



STATE OF MARYLAND  
**DHMH**

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Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Family Health Administration

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November 17, 2010

Dear Negotiated Rulemaking Committee:

The Maryland Primary Care Office's Advisory Council would like to share some of its concerns with you regarding the update of criteria for the Health Resources and Services Administration's (HRSA's) shortage designations. HRSA's 2008 impact analysis of the previously proposed methodology found that the northeast states would be most negatively affected, retaining the least amount of shortage designations, primarily due to higher density, more providers, and lower poverty. HRSA's analysis showed that Maryland would retain only 64 percent of their Medically Underserved Areas or Medically Underserved Populations (MUA/Ps) and 66 percent of Health Professional Shortage Areas (HPSAs). Metropolitan areas generally would have only retained 18 percent of their designations, in comparison to non-metro and frontier areas, which would have retained 98 percent and 99 percent of their designations, respectively.

It is our hope that these concerns could be addressed in this forum which will aid in the acceptance of any proposed rules by most metropolitan areas where there is a mix of populations that include urban and rural lifestyles.

**Concerns:**

1. It is our understanding that the new methodology might require the MUA/Ps to be updated every four years like HPSAs. Therefore, there is a concern that under the new methodology some areas might lose their designation. It is our suggestion that MUA/Ps with Federally Qualified Health Centers (FQHCs) not expire because it will affect the recruitment and retention of primary care providers at FQHCs and other health care providers within the designation border. It would not benefit the community if the healthcare resources established were dissolved. We support a special designation as previously proposed that allowed FQHCs to remain in the area and continue to serve the residents living within that community.
2. The current population to provider primary care ratios should be revised. These ratios should change from 3,500:1/3,000:1 to a lower ratio; such as 2,000:1. There are various documents that can be forwarded showing what a sufficient provider to population mix should look like. The current criterion, which relies on income and socioeconomic characteristics, does not correlate with health outcomes. Other data should be used for methodology computation; for example, adding more health indices, including those for chronic diseases with high utilization rates, considering subspecialty providers, measuring ER utilization, wait times,

practice sizes, provider productivity distinctions among private and community practices, and addressing compliance and quality issues such as hospital emergency department rates and utilization for primary care treatable diagnoses. The Brookings Institute conducted a study looking at the increased levels of poverty occurring within suburban communities. It increased dramatically in certain areas between 2000 and 2008. This was the case in certain areas of Prince Georges, Montgomery and parts of Anne Arundel County. The poverty was obscured by the integration of low income families within middle and high income neighborhoods. While this mixed use urban planning strategy works well for integrating families and avoiding blight, it makes it difficult to target resources into these areas of our state. I have attached a link to the Brookings Study as a reference, [http://www.brookings.edu/papers/2010/0120\\_poverty\\_kneebone.aspx](http://www.brookings.edu/papers/2010/0120_poverty_kneebone.aspx) .

3. It is our hope that the new methodology would encourage collaboration and unity among all healthcare entities providing care for a common region or population as is consistent with the goals of the new health care reform legislation which aims to increase access to health care.
4. We also suggest the term 'primary care' be broken down into subspecialty levels such as Internal Medicine, OB/GYN, Pediatrics, Family Medicine, and General Practice in order to look at each specialty separately.
5. The Council also suggests a Governor's exceptional MUP be added to the HPSA's methodology. The Governor's MUP is crucial for bringing services to areas that have special needs, but do not meet current designation criteria. It's a valuable tool for preventing populations' health status from deteriorating further, curtailing to decreased quality of life and increased costs. For instance, this would be a type of designation that does not qualify with the current methodology, but other data such as a health indices in comparison to state and national norms would be cited, and the report would include a recommendation from the Governor and other officials related to the designation, i.e.; local health department, local hospital, county delegate, etc. This special designation could also be used for states with access to data that shows a local level of need. Thus not penalizing states that are readily available to prove need for their residents with the same types of data.
6. It has been brought to our attention that the committee might be considering Primary Care Service Areas (PCSAs) as a unit basis for factoring HPSAs and MUA/Ps. The Council is in opposition to this proposal due to challenges with using the PCSAs in Maryland:
  - a. Some PCSAs appear to be representative of a defined area and/or population, but far too many do not. For example, Baltimore City is a part of four different PCSAs (21204, 21133, 21228, and 21224); all of these PCSAs include a part of Baltimore, but they extend far beyond the city into suburban and rural areas. One PCSA, number 21204, begins in North Baltimore and extends all the way to the border with Pennsylvania. This area is too large and diverse to be representative of how people seek care in an area.
  - b. PCSAs vary widely in land area and population size. Due to this factor, it may be difficult to discern need in specified populations and to differentiate need between Washington, D.C. and Maryland areas.

Public Comment Letter to Negotiated Rulemaking Committee

To illustrate this variance, many of the suburbs of Washington in Prince George's/Montgomery Counties are small in land area, lending themselves to easier and more comparable measurement of needs. But the four PCSAs that contain segments of Baltimore range in size between 9 square miles and 287 square miles. These disparities make accurate assessments difficult.

The Advisory Council is very excited at the aspect that the shortage designation methodology will be updated which will improve access to primary healthcare. If any further research, testing or consultation is necessary, the Advisory Council should be considered available and ready to help.

Sincerely,



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The Maryland Primary Care Office Advisory Council includes representatives of the following organizations:

Maryland Community Health System/Community Health Integrated Partnership  
Maryland Rural Health Association  
Maryland Department of Health and Mental Hygiene (DHMH)  
Choptank Community Health System  
Johns Hopkins University's Bloomberg School of Public Health  
Maryland Area Health Education Center (AHEC)  
Maryland Association of County Health Officers (MACHO)  
Worcester County Health Department  
Maryland Hospital Association  
Mid-Atlantic Association of Community Health Centers  
Maryland State Medical Society  
University of Maryland School of Medicine  
Jai Medical Systems, Inc.