not only does the use of emergency rooms for non-emergency care contribute to overcrowding and escalating costs, but it also diverts resources away from patients with life-threatening conditions and compromises the ability of emergency departments to respond to more serious events such as a natural disaster, epidemic, or terrorist attack.

A number of strategies may help reduce emergency room use for non-emergency conditions. In addition to offering discounted fees and subsidized services, access to community health centers and other community health resources might be increased through marketing and consumer education, expanded operating hours, and infrastructure and service improvements. Programs to improve chronic disease management might also reduce demand for emergency room care. The Commission will consider applications proposing any of these, or other, approaches to reducing non-emergency visits to hospital emergency rooms.

2. Integrating Community-Based Mental Health and Substance Abuse Services with Somatic Services

Adults with severe mental illness have higher rates of chronic medical conditions such as diabetes, hypertension, and HIV/AIDS, which further compounds the already high levels of functional impairment in this population. This population is less likely to have health insurance coverage and encounters more barriers to obtaining quality medical care. Adults and adolescents with co-occurring substance abuse and mental health disorders are also confronted by a disjointed health care system that does not routinely provide effective integrated clinical interventions.

Strategies to link mental health and substance abuse services with primary care include clinical integration strategies such as case management



services, deployment of primary care providers with expertise in behavioral health, and co-location of primary care providers and mental health professionals. Similarly, services for individuals with co-occurring substance abuse and mental health disorders might be better coordinated through clinical models that provide services in a single setting. The Commission will consider applications proposing strategies such as these or other approaches that will integrate mental health and substance abuse services with somatic care.

3. Other Initiatives to Develop Coordinated, Integrated Systems of Community-Based Care

The Commission will also consider proposals from community health resources for projects that will improve access to care and/or promote service integration for low-income families and under- and uninsured populations in new and creative ways.

Selection Criteria

Applicants may submit proposals for projects in the three areas described above. The Commission will use the following criteria to assess and select proposals for funding:

Prospects for Success: The goals and objectives of the proposed project are clear, feasible, and achievable. The work plan and budget are reasonable. The team assembled possesses the skills, competencies, commitment, and sufficient capacity to carry out the proposed work and has a supportive organizational and community environment.

Potential Impact: The project is likely to lead to improved access to care for the target population and improved health outcomes. The project has potential for expansion or replication within the community, in neighboring areas, or more broadly across the state.

Community Need: The target population is clearly identified and geographically defined, the number of individuals targeted is reliably quantified, and the needs of this population are adequately documented through qualitative and quantitative data, such as demographics, rates of insurance coverage, and service utilization

statistics. The applicant demonstrates a deep understanding of the community to be served.

Sustainability: The project is likely to continue to provide benefits to the target population and the community at large beyond the duration of the proposed grant.

Participation of Stakeholders and Partners:

The project has enlisted as key participants relevant stakeholders and partners from the community and appropriate agencies and organizations. These collaborators will be actively engaged as evidenced by participation in the planning and implementation process, dedicated staff and other resources allocated to the project, contributions of facilities and equipment, and/or provision of free or discounted health care services. Letters of commitment from collaborators are required, but letters alone may not be sufficient for demonstrating active engagement.

Data Collection: The project team has the ability to measure and report progress in achieving project goals and objectives through quantitative measures, such as the number, demographics, characteristics, and service utilization of the target population, both at baseline and as the project proceeds. The project team must also have the ability to comply with the evaluation and monitoring requirements of this grants program.

Organizational Commitment: The applicant organization is committed to improving access to care for the target population and can demonstrate that the proposed project will significantly contribute to this goal.

Financial Viability and Accountability: The applicant organization is in sound financial standing, has adequate financial management systems, and is capable of managing grant funds.

Provision of Sliding Scale Fee Schedule

Services: The Commission will consider the extent to which the applicant organization demonstrates use of a sliding scale fee schedule effectively to increase access to care for low-income uninsured and under-insured individuals in Maryland.



The Commission will also consider the funding priorities in the regulations submitted on September 26, 2006, to the legislature's Administrative, Executive and Legislative Review (AELR) Committee. These funding priorities are listed in the Appendix to this Call for Proposals.



Evaluation and Monitoring

Grantees will be required to submit periodic progress reports and expenditure reports, as well as deliverables produced under the grant. To facilitate project monitoring, clearly defined data elements will be required from all grantees on a regular basis so that project accomplishments can be monitored, compared, and compiled.

The project team may be asked to attend meetings, participate in site visits, and give reports on progress and accomplishments to the Commission, its staff and advisors, and other grantees. At the conclusion of the project, the grantee will be required to provide a written report on the project.

As a condition of receiving grant funds, grantees must agree to participate in an evaluation of the grants program. This includes assisting with any data collection and information gathering required, such as participation in surveys, site visits, meetings, and interviews with the evaluators.

Use of Grant Funds

Grant funds may be used for project staff salaries and fringe benefits, consultant fees, data collection and analysis, project-related travel, conference calls and meetings, and office supplies and expenses. Grant funds may also be expended for a limited amount of essential equipment and minor infrastructure improvements required by the project. With the Commission's approval, grantees may subcontract with other organizations as appropriate to accomplish the purposes of the project.

Grant funds may not be used for major equipment or construction projects, to support clinical trials or unapproved devices or drugs, or for lobbying or political activity.

Awards

The Commission will award grants totaling up to \$3.5 million during this first round of grantmaking. Single-year and multiple-year one-time grants will be awarded:

- Single-year grants of up to \$100,000 are anticipated

- Multiple-year grants of up to \$500,000 with a duration of up to three years

As part of the grant application review process, the Commission may request that an applicant organization provide additional information or revise its application as a condition of approving an award. Awards will be made by the Commission. The Commission will consider geographic diversity within the state of Maryland in making awards.

How to Apply

There are three steps in the competitive application process:

Step 1: Letter of Intent

Applicants are requested to submit a letter of intent, but a letter of intent is not required. Letters of intent should be received by 5:00 p.m. EDT on September 20, 2006, by hand delivery, U.S. Postal Service, or private courier. The letter of intent should include:

- The type of grant for which the applicant will apply: 1) Redirecting Non-Emergency Use of Hospital Emergency Departments to Community Health Resources; 2) Integrating Community-Based Mental Health and Substance Abuse Services with Somatic Services; or 3) Other Initiatives to Develop Coordinated, Integrated Systems of Community-Based Care.
- A succinct description of the proposed project that does not exceed 250 words in length.
- Estimated project cost and duration.
- Name and location of the applicant organization.
- Name, title, address, telephone number, and e-mail for the proposed project director.
- Name, affiliation, and e-mail address of individuals in addition to the project director who would like to receive updates related to this grants program.

Letters of intent should be sent to:

Joyce Meyers
Center for Health Program
Development and Management
UMBC
Sondheim Hall, 3rd Floor



1000 Hilltop Circle
Baltimore, MD 21250

Step 2: The Proposal

Applicants should prepare proposals following the “Proposal Guidelines” on pages 8-9 of this Call for Proposals.

Step 3: Submission of Applications

Grant applications are due by 5:00 p.m. EDT on October 20, 2006. Applications must include:

1. **Transmittal letter:** This letter from the applicant organization’s chief executive officer should specify the title of the proposal, the applicant organization, and the project director and state that the applicant organization understands that submission of a proposal constitutes acceptance of the terms of the grants program.
2. **Grant Application Cover Sheet:** This form is posted at <http://dhmh.state.md.us/mchrc/>. The form should be completed and signed by the project director and the individual responsible for conducting the affairs of the applicant and legally authorized to execute contracts on behalf of the applicant.
3. **Contractual Obligations, Assurances, and Certifications:** A form for this agreement is available at <http://dhmh.state.md.us/mchrc/>. The agreement should be completed and signed by the individual responsible for conducting the affairs of the applicant and authorized to execute contracts on behalf of the applicant.
4. **Proposal:** See “Proposal Guidelines” in the Call for Proposals.

By the deadline for receipt of applications (October 20, 2006, 5:00 p.m. EDT), applicants should e-mail an electronic version of their transmittal letter, Grant Application Cover Sheet, and proposal to jmeyers@chpdm.umbc.edu.

Also by the required deadline, the following must be received at the address below by hand delivery, U.S. Postal Service, or private courier:

- 1) original signed transmittal letter, original

signed Grant Application Cover Sheet, original signed Contractual Obligations, Assurances, and Certifications, and original proposal, all bound together and labeled “original;” and 2) ten bound copies of transmittal letter, Grant Application Cover Sheet, and proposal.

Joyce Meyers
Center for Health Program
Development and Management
UMBC
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250

Inquiries

Conference Call for Applicants: The program office will host a conference call for interested applicants to provide information on the grants program and assistance with the application process. This conference call, on October 3, 2006, at 3:00 p.m. EDT, is optional. Registration is required. To register, send an e-mail by October 2, 2006, to jmeyers@chpdm.umbc.edu with the name(s) of the individual(s) who will participate in the call, the name of the applicant organization, and contact information.

Questions from Applicants: Applicants may also submit written questions about the grants program. Send questions to jmeyers@chpdm.umbc.edu. Questions may be submitted at any time. Responses to Frequently Asked Questions (FAQs) will be posted periodically at <http://dhmh.state.md.us/mchrc/>.

Program Office: The program office for the grants program is located at the Center for Health Program Development and Management at the University of Maryland, Baltimore County (UMBC). Staff members are:

John O’Brien, Consultant
E-mail: jobrien@chpdm.umbc.edu

Joyce Meyers, Staff Assistant
E-mail: jmeyers@chpdm.umbc.edu

Telephone: 410-455-6377

Fax: 410-455-6850

Website: <http://dhmh.state.md.us/mchrc/>



Timetable

September 20, 2006 5:00 p.m. EDT	Deadline for receipt of letters of intent
October 3, 2006 3:00 p.m. EDT	Optional conference call with applicants (registration required)
October 4, 2006	Frequently Asked Questions (FAQs) posted at http://dhmh.state.md.us/mchrc/ (to be updated periodically)
October 20, 2006 5:00 p.m. EDT	Deadline for receipt of applications
November – December 2006	Review of applications
January 15, 2007	Notification of grant awards
February 1, 2007	Grant funding begins



Proposal Guidelines

Proposals should be well written, clear, and concise. Original and creative approaches to addressing access to health services are encouraged. Proposals may not exceed 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. All pages of the proposal must be numbered. The budget and budget justification and the appendices specified in the guidelines below are excluded from the 25-page limit.

The proposal should be structured using these topic headings:

1. Project Summary
2. The Project
3. Evaluation
4. Work Plan
5. Applicant Organization
6. Key Personnel
7. Partners and Collaborators
8. Project Budget

The suggested content of each of these eight sections is discussed below. Provide as much detail as possible.

1. Project Summary

- Provide a one-page summary of the proposal.

2. The Project

- *What will the project do?* What are the goals and measurable objectives of the project? Quite literally, who will do what for whom, with whom, where, and when?
- *Does the project address legislative priorities?* Discuss the extent to which the project addresses the priorities for community health resources in the *Community Health Care Access and Safety Net Act of 2005* (for more information, refer to the legislation or the discussion of legislative priorities in the Call for Proposals).
- *Who is the target population?* Identify the population(s) to be served (i.e., estimated numbers, demographics, insurance coverage, income levels, other distinguishing characteristics). Document the needs of this population using qualitative and quantitative data. Specify the service area(s). Service maps, data, and other statistics on the target population may be provided as an appendix.
- *What problem will be addressed?* Identify the specific problem(s) encountered by the target

population(s) in accessing health care services and how this project will ameliorate the problem(s).

- *Does the proposal address health disparities that exist in Maryland?* Discuss the specific health disparity(s) the project is intended to address and how the project will address that disparity(s).
- *Is there a precedent for this project?* Is the project based on a prior model or approach? What is the evidence that the proposed model or approach will be successful? If the project is a new, original approach, how does it improve service delivery to Marylanders?
- *What will be the benefits of success?* If the project is successful, what visible, tangible, objectively verifiable results will you be able to report at the end of the grant? What longer-term benefits do you expect for the target population and the broader community?
- *How will the project be sustained after grant support ends?* Will the project require ongoing outside support after the proposed grant ends? If so, describe your plans for securing ongoing funding or, if plans are not yet firm, the process you will employ to work towards sustainability. Do you foresee opportunities for expanding or replicating this project within the community, in neighboring areas, or more broadly?

3. Evaluation

- *How will you measure project success?* What will be your methodology for evaluation of project outcomes? What data will you collect and analyze? Does the applicant organization have the capacity to collect and analyze data, or must new capacity be acquired or developed?

4. Work Plan

- *What are the major milestones in carrying out the project?* List key benchmarks of project progress. Describe the process and timeframe for reaching these benchmarks.
- *What are the project deliverables?* What specific products would be submitted to the Commission as evidence of completion of project milestones? How and when will these deliverables be produced?
- *What is the timeline for accomplishing milestones and deliverables?* Prepare a Gantt chart or other timeline listing project tasks and the time period over which these tasks will be undertaken. This may be attached as an appendix to the proposal.



5. Applicant Organization

- *Is the applicant organization a community health resource?* Provide documentation that your organization qualifies as a community health resource pursuant to the Maryland *Community Health Care Access and Safety Net Act of 2005* and related regulations.
- *What is the applicant organization's mission?* Describe your mission, programs, and service area. Discuss your organizational strengths and challenges.
- *What is the organizational structure?* Is the applicant a for-profit or not-for-profit organization? If applicable, attach as an appendix the organization's determination letter from the IRS indicating 510(c)(3) tax-exempt status. Describe the type of organization (e.g., federally qualified health center, free-standing clinic, clinic affiliated with a hospital or county health department, private primary care practice).
- *How is the organization governed?* Specify the governance structure. In an appendix, provide a list of the officers and board of directors or other governing body.
- *How is the organization staffed?* Describe the staffing and provide an organizational chart as an appendix.
- *How is the organization financed?* Specify revenue sources and the percentage of total funding. What is the annual budget? As appendices to the proposal, provide your overall organizational budget (projected revenues and expenses) for the current fiscal year, your most recent audited financial statements and accompanying management letter, and, if your organization files a Form 990, your most recent filing.
- *What facilities are available?* Describe the facilities owned and/or operated by the organization.
- *Does the organization publish an annual report?* If so, provide a copy as an appendix.

6. Key Personnel

- *Who will direct the project?* Identify the project director and describe his/her level of responsibility within the applicant organization, qualifications to lead the project, and role in carrying out the project.
- *Who are the other key staff?* Identify other essential staff, their roles in the project, and their relevant qualifications. As an appendix, include

resumes (maximum three pages each) for all key personnel.

7. Partners and Collaborators

- *Who are the key partners?* What other community organizations will play a crucial role in the proposed project? Why is their participation important?
- *In what ways will the partners contribute to the project?* Who are the leaders of these organizations and what is their role? Which staff will be involved, what will be their responsibilities, and how much time will they devote to the project? What other resources will partners contribute? In an appendix, provide letters of commitment from the leaders of these organizations and resumes (maximum three pages each) for key staff.
- *What is the management plan?* What processes and organizational structures will be put into place to ensure that the partnership(s) are effective?

8. Project Budget

- *General Format:* Provide a line-item budget. To the extent possible, break down the budget into major tasks or phases of work consistent with the project work plan. If the project spans more than one year, the line item budget should be broken down into annual budget periods. The beginning and ending date should be indicated for each budget period. Grant funding will be available beginning February 1, 2007.
- *Personnel:* The name, title, percent effort, annual salary, and fringe benefits should be listed separately for each individual in the budget. Fringe benefits should be shown at the applicant organization's standard rate.
- *Project Co-Funding:* If the project will be supported by funder(s) other than the Commission, the line-item budget should include a separate column for each funding source along with a "total funding" column.
- *Indirect Costs:* Indirect costs may not exceed 10 percent of direct project costs. Direct costs generally include project-related personnel, consultants, travel, equipment, and office expenses.
- *Budget Justification:* A budget justification should accompany the line-item budget detailing the purpose of each budgeted expenditure.



About the Commission

Governor Robert L. Ehrlich, Jr., signed into law the *Community Health Care Access and Safety Net Act of 2005* on May 10, 2005. The law authorized establishment of the 11-member Maryland Community Health Resources Commission. The Commission was created to help communities in Maryland improve access to care for low-income families and under- and uninsured individuals. In January 2006, Governor Ehrlich appointed members of the Commission with the advice and consent of the Senate.

Maryland Community Health Resources Commission

Samuel Lin, M.D., Ph.D., M.B.A., Chair
Yvette J. Benjamin, P.A., M.P.H.
Judith L. Boyer-Patrick, M.D., M.P.H.
Alice Burton, M.H.S.
Jorge E. Calderon, M.D., M.P.H.
Kendall D. Hunter
John A. Hurson, J.D.
Leon Kaplan, C.P.A., M.B.A.
Donald C. Roane, M.D.
Karla R. Roskos, B.S.N., M.P.H.
Joseph P. Ross



Appendix

Chapter 10.45.07.02. Funding Priorities

In selecting community health resources' proposals to be funded under this subtitle, the Commission shall:

- A. Consider geographic balance; and
- B. Give priority to community health resources that:
 - (1) In addition to normal business hours, operate during evening and weekend hours;
 - (2) Have partnered with a hospital to establish a reverse referral program at the hospital;
 - (3) Reduce the use of the hospital emergency department for non-emergency services;
 - (4) Assist patients in establishing a medical home with a community health resource;
 - (5) Coordinate and integrate the delivery of primary and specialty care services;
 - (6) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;
 - (7) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;
 - (8) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and
 - (9) Support the implementation of evidence-based clinical practices.

Appendix F

Meeting Presentations