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DEPARTMENT OF HEALTH POLICY AND MANAGEMENT
JOHNS HOPKINS UNIVERSITY
BEFORE THE SENATE BUDGET AND TAXATION COMMITTEE AND THE SENATE FINANCE COMMITTEE
IN SUPPORT OF SB 172, THE MARYLAND HEALTH EQUITY RESOURCE ACT
JANUARY 27, 2021

Maryland has a number of advantages that allow its citizens access to quality health care. The state has outstanding medical schools, hospitals, and among the 50 states, it has one of the highest median household incomes and the second highest number of primary care physicians per 100,000 population. Despite these advantages, important and persistent health disparities by race/ethnicity and by place of residence, exist in our state.

Historically, racial/ethnic minorities and residents living in underserved areas have suffered unequal access to health care. These same communities have inequitable outcomes in infant mortality and maternal mortality, and disproportionate rates of chronic disease and death. Though very preventable, chronic diseases are among the most common and costly health problems in the country. In Maryland, chronic diseases disproportionally impact those of lower socioeconomic status, those with less than a high school education, and those within communities of color.

In some communities, neighborhoods within a 5 miles radius experience gaps in life expectancy up to 18 years, including some neighborhoods in Baltimore City and Prince Georges county.

In response, in 2012 the Maryland General Assembly passed SB234, authorizing the Maryland Health Improvement and Disparities Reduction Act which established the Health Enterprise Zone Initiative.

The goals of the legislation were three-fold:

1. reduce health disparities among racial/ethnic groups and geographic areas,
2. improve health outcomes, and
3. reduce health care costs and hospital admissions and readmissions.

Through a competitive process, five Health Enterprise Zones were selected which showed creative and tailored plans for targeted investments in community health and involved local coordinating organizations. Of the five HEZs, three were based in hospital systems and two HEZs in local health departments. Two HEZs were in rural settings, one in an urban area, and two in suburban areas.

Analysis conducted by my research colleagues at Johns Hopkins found the HEZ Initiative was associated with a reduction in inpatient hospital stays, an increase in emergency department visits and a net savings of over $93 million for Maryland's health care system.
As examples:

- The Prince George's County HEZ established four Patient Centered Medical Homes and one specialty care practice, created a Community Care Coordination/Community Health Worker Program to link high-risk patients with services and implemented a Public Health Information Network and a comprehensive Health Literacy Campaign.
- The West Baltimore HEZ developed a tiered care coordination program to target high utilizers of emergency and inpatient services, provided community-based health education programs and health screenings, and delivered health classes to reduce risk factors for obesity and other chronic conditions.

These are only a few examples of what the HEZs accomplished. All HEZs expanded primary care services, and all did so with a focus on community health.

Overall, the Health Enterprise Zones were able to:

- Positively impact individual health behaviors and favorably influence health in the community,
- Improve health outcomes and costs associated with chronic conditions, including diabetes and cardiovascular related illnesses,
- Develop and test a variety of creative community-based solutions, and
- Address racial/ethnic and geographic health disparities in Maryland by improving outcomes and access to resources in medically under-served communities.

I am pleased that SB 172 builds on the 2012 HEZ law by making the Heath Equity Resource Communities permanent so they do not abruptly end like the HEZs did in 2016, by giving them a permanent and dedicated funding source. The proposed one penny per dollar increase in the state alcohol sales tax will make sure the Health Equity Resource Communities have the funding they need and will have the added public health benefit of reducing underage drinking and drunk driving.

This afternoon, I am honored to stand with Johns Hopkins University President Ron Daniel, President of Johns Hopkins Medicine, Kevin Sowers, Vinny DeMarco, and many elected officials in supporting this bill. This bill builds on experience and evidence from previous state investment in the HEZs and serves as a model for future programs aiming to address the health and social needs of communities across our state. This bill addresses racial/ethnic health disparities, that will improve access to health care, and reduce health care costs in low-income and medically underserved communities. I stand with the experience and evidence of what is achievable.

I stand in support of **SB 172 - The Maryland Health Equity Resource Act** – and look forward to your favorable report.

Thank you.

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