# CHAPTER 1
# THE BALTIMORE ELIGIBLE METROPOLITAN AREA IN COMPARATIVE CONTEXT.

## 1.1. Introduction.

The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (Ryan White) provides grants to the areas that have been the most impacted by HIV and AIDS. Under Part A of Ryan White, funds are provided to eligible metropolitan areas (EMAs), which are defined by having reported at least 2,000 AIDS cases in the previous 3 years and by having a population of at least 50,000. Ryan White Part A funds for the Baltimore EMA are granted to the mayor of Baltimore City. Services are prioritized and allocation levels are determined by the mayor-appointed Greater Baltimore HIV Health Services Planning Council (planning council). The grant is administered by the Baltimore City Health Department (BCHD) working with nearly 50 service providers.

This chapter describes the Baltimore EMA in the context of the country, neighboring states and the rest of Maryland. The chapter will also use many of the same indicators employed in the last comprehensive plan to show how the EMA has changed over time. Each of the EMA's jurisdictions (i.e., Baltimore City and the counties of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's) will be included in the sections that follow.

Among the topics that will be addressed in this chapter of the comprehensive plan are the geography and demographic composition of the EMA; socio-economic characteristics of the EMA, including poverty, infant mortality, Medicaid enrollment and homelessness; and access to health care in the EMA. Specific information about EMA residents that are infected with and/or affected by HIV and AIDS, potential Ryan White Part A clients, and their characteristics and context can be found in the next chapter.

Using the above indicators as a guide, it is evident, from a socio-economic standpoint, that the residents of the Baltimore EMA, as a whole:

- Are faring better than those from neighboring states and the country.
- Are faring as well as those from the rest of the state.
- Are, for the most part, seeing their conditions improve over time.

However, the aggregation of the EMA masks deep disparities between the jurisdictions. Economic expansion in the nation's capital is disproportionately benefiting counties such as Anne Arundel, Carroll and Howard. These three counties are among the best-off jurisdictions in the country and the counties of Harford, Queen Anne's and Baltimore are not far behind.

On the other hand, the same indicators show that Baltimore City continues to struggle with one of the most socio-economically impoverished populations in the country. The good news for Baltimore City is that most of the indicators appear to be improving or, at the very least, did not worsen over the past three years.

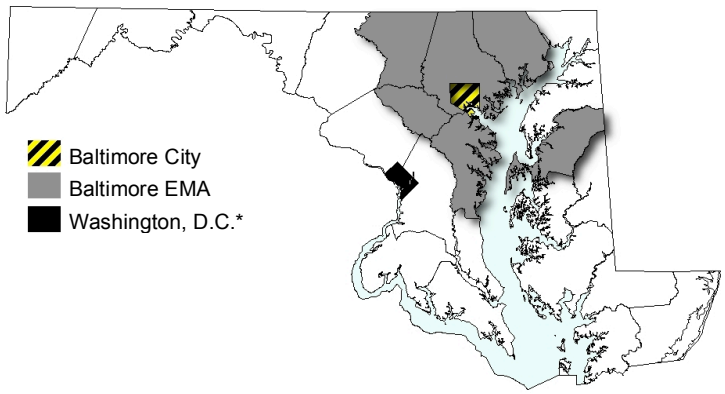
In short, the chapter presents an EMA with both cause for concern and reason for hope.

## 1.2. Geography of the EMA.

The Baltimore EMA, nestled between the northwestern shore of the Chesapeake Bay and the Pennsylvania state line, and just north of Washington, D.C.'s inner suburbs in Maryland, is composed of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties, and Baltimore City. These jurisdictions are also classified as the Baltimore-Towson metropolitan statistical

Figure 1.1.

**Baltimore Eligible Metropolitan Area (EMA)**




* Washington, D.C. is included solely as a geographical reference — it is not a jurisdiction of the Baltimore EMA.

area (MSA) for the U.S. Census Bureau and the "central region of Maryland" (except Queen Anne's County) by several state agencies (including the Department of Health and Mental Hygiene [DHMH]).

Baltimore City, built on the banks of the Patapsco River and a wholly independent municipality of the state, anchors the EMA. It is almost completely surrounded by Baltimore County, which, from north to south on the western side, is bordered by Carroll, Howard and Anne Arundel counties, and to the east by Harford County. Queen Anne's County, located at the eastern terminus of the Chesapeake Bay Bridge across from the state capital of Annapolis in Anne Arundel County, is the only jurisdiction of the Baltimore EMA located on the Eastern Shore of Maryland.

The Baltimore EMA contains 2,661,967 people, or 47.4 percent of Maryland's population of 5,618,344, on 26.7 percent of the state's land area (BC 2000, BC 2008a). While the absolute number of people in the EMA has grown, the relative proportion of EMA residents to the state's population is basically unchanged from the last comprehensive plan (three years past) when the EMA contained 47.5 percent of Maryland's population (IGS 2005).[1]

Spread over a wide area (2,609 square miles) and, in the case of Queen Anne's County, separated by a large body of water, the geographic diversity of the EMA should not be surprising. The needs of the residents of urban Baltimore City (7,889 people per square mile [people/miles$^2$]) must be considered in tandem with the needs of those from rural Queen Anne's County (125 people/miles$^2$). Likewise, Carroll (377 people/miles$^2$) and Harford (545 people/miles$^2$) counties are also mostly composed of rural communities.

Table 1.1.

**Demography of the Baltimore EMA by Jurisdiction**

| Jurisdiction | Population (2007) | Land Area* (miles$^2$) | Population Density (population per mile$^2$) |
|---|---|---|---|
| *Maryland* | *5,618,344* | *9773.82* | *574.84* |
| **Baltimore EMA** | **2,661,967** | **2609.06** | **1020.28** |
| Anne Arundel County | 512,154 | 415.94 | 1231.32 |
| Baltimore City | 637,455 | 80.80 | 7889.29 |
| Baltimore County | 788,994 | 598.59 | 1318.09 |
| Carroll County | 169,220 | 449.13 | 376.77 |
| Harford County | 239,993 | 440.35 | 545.01 |
| Howard County | 273,669 | 252.04 | 1085.82 |
| Queen Anne's County | 46,571 | 372.21 | 125.12 |

**Source:** BC 2000*, 2008a.

[1] The between-census population figures are based on statistical models and the resulting "change" is almost certainly not of substantive interest.

Anne Arundel County (1,231 people/miles$^2$) adds a distinctively suburban flavor to the EMA. The same is true of Howard County (1,086 people/miles$^2$) whose fate, as the home of thousands of federal employees and their families, is as tied to decisions made and trends found in the nation's capital and its surrounding counties, as it is to the rest of the EMA.

Nowhere is the geographic diversity of the EMA better epitomized than in Baltimore County (1,318 people/miles$^2$). Without signs announcing the political demarcation between city and county it would be impossible to mark the transition in most places. However, the county begins to take on a distinctively suburban feel once one leaves the confines of interstate highway 695 (the Baltimore Beltway), which rings the city. Moving away from the beltway, especially in the direction of the Pennsylvania state line, Baltimore County, with one of the highest concentrations of horse farms on the east coast, becomes one of the most rural areas in Maryland.

The diversity of the Baltimore EMA is not only evident in the geographic characteristics of the jurisdictions, it can also be seen in the demographic and socio-economic indicators presented in this chapter.

### 1.3. Ethnic Composition of the EMA.

The ethnic composition of the Baltimore EMA is similar to that of Maryland in most respects (BC 2008b). The one major difference is that the rest of Maryland has a higher concentration of Hispanic residents (6.3 percent) than the EMA (3.1 percent). As can be seen from the U.S. Census Bureau's population estimates, there are fewer Hispanic residents in both Maryland and the EMA than there are in the northeast corridor (10.3 percent), and the nation (15.1 percent) as a whole (BC 2008b).[2]

Both the EMA (28.5 percent) and Maryland as a whole (28.9 percent) have proportionally more African-American residents than the northeast corridor (14.0 percent), and the country as a whole (12.3 percent). The EMA (3.8 percent) has slightly fewer Asian-American residents than Maryland, the northeast corridor (both 5.0 percent) and the country (4.3 percent).

A quick glance at the ethnic compositions of the jurisdictions that compose the region displays the demographic diversity of the EMA. The high proportion of African-American residents in the EMA can almost wholly be attributed to just two jurisdictions, Baltimore City (63.5 percent) and Baltimore County (24.6 percent). Other jurisdictions such as Howard County (16.8 percent) and Anne Arundel County (15.1 percent) also have a higher percentage of African-American residents than the rest of the country, but they are well behind the state of Maryland as a whole.

Howard County (11.5 percent), at more than double the rate for Maryland and the northeast corridor, and nearly triple that of the nation, is the only jurisdiction in the EMA whose concentration of Asian-Americans exceeds the rate found in the rest of the country. Carroll (91.8 percent), Queen Anne's (87.8 percent), Harford (81.6 percent) and Anne Arundel (75.8 percent) counties are all well above the national average (66.0 percent) for white residents. As with the rest of the country, multi-racial Americans, Native Americans and Pacific Islanders are not found in large numbers in the Baltimore EMA, Maryland or the northeast corridor.

[2] The northeast corridor is the 12 states, and the District of Columbia, containing any part of the metropolitan areas linked by interstate highway 95 between Boston and Washington D.C. From south to north, these jurisdictions are: Virginia, the District of Columbia, Maryland, Delaware, New Jersey, Pennsylvania, New York, Connecticut, Rhode Island, Massachusetts, New Hampshire, Vermont and Maine. This should not be confused with the U.S. Census Bureau's northeast region, which groups Delaware, Maryland, Virginia and the District of Columbia in the south Atlantic region with states such as Florida, Georgia and South Carolina.

Table 1.2.

**Race/Ethnicity of the Baltimore EMA by Jurisdiction (2007)**

| Jurisdiction | Population | Non-hispanic | | | | | | Hispanic |
|---|---|---|---|---|---|---|---|---|
| | | White | African-American | Asian-American | Multiple Races | Native American | Pacific Islander | All |
| United States | 301,621,157 | 66.0% | 12.3% | 4.3% | 1.4% | 0.8% | 0.1% | 15.1% |
| Northeast Corridor | 69,464,117 | 69.2% | 14.0% | 5.0% | 1.2% | 0.3% | 0.0% | 10.3% |
| *Maryland* | *5,618,344* | *58.1%* | *28.9%* | *5.0%* | *1.4%* | *0.3%* | *0.0%* | *6.3%* |
| **Baltimore EMA** | **2,668,056** | **62.9%** | **28.5%** | **3.8%** | **1.3%** | **0.3%** | **0.1%** | **3.1%** |
| Anne Arundel County | 512,154 | 75.8% | 15.1% | 3.0% | 1.5% | 0.3% | 0.1% | 4.2% |
| Baltimore City | 637,455 | 30.6% | 63.5% | 2.0% | 1.0% | 0.3% | 0.1% | 2.5% |
| Baltimore County | 788,994 | 66.8% | 24.6% | 4.1% | 1.3% | 0.3% | 0.0% | 2.9% |
| Carroll County | 169,220 | 91.8% | 3.7% | 1.6% | 0.9% | 0.2% | 0.0% | 1.8% |
| Harford County | 239,993 | 81.6% | 12.0% | 2.1% | 1.4% | 0.2% | 0.1% | 2.6% |
| Howard County | 273,669 | 64.6% | 16.8% | 11.5% | 2.0% | 0.2% | 0.1% | 4.8% |
| Queen Anne's County | 46,571 | 87.8% | 8.0% | 0.9% | 1.1% | 0.2% | 0.0% | 2.0% |

**Source:** BC 2008b.

Note: The U.S. Census Bureau disaggregates both Hispanic and Non-hispanic populations by six groups: white, African-American, Asian-American, Native American, Pacific Islander and those of multiple races. The Hispanic column in table 1.2 is an aggregation of all six groups. Each column (except population) is exclusive of the others.

As of 2007, none of the jurisdictions in the Baltimore EMA had Hispanics as more than 4.8 percent of their residents — less than one third the national rate. Census figures do not suggest that the need to scale up Hispanic-specific programming in the Baltimore EMA is quite as pressing as it is elsewhere in the country. However, recent actions taken by public officials in neighboring jurisdictions in both Virginia and Maryland are reputedly channeling Hispanic residents to the EMA at an increasing rate. To the extent that anecdotal evidence can be distinguished from baseless rumors, the EMA could experience an influx of new Hispanic residents over the next three years.

## 1.4. Poverty in the EMA.

The EMA and Maryland had lower levels of poverty than the nation and the surrounding region. However, the relative prosperity of the area should not obscure the real need of the thousands of residents below the poverty threshold, especially the more than 100,000 such individuals residing in Baltimore City.

At the last count, in 2007, an estimated 13.0 percent of Americans were living below the poverty threshold (BC 2008e). The residents of the northeast corridor (10.9 percent) were a little less likely to be in poverty than other Americans. Marylanders (8.3 percent) were among the least likely Americans to be living in poverty.[3] Residents of the Baltimore EMA, at 10.0 percent, were somewhere between Maryland and the other states of the northeast corridor (BC 2008c); Baltimore City was the single greatest contributor to the EMA's and Maryland's poverty rate.

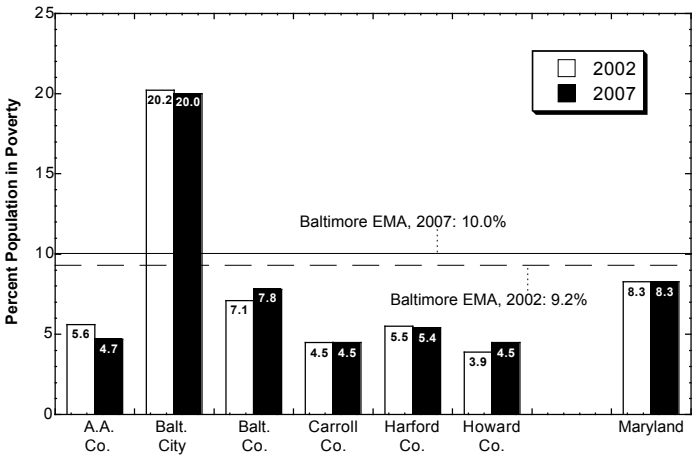
Baltimore City's estimated poverty rate of 20.0 percent in 2007 was more than twice the state average. All the other jurisdictions

[3] Residents of New Hampshire (7.1 percent), Connecticut (7.9 percent) and Hawaii (8.0 percent) were the only Americans less likely to be living in poverty (BC 2008e).

of the EMA were below the state average. Because much of the state's poverty rate can be attributed to the city, a more telling comparison would be to compare the counties' poverty rates to those found in the non-EMA portion of the state, where 6.7 percent of Marylanders were in poverty.

Figure 1.2.

**Poverty in the EMA by Jurisdiction, 2002 and 2007**




**Source:** BC 2004a, 2008c.

Note: The U.S. Census Bureau does not estimate the poverty level of Queen Anne's County on a yearly basis. The last estimate put the county's poverty rate at 6.3 percent in 2004.

Carroll (4.5 percent) and Howard (4.5 percent) county residents were the least likely of all Marylanders to be in poverty. The residents of Anne Arundel (4.7 percent) and Harford (5.4 percent) counties were slightly less likely to be in poverty than residents in the non-EMA areas of the state. The poverty rate in Baltimore (7.8 percent) and Queen Anne's (6.3 percent) counties could not be distinguished from the rates in the non-EMA areas of the state using U.S. Census Bureau information.

The rise from 9.2 to 10.0 percent in the EMA between 2002 and 2007 did not represent a significant change in the poverty level (BC 2004a, 2008c).[4] Estimated poverty rates increased or decreased by less than a percentage point in the various jurisdictions of the EMA (e.g., the fall in Anne Arundel County's rate from 5.6 to 4.7 being the largest change) — none of these changes was significant. In short, since the last comprehensive plan, the condition of the city's residents, among the worst in the nation, has not improved with respect to poverty and the condition of the counties' residents (among the best in the nation) has not worsened.

Taken from a different perspective, Maryland has the highest household income in the country (BC 2008d). Of the approximately 800 counties that the U.S. Census Bureau tracks on an annual basis, Howard County ($101,672) had the third-highest median household income in the nation in 2007.[5] Carroll County ($82,492, rank 23), Anne Arundel County ($80,402, rank 30) and Harford County ($72,372, rank 62) were all among the 100 richest counties tracked by the U.S. Census Bureau.

The last estimate, from 2004, by the U.S. Census Bureau for median household income in Queen Anne's County was $63,938 (BC 2004b). Assuming that the median income of the county followed the trend of the state and other counties in the

[4] The U.S. Census Bureau reports 90 percent confidence intervals for poverty estimates, instead of the more conventional 95 percent levels used for assessing statistical significance. However, even with this more relaxed standard, there were no significant differences in poverty levels in any of the jurisdictions.

[5] Ten suburban Washington, D.C. counties, all of the tracked ones except Prince George's County (rank 80), are among the top 20 richest counties in the country (BC 2008d). Prince George's County is the richest majority-minority county in the country.

area, and did not decline between 2004 and 2007, Queen Anne's would have also been found among the richest counties in the nation. Baltimore County, at $60,844, is also faring comparatively well (rank 146). However, as the poverty indicator suggests, the same cannot be said for Baltimore City whose median household income of $36,949 (just over a third of the median household income reported in Howard County) ranked 724th of the 798 counties tracked in 2007.

### 1.5. Unemployment in the EMA.

Since the last comprehensive plan, unemployment has declined in every jurisdiction of the EMA, including Baltimore City (LLR 2007, LLR 2008). Estimated unemployment in the Baltimore EMA declined from 4.7 percent in 2004 to 4.0 percent in 2007. Declines occurred in Anne Arundel County (3.8 to 3.2 percent), Baltimore City (7.3 to 6.1 percent), Baltimore County (4.5 to 3.8 percent), Carroll County (3.5 to 3.2 percent), Harford County (4.1 to 3.6 percent), Howard County (3.3 to 2.7 percent) and Queen Anne's County (3.6 to 3.4 percent). The declines found in the EMA jurisdictions match the trend found throughout the state of Maryland where unemployment declined from an estimated 4.3 percent to 3.8 percent over this same period.

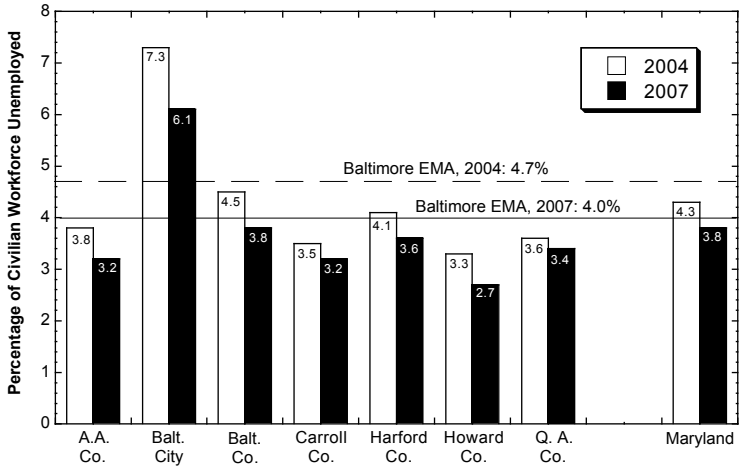
Baltimore City was the only jurisdiction in the EMA whose unemployment rate was higher than the rate for the entire state in 2007. Not including the Baltimore EMA, the state's unemployment rate was 3.6 percent in 2007. Baltimore City and the counties of Baltimore and Harford were the only jurisdictions whose estimated unemployment rates were higher than the rate found in the rest of the state.

As of March 2008, Maryland (3.6 percent) had the lowest unemployment rate of any state in the northeast corridor (4.6 percent) and was among the states with the lowest unemployment rates in the nation (5.0 percent) (BLS 2008). Due to differences in data, it is not possible to make a direct comparison between the EMA and the northeast corridor, or the nation as a whole.

With the exception of Baltimore City, the EMA enjoys high levels of employment compared to the rest of the state, and the state is faring better than neighboring states. Furthermore, employment prospects for all EMA residents, including those in Baltimore City, have improved since 2004. However, a recent downturn in the economy threatens to erase much of the progress achieved over these past three years and any prospective planning must consider the possibility of substantially higher unemployment rates over the course of the next three years.

Figure 1.3.

**Unemployment in the EMA by Jurisdiction, 2004 and 2007**




**Source:** LLR 2007, 2008.

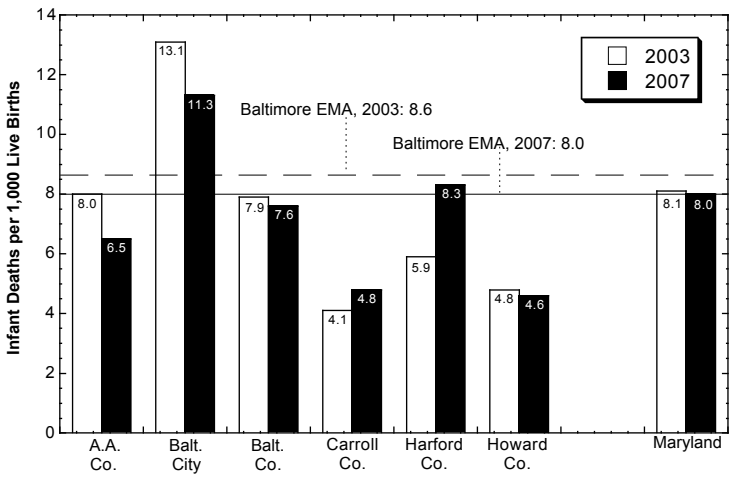
### 1.6. Infant Mortality in the EMA.

Since the last comprehensive plan, infant mortality has declined in many of the

EMA's jurisdictions, including Baltimore City. Infant mortality in the Baltimore EMA declined from 8.6 to 8.0 deaths per 1,000 live births between 2003 and 2007 (DHMH 2004, DHMH 2008a).

Figure 1.4.

**Infant Mortality in the EMA by Jurisdiction, 2003 and 2007**




**Source:** DHMH 2004, 2008a.

Note: Queen Anne's County (1 death of 501 live births in 2003 and 4 deaths of 557 live births in 2007) is not depicted in graph.

Declines occurred in Anne Arundel County (8.0 to 6.5 deaths per 1,000 live births), Baltimore City (13.1 to 11.3 deaths per 1,000 live births), Baltimore County (7.9 to 7.6 deaths per 1,000 live births) and Howard County (4.8 to 4.6 deaths per 1,000 live births). Harford County (5.9 to 8.3 deaths per 1,000 live births) and Carroll County (4.1 to 4.8 deaths per 1,000 live births) both experienced increases in their infant mortality rates during this period. There was one infant death in Queen Anne's County in 2003 as compared to four such deaths in 2007. Infant mortality declined slightly in Maryland, from 8.1 to 8.0 deaths per 1,000 live births, over this same period. Most, if not all, of the state's falling rate was driven by declines in the Baltimore EMA.

Baltimore City and Harford County were the only jurisdictions in the EMA whose infant mortality rates exceeded the rate for the entire state in 2007. However, not all the infant mortality indicators for Baltimore City were negative. Declines in the city's infant mortality rate, along with those in Anne Arundel, Baltimore and Howard counties, were instrumental in the declining infant mortality rate in the EMA between 2003 and 2007 — infant mortality rates in the rest of the state increased during this period (7.8 to 8.0 deaths per 1,000 live births).

Even factoring in the declines noted above, infant mortality was higher in both the EMA and Maryland in 2007 than it was in the northeast corridor (6.38 deaths per 1,000 live births) and the nation (6.71 deaths for 1,000 live births) according to preliminary data for 2006 from the Centers for Disease Control and Prevention (CDC) (CDC 2008). The distribution of the 10 leading causes of infant death in Maryland is similar to that of the country as a whole; the primary difference is that there are more deaths in the state.[6] Sudden infant death syndrome

[6] The five leading causes of infant mortality in Maryland (in descending order) are disorders related to short gestation and low birth weight (20 percent); congenital malformations, deformations and chromosomal abnormalities (18 percent); sudden infant death syndrome (11 percent); newborns affected by maternal complications of pregnancy (7 percent); and newborns affected by complication of placenta, cord and membranes (4 percent) (DHMH 2007).

The five leading causes of infant mortality in the nation (in descending order) are congenital malformations, deformations and chromosomal abnormalities (20 percent); disorders related to short gestation and low birth weight (17 percent); sudden infant death syndrome (8 percent); newborns affected

was responsible for more deaths in Maryland than in the U.S. However, unintentional accidents, the fifth leading cause of infant deaths in the U.S., was not among the top 10 causes of infant mortality in Maryland.

While Maryland and the EMA suffer from higher rates of infant mortality, the news again is not all bleak. All of the jurisdictions of the EMA whose rates exceeded those of the northeast corridor and the nation in 2004 experienced declines in their rates between 2003 and 2006. However, infant mortality remains a major problem in the EMA, and once again the epicenter is Baltimore City.

### 1.7. Low Birth Weight in the EMA.

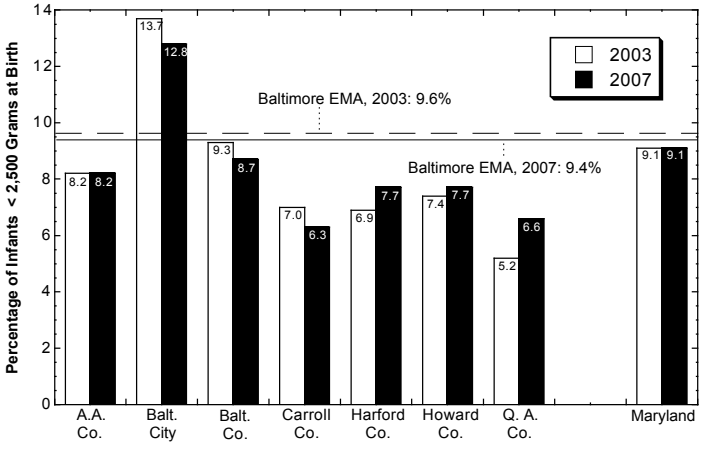
Preliminary data for 2006 show that the prevalence of low-birth-weight babies in Maryland (9.4 percent of all births), as compared to the northeast corridor (8.4 percent) and the rest of the country (8.3 percent), closely mirrors the findings for infant mortality (CDC 2007b). Data from the state for 2007 show that 9.1 percent of infants born in Maryland weighed less than 2,500 grams (i.e., were low-weight infants) (DHMH 2008a). The problem, which disproportionately affects Maryland's infants as compared to the rest of the nation's infants, is even more severe for infants in the Baltimore EMA.

The number of low-birth-weight infants is a persistent problem in the Baltimore EMA. Since the last comprehensive plan, the prevalence of such infants in the EMA has decreased from 9.6 percent to 9.4 percent (DHMH 2004, DHMH 2008a). Baltimore City continued to be the absolute and relative leader in the prevalence of low-birth-weight babies. However, Baltimore did see a decline between 2003 (13.7 percent) and 2007 (12.8 percent). Baltimore County (9.3 to 8.7 percent) and Carroll County (7.0 to 6.3 percent) were the only other jurisdictions to register a decline during this period.

Baltimore City was the only jurisdiction whose low-birth-weight rate exceeded the rate found for the non-EMA portions of the state in 2007 (8.9 percent). However, this should not obscure the depth of the EMA's growing problem. As mentioned above, Maryland has a relatively high rate compared to its neighbors and the rest of the country. Furthermore, most of the jurisdictions whose rates were below the national rate (i.e., Harford [6.9 to 7.7 percent], Howard [7.4 to 7.7 percent] and Queen Anne's [5.2 to 6.6 percent] counties) experienced increases in their low-birth-weight rates between 2003 and 2007. The exception was Anne Arundel County (8.2 percent in both 2003 and 2007).

Figure 1.5.

**Low Birth Weight in the EMA, by Jurisdiction, 2003 and 2007**




**Source:** DHMH 2004, 2008a.

### 1.8. Medicaid in the EMA.

Medicaid enrollment has been steadily increasing throughout the country for nearly a decade, due, in

by maternal complications of pregnancy (6 percent); and accidents (4 percent) (CDC 2007a).

large part, to the inclusion of millions of new children through the State Children's Health Insurance Plan (Kaiser 2008). Because of the changing eligibility requirements, it is difficult to make inferences about the changing level of Medicaid need over time.

Residents of the Baltimore EMA (13.8 percent) were more likely than other Marylanders to be Medicaid recipients in 2008, but this is almost entirely attributable to Baltimore City (30.0 percent) (DHMH 2008c). While nearly one of every three residents of the city received some form of medical assistance from Medicaid, none of the other jurisdictions had an enrollment rate higher than the non-EMA portions of the state (11.6 percent).

Table 1.3.

**Medicaid Enrollment by Jurisdiction, 2005 and 2008**
(Percent of All Residents)

| Jurisdiction | 2005 | 2008 | % Change* |
|---|---|---|---|
| *Maryland* | *12.0%* | *12.6%* | *5.3%* |
| **Baltimore EMA** | **13.7%** | **13.8%** | **0.5%** |
| Anne Arundel County | 7.7% | 7.8% | 1.6% |
| Baltimore City | 28.9% | 30.0% | 3.6% |
| Baltimore County | 10.9% | 10.5% | -3.5% |
| Carroll County | 6.4% | 6.3% | -1.6% |
| Harford County | 9.0% | 8.7% | -3.3% |
| Howard County | 6.4% | 6.3% | -1.2% |
| Queen Anne's County | 9.1% | 9.4% | 3.2% |
| *Maryland, non-EMA* | *10.4%* | *11.6%* | *11.1%* |

**Source:** BC 2008a; DHMH 2008c.

* Percent change in the percentage of enrollment, not to be confused with the simple change in the percentage of enrollment. (Percent change based on the non-rounded 2005 and 2008 percentages.)

As shown in table 1.3, Anne Arundel (7.7 to 7.8 percent) and Queen Anne's (9.1 to 9.4 percent) counties joined Baltimore City (28.9 to 30.0 percent) in increasing enrollment between 2005 and 2008. Baltimore (10.9 to 10.5 percent), Carroll (6.4 to 6.3 percent), Harford (9.0 to 8.7 percent) and Howard (6.4 to 6.3 percent) counties all experienced declines in Medicaid enrollment over this period.

As mentioned above, it is difficult to tell what these increases in enrollment mean for the state of health care in the EMA; this is especially true of the surrounding counties. In addition to changes in eligibility over time, there are different standards set by each state.

In an effort to produce comparable statistics the Kaiser Commission on Medicaid and the Uninsured conducts an annual state-by-state analysis of Medicaid enrollment that incorporates differences in eligibility requirements. The last update found that, controlling for differences in eligibility, an estimated 8.9 percent of Marylanders were enrolled in Medicaid as of December 2006, as compared to 14.1 percent of all Americans and 14.7 percent of residents in the northeast corridor (Kaiser 2008).

## 1.9. Homelessness in the EMA.

Homelessness is another telling indicator of the social and economic health of a region. In a March 2008 report on homelessness to Congress, the Department of Housing and Urban Development (HUD) estimated that, as a unique sub-population, people living with HIV and AIDS constituted a larger portion of the total homeless population than military veterans, who are, in many ways, the face of homelessness in the United States (HUD 2008).

Counting the homeless population in the best of times is a difficult feat considering the transitory nature of the population and seasonal variations in the usage of facilities. Past counts have been attacked for being methodologically unsound and politically motivated.[7] Recent efforts have been

[7] In 1983, local advocacy groups estimated that the homeless population of the U.S. was between 2.2 and 3 million individuals. The following year the U.S. Census Bureau claimed that the number was closer to

Table 1.4.

**Homelessness by Jurisdiction, 2005**

| Jurisdiction | Homeless Population | Total Population | Homeless per 100,000 |
|---|---|---|---|
| United States | 744,313 | 296,410,334 | 251 |
| Northeast Corridor | 154,632 | 69,203,793 | 223 |
| *Maryland* | *7,995* | *5,600,388* | *143* |
| **Baltimore EMA** | **4,135** | **2,650,144** | **156** |
| Anne Arundel County | 273 | 510,088 | 54 |
| Baltimore City | 2,904 | 640,064 | 454 |
| Baltimore County | 398 | 782,885 | 51 |
| Carroll County | 215 | 166,961 | 129 |
| Harford County | 115 | 237,317 | 48 |
| Howard County | 182 | 267,779 | 68 |
| Queen Anne's County* | 48 | 45,050 | 107 |
| *Maryland, non-EMA* | *3,860* | *2,950,244* | *131* |

**Source:** NAEH 2007; BC 2008a.

* Queen Anne's County figures were apportioned using the data on the Mid-shore Regional Continuum of Care (CoC) and the assumption that homelessness was evenly distributed throughout this CoC. The Mid-shore Regional CoC includes Kent, Queen Anne's, Talbot, Caroline and Dorchester counties.

undertaken to standardize the methodology across the country and to depoliticize the counting process in other ways. As a result, the following data should only be used for relative comparisons of jurisdictions and not as an absolute measure of homelessness, as estimates can vary wildly.[8]

The homelessness figures in table 1.4, compiled by the National Alliance to End Homelessness (NAEH), are consistent with the data reported by BCHD, and are disaggregated by geographic areas (continuums of care), which, with the exception of Queen Anne's County, match the EMA's jurisdictions (NAEH 2007).

The rate of homelessness in the Baltimore EMA (156 per 100,000) is slightly higher than the Maryland rate (143 per 100,000), but much lower than the rates found in neighboring states of the northeast corridor (223 per 100,000) and the nation (251 per 100,000). These findings should not obscure either high levels of homelessness in Baltimore City, or the very real conditions of individuals and families confronting homelessness and housing insecurity in the EMA as a whole.

Baltimore City (454 per 100,000) has nearly twice the national rate of homelessness. Of the surrounding counties, only Carroll County (129 per 100,000) has a rate of even a quarter of the city rate. Harford (48 per 100,000), Baltimore (51 per 100,00), Anne Arundel (54 per 100,000), Howard (68 per 100,000) and Queen Anne's (107 per 100,000) counties all had homelessness rates that were appreciably lower than rate found in the non-EMA portions of Maryland (131 per 100,000).

## 1.10. Access to Health Care in the EMA.

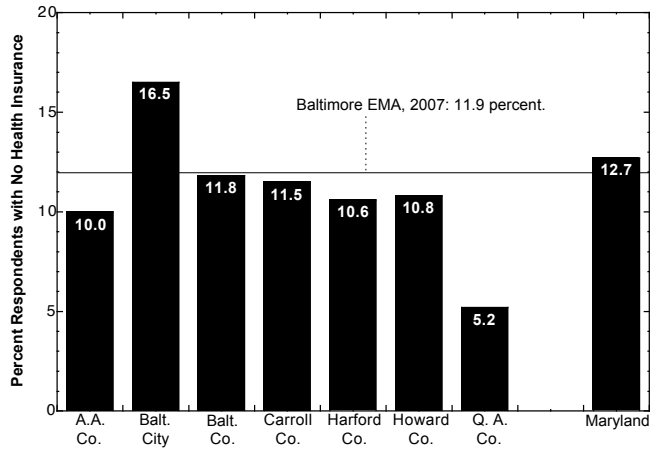
Medicaid, in addition to being a measure of socio-economic status, is also an indicator of health-care access. As noted in the prior section, many of the EMA's low-income

250,000 to 350,000. The difference between these two numbers has obvious funding implications, and, as a result, while the two sides have come closer in their estimates, tensions remain over homelessness counts (NAEH 2007:8).

[8] For example, according to the Maryland Department of Human Resources' (DHR) 2005 Fact Pack, facilities from the EMA tracked by the state reported the provision of 58,112 bed nights for the homeless, with an average stay of 39 days (DHR 2006a, 2006b, 2006c, 2006d, 2006e, 2006f, 2006g). By the most liberal estimation (stays limited to one per year and no overlap between the populations served by the different EMA jurisdictions) this would suggest that EMA facilities served 1,494 unique individuals in 2005. However, a count by the Baltimore City Health Department (BCHD 2007) found that at one point during the same year, there were 2,321 homeless individuals in Baltimore City facilities alone (according to the Fact Pack, there should have been at most 626 unique individuals served by facilities tracked by DHR over the entire year).

residents rely — for better or worse (discussed below) — upon Medicaid for their health-care needs. However, Medicaid does not cover everyone: according to data taken from the Maryland Behavioral Risk Factor Surveillance System (BRFSS), 11.9 percent of respondents from the Baltimore EMA reported not having any health insurance (95 percent confidence interval: 10.5 to 13.3 percent) (DHMH 2008b).

Figure 1.6.




**Source:** DHMH 2008b

Baltimore City (16.5 [12.5-20.5] percent) has the most residents in the EMA without health insurance. These numbers, in addition to the Medicaid figures, suggest that just over half of the city's residents rely on private insurers for their health care costs. The city has significantly more residents without health insurance than Baltimore County (11.8 [9.3-14.3] percent, p=.002), Howard County (10.8 [6.8-14.9] percent, p=.006), Harford County (10.6 [6.4-14.8] percent, p=.007), Anne Arundel County (10.0 [7.0-13.1] percent, p<.001) and Queen Anne's County (5.2 [1.9-8.5] percent, p=.001).[9] There were also fewer respondents from Carroll County (11.5 [6.1-16.9] percent, p=.055) reporting a lack of health insurance than in Baltimore City. Queen Anne's County had significantly fewer residents without health insurance than all the other EMA jurisdictions in 2007.

While Baltimore City has the highest rate of uninsured in the EMA, on this indicator, unfortunately and fortunately, it is not dramatically outpacing the rest of the state (unfortunate because this is primarily due to the fact that nearly one in every three Baltimore residents is enrolled in Medicaid, and fortunate because these residents do have access to health care). The rate for non-EMA portions of the state (13.4 [12.3-14.5] percent) was significantly higher than that of the EMA (p=.015).[10]

Even with insurance, many of the EMA's residents are not guaranteed quality health care. One of the drawbacks of having such a high population of Medicaid recipients, as Baltimore City does, is that many doctors are not interested in working in these areas. The U.S. Department of Human Services, Health Resources and Services Administration (HRSA) estimates that Baltimore City currently has 12 medically underserved areas (MUA) (HRSA 2008b) and a heath professional shortage of 41

[9] Large-sample Z tests (two-tailed) were used to compare proportions from independent samples. Differences were designated as "significant" if p≤.05.

[10] Garrett County (28.2 [21.1-35.3] percent, p<.001) had a significantly higher proportion of residents without insurance than Baltimore City. Also, a higher percentage of BRFSS respondents reported not having insurance in Wicomico County (19.5 [13.9-25.1] percent, p=.224), Caroline County (19.0 [12.0-26.0] percent, p=.373) and Washington County (17.2 [12.9-21.5] percent, p=.743) than in the city, but these differences did not reach significant levels. Maryland counties with a higher proportion of respondents reporting a lack of insurance than in the Baltimore EMA were as follows: (in decreasing order) Garrett, Wicomico, Washington, Caroline, Somerset, Dorchester, Prince George's, Montgomery, Calvert, Cecil and Talbot counties (DHMH 2008b).

primary care, 9 dental and 21 mental health providers (HRSA 2008a).

Compare this to Howard and Carroll counties, which have no MUAs or shortages of health professionals. According to HRSA, Anne Arundel, Baltimore, Harford and Queen Anne's counties are only short a total of one primary care provider (in Harford County). Anne Arundel County has three MUAs and one medically underserved population (MUP); Baltimore County has two MUAs and one MUP; and Queen Anne's County has two MUAs.

However, if there is one area where the average Baltimore City resident has an advantage over his or her counterparts from the counties, it is in access to hospital facilities. According to the University of Maryland's Health Science and Human Service Library (HS/HSL), 20 of the EMA's 36 hospitals are in Baltimore City (1 hospital per 17,538 persons) (UMD 2008). That leaves 6 hospitals in Baltimore County (1 per 131,449 persons); 3 in Anne Arundel County (1 per 170,718 persons); 2 each in Carroll (1 per 84,610 persons), Harford (1 per 119,997 persons) and Howard (1 per 136,834 persons) counties; and 1 in Queen Anne's County (1 per 46,571 persons).

The population figures are a bit misleading as many of the county residents are able to rely upon Baltimore City hospitals, such as Johns Hopkins and the University of Maryland Medical Center. Still, the limited number of hospitals, often looking to serve large geographic areas, poses a challenge to county residents — one that can be particularly burdensome for less affluent residents who need to make their way into the city for specialty services, such as Ryan White Part A clients.

## 1.11. Conclusion.

Planning for the challenges that will confront the Baltimore EMA over the next three years is complicated by the diversity of the EMA's constituent jurisdictions. Solutions have to be tailored that address the highly concentrated need found in Baltimore City and the dispersed need found in the counties, which, despite their relative prosperity, are lacking many of the services required by potential Ryan White clients.

Planners will also have to contend with several factors that are not captured by statistical data. A recent downturn in the economy, and the resulting loss in tax revenues, is making it even more difficult for government agencies to keep pace with rising needs. At the very least, it appears that planners will have to make do with level funding that, when inflation and increasing need are included, will require that more is provided with fewer resources. At worst, the next three years could see substantial funding cuts at just the time that potential Ryan White clients will need the greatest assistance.

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