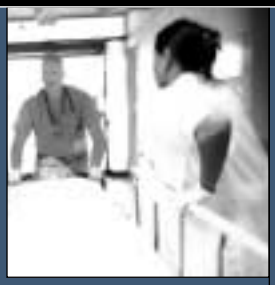
AN ASSESSMENT OF THE

SAFETY NET
in Boston, Massachusetts



Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

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Health Care for All is a non-profit, consumer health advocacy organization that works with organizations and consumers to identify the current health system's failures and to design solutions for the existing health care crisis. More information on Health Care for All can be found at www.hcfama.org.

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The Department of Health Policy is the home for health policy research and studies at the George Washington University Medical Center, School of Public Health and Health Services. The Department of Health Policy is dedicated to providing policymakers, public health officials, health care administrators, and advocates with the information and ideas they need to improve access to quality, affordable health care. This report and other *Urgent Matters* safety net assessments are available at the Department of Health Policy website www.gwhealthpolicy.org or the *Urgent Matters* website www.urgentmatters.org.

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Foreward

After several years of decline, the number of Americans without health insurance is climbing rapidly. Meanwhile erosion in tax revenues is driving states to cut funding for Medicaid. Both trends are hitting all health care providers hard, as they simultaneously attempt to cope with a nursing shortage, escalating labor costs, and the adoption of expensive new technologies.

These forces are felt the most in the health care safety net. These providers of care for the poor, uninsured and other vulnerable populations have not had to face such a confluence of challenges in recent memory. They must survive in an industry in upheaval, while attempting to serve the ballooning numbers of our fellow Americans in need. They must also continue to provide a set of highly specialized services, such as burn, trauma and neonatal care to a broad swath of their local communities.

It is against this backdrop that we have assessed the "state of the safety net" in Boston. Due to the foresight of the Robert Wood Johnson Foundation, a team of researchers at The George Washington University Medical Center led by Marsha Regenstein, PhD, MCP, has assessed the health of the safety net in ten United States communities. In each community we worked with a Community Partner—a local organization that helped us to identify the key issues and stakeholders. In Boston, we are deeply indebted to Health Care for All. These community partners have also committed to convening opinion leaders and others in their region to discuss the implications of the reports' findings. All of this was done as part of the *Urgent Matters* project, a national program designed to spur awareness of safety net issues while finding practical ways to relieve one symptom of distress—crowded emergency departments.

Our goal is to provide new analysis and information on what is happening today in the critical systems of care for the underserved in these communities. By doing so we seek to inform the health care discussions in these places and the nation, and to lay a foundation for rational change and improvement. We do not presume to know all the answers. But we believe that an objective analysis by an unbiased team can be immensely helpful to communities in need of a critical analysis of their safety net. This report seeks to meet this need.

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Executive Summary

The *Urgent Matters* program is a new national initiative

of The Robert Wood Johnson Foundation, designed to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. *Urgent Matters* examines the interdependence between emergency department (ED) use and the health care safety net in ten communities throughout the United States. One component of this program was the development of comprehensive assessments of the safety nets in each of the ten communities that served as the focus of the study. This report presents the findings of the Boston, Massachusetts, safety net assessment.

Each of the *Urgent Matters* safety net assessments was prepared by a research team from The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the project staff from the hospitals selected for the study and a community partner. The Boston assessment draws upon information collected from interviews with senior leaders in the Boston health care community and from on-site visits of safety net facilities. The research team also met with key stakeholders in Boston as well as with residents who use safety net services.

To set the context for this study, the team drew upon secondary data sources to provide demographic information on the populations in Boston, as well as data on health services utilization, coverage statistics, and related information. The assessment includes an analysis of data that indicates the extent to which the emergency department at Boston Medical Center provides care that could safely be provided in a primary care setting.

This report examines key issues that shape the health care network available to uninsured and underserved residents in Boston. It provides background on the Boston health care safety net and describes key characteristics of the populations served by the safety net. It then outlines the structure of the safety net and funding mechanisms that support health care safety net services. The report also includes an analysis of key challenges facing providers of primary and specialty care services and specific barriers that some populations face in trying to access them.

Key Findings and Issues for Consideration: Improving Care for Uninsured and Underserved Residents of Boston

The safety net assessment team's analysis of the Boston safety net generated the following key findings:

Boston has an extensive health care safety net with far-reaching penetration in the community. Uninsured and low-income populations are served by Boston Medical Center (BMC) and a well-integrated community health center network. Public programs including Massachusetts' Medicaid program, MassHealth, and the Free Care Pool have enabled low-income residents to receive insurance coverage or subsidized care to address their health care needs.

After serving as a model for state-sponsored health insurance expansions and robust safety net services, Massachusetts has responded to a severe downturn in the economy with slow but significant erosions to its public support for safety net providers, outreach activities, and MassHealth services. These trends are likely to place additional burdens on the state's Free Care Pool as more residents become uninsured. Hospital emergency departments will be burdened as well, as many residents forgo care until their needs become emergent.

The Free Care Pool, which has served as the foundation for subsidizing health care for uninsured individuals, faces an uncertain future. New financing arrangements are being developed that will alleviate some of the financial stresses on community hospitals. At the same time, the redistribution of funds may impair the ability of large safety net providers, such as Boston Medical Center, to serve the growing uninsured population.

Cuts to the Massachusetts Department of Health and Human Services budget have eroded important aspects of the mental health safety net in Boston. These budget reductions have forced community mental health programs to reduce or eliminate services for the uninsured, and limit essential medications for mentally ill patients. In addition, the state's elimination of MassHealth Basic deprived a seriously vulnerable population of coverage for important mental health services.

Hospital emergency departments are feeling the backlash of reductions in MassHealth coverage and substance abuse and mental health care programs for adults and children. Without these public resources, patients are not getting timely care and ending up in crisis in the emergency department.

A significant percentage of emergency department visits at BMC are for patients whose conditions are non-emergent. Over one-fifth (22.3 percent) of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. Nearly another fifth (19.4 percent) were for patients whose conditions were emergent but could have been treated in a primary care setting.

Low-income and uninsured residents of Boston struggle to navigate the health care system. Coordinating care across multiple providers and insurance programs is a particular challenge to patients with little knowledge of the local safety net and limited English proficiency. The loss of funding for outreach programs has made it all the more difficult for low-income individuals, immigrants, and working, uninsured residents in Boston to negotiate the health care system.

The Urgent Matters *safety net assessment team offers the following issues for consideration:*

Boston safety net providers must educate the health care community about the importance of preserving a Free Care Pool mechanism that does not place any additional burden on principal safety net facilities. Realistic reforms must be developed that will preserve this important funding mechanism.

Safety net providers, community-based organizations, faith-based institutions and other stakeholders should work together to develop strategies to reach out to uninsured residents of Boston and enroll them in the new MassHealth Essential program or other public insurance plans. Many eligible individuals do not have the means or knowledge to apply for benefits, and require help from outreach workers and other community groups. As the state appears to be withdrawing support from the safety net, it is even more crucial for the key players in the safety net to continue to collaborate in their efforts to address these issues and other local problems in access.

Hospitals, safety net providers and community-based organizations must agree to work together to build an adequately funded mental health care infrastructure. Significant reductions in Department of Mental Health funding have severely affected the ability of safety net providers to offer mental health services to Boston residents.

The Boston health care community must work together to increase funding for vital community health resources in Boston, including longer hours of service at community health centers, new points of access for uninsured and underserved residents, better transportation to and from key safety net facilities, and greater prescription drug availability in safety net pharmacy formularies. It remains unclear whether safety net providers can respond to the growing demand as low-income and uninsured patients in and outside the Boston area continue to seek specialty services, emergency care, and pharmacy assistance from Boston safety net providers.

Public awareness campaigns and outreach efforts should be employed to help poor and uninsured residents learn how to navigate the health care system. Boston is fortunate to have a well-integrated, progressive safety net system in place. Still, some residents are overwhelmed by the complexities of the system and uncertain how to access its services.

All hospitals in the Boston safety net should conduct analyses of the use of their emergency departments for emergent and non-emergent care. These studies would help determine whether area hospitals are experiencing trends in ED use similar to those seen in safety net hospitals. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in hospital EDs.

Introduction

In 2000, the Institute of Medicine (IOM) published a report on the health care system serving uninsured and underserved individuals in the United States. Entitled *America's Health Care Safety Net: Intact but Endangered,* the report examined the viability of the safety net in the face of major changes in the financing and delivery of health care. The IOM report concluded that the safety net in America is under significant pressure from changing political and financial forces, including the growth in the number of uninsured, the reduction or elimination of subsidies funding charity care, and the growth of mandated managed care.

The Robert Wood Johnson Foundation established *Urgent Matters* in 2002 to further study the dynamics of the health care safety net. While the IOM report focused its review principally on ambulatory and primary care settings, *Urgent Matters* takes IOM's research a step further and examines the interdependence between the hospital emergency department (ED)—a critical component of the safety net—and other core safety net providers who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[1]

The purpose of *Urgent Matters* is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. The program consists of three key components: 1) technical assistance to ten hospitals whose EDs serve as critical access points for uninsured and underserved patients; 2) demonstration grants to four of these ten hospitals to support innovative and creative solutions to patient flow problems in the ED; and 3) comprehensive assessments of the safety nets in each of the communities that are home to the ten hospitals. This report presents the findings of the safety net assessment in Boston, Massachusetts.

These assessments have been developed to provide information to communities about the residents who are most likely to rely on safety net services.

Each of the *Urgent Matters* safety net assessments has been prepared by researchers at The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the hospital ED project staff and a community partner—an organization that is well-positioned to convene key stakeholders in the community to work together to strengthen safety net services on behalf of community residents. The *Urgent Matters* grantee hospitals and community partners are listed on the back cover of the report.

These assessments have been developed to provide information to communities about the residents who are most likely to rely on safety net services. They are designed to highlight key issues affecting access to care for uninsured and underserved residents, as well as to identify potential opportunities for improvement.

The assessments were conducted during the summer and fall of 2003. Each assessment draws upon information obtained from multiple sources. The Boston assessment team conducted a site visit on September 15 to September 17, 2003, touring safety net facilities and speaking with numerous contacts identified by the community partner and others. During the site visit, the community partner convened a meeting of key stakeholders who were briefed on *Urgent Matters*, the safety net assessment, and the key issues under review. This meeting was held on September 15, 2003, at Boston Medical Center.

Through the site visits and a series of telephone conferences held prior to and following the visit to Boston, the assessment team interviewed many local informants, including senior leaders at hospitals and health systems, community health centers and other clinics, public health and other service agencies and

mental health agencies. Individual providers or provider groups, advocates, and policymakers were interviewed as well. The team also drew upon secondary data sources to provide demographic information on the population in Boston, as well as data on health services utilization and coverage.

While in Boston, we conducted focus groups with residents who use safety net services. We held three groups with a total of 29 participants; one of the focus groups was conducted in English, one was in Spanish and the third was in Haitian Creole. The assessment team worked with the community partner to recruit patients who were likely to use safety net services. Finally, the assessment included an application of an ED profiling algorithm to emergency department data from Boston Medical Center. The algorithm classifies ED encounters as either emergent or non-emergent cases.

Section one of the Boston safety net assessment provides a context for the report, presenting background demographics on Boston and Massachusetts. It further describes the structure of the safety net, identifying the providers and facilities that play key roles in delivering care to the underserved. Section one also outlines the financial mechanisms that support safety net services. Section two discusses the status of the safety net in Boston based on the site visits, telephone conferences and in-person interviews. This section examines challenges to the safety net, highlighting problems in access to needed services, growing burdens on hospital emergency departments, stresses on safety net providers, declining rates of insurance coverage, and other barriers to care faced by the underserved.

Section three presents findings from the focus groups and provides insights into the challenges that uninsured and underserved residents face when trying to access services from the local health system. Section four includes an analysis of patient visits to the emergency department at Boston Medical Center. This analysis includes demographic information on patients who use the emergency department and examines the extent to which the emergency department at Boston Medical Center may be providing care that could safely be provided in a primary care setting. Finally, Section five presents key findings and issues that safety net providers and others in the Boston area may want to consider as they work together to improve care for uninsured and underserved residents in their communities.

Background

Boston is the largest city in Massachusetts, with over 545,181 people residing in the city limits.[2] Its residents are poorer and more ethnically diverse than are the residents of the state as a whole (see Table 1). Nearly 30 percent of its residents are black and 7.5 percent are Asian. Approximately one in seven residents (14.8 percent) are of Latino origin.[3] By comparison, 85.8 percent of Massachusetts residents are white, only about 6 percent are black and 4 percent are Asian. About one in thirteen state residents (7.3 percent) are of Latino origin.[4] Over a quarter of Boston residents were born in another country and 28.6 percent speak a language other than English at home.

Table 1 A Snapshot of Boston and Massachusetts

Selected Demographics	Boston	Massachusetts
Population		
Size	545,181	6,210,578
Density: Persons/square mile	12,165.8	792.3
Race		
White	55.7%	85.8%
Black	29.3%	5.6%
Asian	7.5%	4.2%
Other	7.3%	4.0%
Latino origin and race	14.8%	7.3%
Birthplace/Language		
Foreign born	27.0%	13.1%
Language other than English spoken at home	28.6%	18.7%
Age		
18 years and over	80.4%	76.6%
65 years and over	9.5%	13.0%
Median age (in years)	32.4	37.5

Sources: American Community Survey Profile, 2002, U.S. Census Bureau.

Nearly one-fifth of Boston residents and 26.9 percent of Boston's children live in poverty (see Table 2).[5] Fenway, one of the poorest neighborhoods in Boston, has more than 37 percent of residents living below the federal poverty level (FPL), followed by Roxbury with 29 percent, and South End and Allston/Brighton each with 24 percent.[6,7]

Table 2 Income, Poverty Level and Insurance Coverage in Boston and Massachusetts

	Boston	Massachusetts
Income and poverty[+]		
Living below poverty—all individuals	19.5%	8.9%
Related children under 18 years	26.9%	11.9%
Median household income	$39,819	$55,266
Insurance coverage		
Commercial	55.2 %[#]	73.7 %*
Medicare	11.1 %[#]	13.8 %*
Medicaid and SCHIP	24.5%[^]	11.9%*
Uninsured	11.7%~	9.9%

[+] *Source: American Community Survey Profile, 2002, U.S. Census Bureau.*
[#] *Data are for Suffolk County. Resources to Expand Access to Community Health (REACH) Data, 2000, National Association of Community Health Centers.*[8]
* *Annual Demographic Survey: March Supplement data, 2003, Current Population Survey.*
[^] *Data are for the non-elderly population in Boston. Massachusetts Division of Health Care Finance and Policy, 2002.*
~ *Source: Data are for Boston. Massachusetts Division of Health Care Finance and Policy, 2002.*

Households of Latino and Asian residents had the lowest median income ($27,141 and $27,963, respectively) and households of white individuals had the highest median income ($47,668) (see Table 3).[9] Latinos and Asians had the highest percentage of residents living below the poverty level, with 31 percent and 30 percent, respectively.[10]

The percentage of uninsured individuals in Boston increased 46 percent between 2000 and 2002 to 11.7 percent in 2002 (see Table 2).[11] The rate of increase for uninsured children was higher during this time period, rising 50 percent to 6.3 percent in 2002. These rates have increased even more since the elimination of the MassHealth Basic insurance program, a state-funded and administered program that insured approximately 50,000 of the state's neediest residents.[12] Most individuals without insurance are not capable of paying for health care costs out of pocket; almost 30 percent of the uninsured in Boston live below 200 percent of the federal poverty level. The uninsured population is also ethnically varied. Over 40 percent of the uninsured are Latino, while 17.7 percent are black and 33.9 percent are white.[13]

Table 3 Income and Poverty by Race/Ethnicity, Boston, 2000

Race	Median Household Income	Population Below Poverty
White	$47,668	13%
Black	$30,447	23%
Latino	$27,141	31%
Asian	$27,963	30%

Source: The Health of Boston 2003, The Boston Public Health Commission, 2003.

Homelessness is a growing problem in Boston. The city has experienced a 40.8 percent increase in homelessness since 1992.[14] As of a 2002 citywide count, approximately 6,210 people in Boston were without homes.[15]

Structure of the Safety Net

Provider Capacity: Suffolk County, where Boston is located, has significantly more physicians per patient population than the state as a whole. The county had 202 primary care providers per 100,000 patient population in 1999, nearly twice as many as the state (see Table 4).[16,17] Suffolk County also surpasses the state for specialists and pediatricians, with 130.7 medical specialists, 127.9 surgical specialists and 245 pediatricians per 100,000 patient population.

Table 4 Physician and Hospital Supply Capacity, Suffolk County and Massachusetts

	Suffolk	Massachusetts
Physician supply (per 100,000)		
Primary care providers	202.0	106.6
Pediatricians	254.2	114.9
OB/GYN	53.5	34.5
Medical specialist	130.7	51.6
Surgical specialist	127.9	52.1
Hospital supply/utilization (per 1,000)		
Inpatient beds	5.49	2.29
Admissions	271	108
Emergency department visits	569	419

Source: Data are for 1999. Billings and Weinick. Monitoring the Health Care Safety Net Book II: A Data Book for State and Counties, Agency for Healthcare Research and Quality, 2003.

In total, 14 hospitals serve the Boston area. Hospital mergers and facility closures, however, have resulted in a significant decline in inpatient beds. Over the past decade, more than 20 acute care hospitals have closed statewide, resulting in a 29 percent decline in available hospital beds.[18] Boston alone has seen a 30.2 percent reduction in available beds from 8,409 beds in 1990 to 5,866 beds in 1999.[19] The county still exceeds the state in bed capacity and admissions. Suffolk County had 5.49 beds per 1,000 population and 271 admissions per 1,000 population. By comparison the state had 2.29 beds and 108 admissions (see Table 4)

Hospital Systems: Eight major hospital systems composed of a total of 25 hospitals serve Eastern Massachusetts. Fourteen of these hospitals are located within Boston proper. Massachusetts General Hospital and Brigham and Women's Hospital are the two largest hospitals in Boston, followed closely by Beth Israel Deaconess Medical Center.

Boston Medical Center (BMC) is the primary safety net hospital in the city. The product of a merger between Boston's only public hospital, Boston City Hospital, and Boston University Medical Center, BMC is a not-for-profit, academic medical center located in the inner-city neighborhood of South End. BMC houses 547 licensed beds and is a level 1 trauma center.

BMC coordinates care with the primary care network in the city. The hospital participates in Boston HealthNet, a partnership with 15 of the city's community health centers (CHCs). Four of these CHCs operate on the hospital's license and one runs as a satellite facility on BMC's operating budget. Through the partnership, CHCs refer patients to BMC for diagnostic testing, specialty care or inpatient services. BMC, in turn, refers patients in need of a primary care medical home to conveniently located community health centers in the network.

BMC serves the largest population of uninsured and Medicaid patients of all the hospitals in Boston. Uninsured/self pay patients represent 18 percent of BMC's patient mix, and the hospital provided over

$105 million in free care last year.[20] Mass General and Brigham and Women's are also considered major safety net providers. These hospitals, however, have a much smaller percentage of uninsured in their patient mix compared to BMC. Less than 2 percent of Mass General's admissions and about 2.3 percent of Brigham and Women's admissions are for uninsured patients.[21]

BMC also serves a larger Medicaid population than other hospitals. Medicaid patients constitute 29 percent of BMC's payer mix.[22] By contrast, about 9 percent of Mass General and Brigham and Women's patients are covered by Medicaid.[23] New England Medical Center Hospital also has a high Medicaid population, with about 16.5 percent of patients covered by the public program. Less than 2 percent of its inpatient admissions, however, are uninsured.[24]

The level of hospital care provided to low-income populations can also be measured in terms of total charges to the Free Care Pool, which partially covers the cost of uncompensated care. BMC and its associated CHCs accounted for 23 percent of total charges to the Free Care Pool, Mass General Hospital accounted for 11 percent, Brigham and Women's Hospital 6 percent, Beth Israel 14 percent, and UMass Memorial Hospital 4 percent.[25] Another key safety net provider, Cambridge Health Alliance, received 14 percent of the Pool's funds. Other state hospitals accounted for 38 percent of total charges to the Free Care Pool.

Primary and Preventive Care: Uninsured patients can obtain primary and preventive care from 27 CHCs located throughout the city.[26] These health centers play a principal role in the safety net, financing the care they provide to the uninsured through direct grants from the federal government, other public health funding, the state's Free Care Pool and CenterCare, a state-sponsored insurance program exclusively for CHC patients ineligible for other public insurance.

The CHCs' mission is to provide care to those in need, regardless of their ability to pay. Services offered vary depending on a community's needs. Some centers provide language services via a phone interpreter line or bilingual staff. Many remain open for service in the evening or have weekend hours. A few, such as the East Boston health center, have urgent care departments open 24 hours a day. Subsidized pharmacy services and transportation to and from affiliated hospitals are also available in some centers. Overall, about 27 percent of community health center patients in Boston are uninsured and another quarter are covered by Medicaid.[27]

Almost all CHCs in the city have strong affiliations with local hospitals. Centers either participate in health care networks such as Boston HealthNet or have separate agreements with individual hospitals. These affiliations give patients access to important resources such as subsidized, hospital outpatient pharmacies or specialty care clinics.

Boston also has a number of health care resources targeting its most vulnerable populations, including children, immigrants, homeless people and the HIV/AIDs community. The Boston Public Health Commission, a quasi-public health agency,[28] operates 10 school-based health centers that serve as safety net providers for school-aged children. A number of community-based ethnic organizations exist in Boston to help immigrants obtain services. These organizations serve as "ports of entry" and help immigrants understand how the health care system works and where to go for care. They offer health fairs and seminars to educate immigrants about the importance of health care and available resources. Neighborhood health centers collaborate with these organizations to refer patients to their services.

The CHCs' mission is to provide care to those in need, regardless of their ability to pay.

Boston's Healthcare for the Homeless operates 68 homeless shelters and soup kitchens across the city, and an on-campus clinic at Boston Medical Center. The organization also operates the Barbara McInness House, a respite center for the homeless. The organization has close ties with safety net providers including BMC and various CHCs in the city. Organizations such as the Multicultural AIDs Coalition (MAC) have programs in place to provide HIV education, prevention and outreach services. MAC helps HIV/AIDs patients find appropriate care through either a community health center or Boston Medical Center, one of MAC's partners.

Specialty and Behavioral Health Care: Uninsured and underserved residents can access limited specialty care at community health centers. East Boston is the only health center in Boston that provides cardiology, orthopedic, gastrointestinal and oncology services on-site. For specialties that are not accessible through a health center, CHC physicians can link patients with specialists through referral lines set up by some of the local hospitals in the area, including Boston Medical Center and Beth Israel Medical Center.

Community health centers remain a primary source of care for uninsured and underserved patients with behavioral health problems, despite having lost significant state funding in the past year. The Massachusetts Department of Mental Health operates six behavioral health facilities that serve the Boston area. School health clinics are relied on heavily to deal with the mental health needs of children. Healthcare for the Homeless clinics and the Pine Street Inn are two resources available to homeless individuals with mental health and substance abuse problems. The ED is also a common source of mental health care for uninsured and underserved patients.

Financing the Safety Net

The principal sources of funding for Boston's safety net providers include MassHealth, the state's Medicaid program, the Free Care Pool, the Children's Medical Security Plan, and various pharmacy plans. These programs offer coverage or subsidized care for a set of services for eligible patients.

MassHealth Medicaid Programs

Low-income Massachusetts residents receive health coverage through a network of public programs, the largest of which is the state's Medicaid program, MassHealth. Established in 1997, MassHealth consists of a redesigned Medicaid program, the State Children's Health Insurance Program (SCHIP), and other state programs that expand coverage to other needy populations, including lower-income families with children, long-term unemployed adults, persons with HIV, undocumented immigrants,[29] and others (see Table 5).[30] Depending on eligibility, individuals can qualify for full or partial benefits, employer-sponsored coverage, prenatal care, or pharmacy benefits. The MassHealth program also provides funding to hospitals, community health centers and nursing homes that provide a disproportionate share of uncompensated care to poor people.[31]

Table 5 MassHealth Coverage Programs

Coverage Program	Eligibility	Benefits
Standard	Individuals eligible for traditional Medicaid, including low-income pregnant women and infants up to 200% FPL; parents and adults with disabilities up to 133% FPL; seniors with incomes at or below 100% FPL and assets less than $2,000 for individuals and $3,000 for couples.	Comprehensive Benefits.
Essential	Low-income, long-term unemployed adults whose gross family income is less than or equal to 100% FPL and who are not eligible for unemployment benefits. The program is capped at 36,000 enrollees.	Standard benefits as offered under MassHealth Basic, but without audiologist, chiropractor, hearing aid, nurse-midwife, orthotic, vision care and home health services.
CommonHealth	Higher income disabled adults and children (over 133% FPL).	Comprehensive benefits. Sliding scale premiums and cost sharing apply above 200% FPL.
Family assistance	**Category 1:** Children with higher incomes (150%-200% FPL) and persons with HIV up to 200% FPL. **Category 2:** Low-income workers up to 200% FPL (mainly for childless adults). **Category 3:** Small businesses (with low-income workers)	**Category 1:** Either direct public coverage with basic benefits and monthly co-pay or, for those in qualified employer-sponsored coverage, assistance with premiums. **Category 2:** Assistance with premiums if at qualified small employer. **Category 3:** Assistance with premiums up to $1,000/year for family coverage.
Limited	Undocumented immigrants, including pregnant women and children under 200% FPL and parents and disabled adults under 133% FPL.	Coverage of medically necessary services to treat acute medical conditions provided by a range of providers.
Buy-in	Medicare-eligible seniors or individuals with assets above MassHealth Standard benefits.	Assistance with premiums, deductible and co-pays.
Prenatal	Presumptive eligibility for prenatal services for pregnant women under 200% FPL who are pending eligibility for MassHealth Standard.	Routine prenatal office visits and tests.
Premium assistance	Low-income, employed adults (less than 200% FPL).	Financial assistance with employer-based insurance premiums, deductibles and co-pays.

Sources: Several sources were used to develop this table. See MassHealth: Dispelling Myths and Preserving Progress*, prepared by the Massachusetts Health Policy Forum;* Access to Health Care in Massachusetts*, prepared by the Massachusetts Division of Health Care Finance and Policy; and* Memo regarding MassHealth Essential: MassHealth Benefits to the Long-term Unemployed*, prepared by the Massachusetts Division of Medical Assistance.*

In 2003, in an effort to close a state deficit of more than $3 billion, Massachusetts Governor Mitt Romney mandated extensive emergency budget cuts.[32] Approximately $113 million in cuts to the state's Health and Human Services agency were included in the action. The Medicaid program suffered a $75 million budget reduction, causing the state to lose $40 million in matching federal funds.[33]

The budget cuts were accompanied by reductions to or eliminations of a number of coverage benefits for MassHealth and other state public programs. Most notably, in April 2003, the state eliminated MassHealth Basic, the program targeting low-income, long-term unemployed individuals, in an effort to curb cost growth in the MassHealth plan. As a result, 50,000 individuals lost coverage. While some of these former enrollees were eligible for other public insurance programs, approximately 36,000 were left with no form of health coverage. Legal immigrants were also shifted to a more limited coverage program. Although in October 2003, the state re-instated a plan for chronically unemployed adults called MassHealth Essential, coverage is more limited than MassHealth Basic and enrollment is capped at 36,000 individuals. As of November 2003, 13,000 of 36,000 individuals were enrolled in MassHealth Essential.[34]

In addition to the elimination of MassHealth Basic, the following changes were among several that were implemented in an effort to decrease costs and curb the growth of public programs:[35]

In November 2002, enrollment for the Children's Medical Security Plan (CMSP) was capped and a waiting list for services was instituted.

In January 2003, MassHealth coverage for five optional services for adults were eliminated: dentures, eyeglasses, orthotics, prosthetics and chiropractic services.

In February 2003, enrollment in Prescription Advantage was closed and cost-sharing was increased.

In March 2003, emergency detoxification services were eliminated for uninsured residents.

In July 2003, income limits for Healthy Start were reduced from 225 to 200 percent of the FPL.

In November 2003, new premium charges were applied to CMSP families with incomes of 150 to 200 percent of the FPL. Premium charges also quadrupled for families with incomes between 200 and 400 percent of the FPL.

Free Care Pool

Created in 1985, the Free Care Pool is the financial mechanism that pays for care for low-income, uninsured residents of Massachusetts. Also referred to as the Uncompensated Care Pool, the Pool encourages hospitals to provide charity care and removes any financial disincentives on their part for serving this population. The Pool reimburses both hospitals and community health centers for a portion of the uncompensated care they provide to the uninsured and underinsured. In so doing, it helps individuals who are not eligible for public insurance and have no other way of paying for care to obtain the services they need.[36]

Patients can apply for free care for medically necessary inpatient and outpatient services at any acute care hospital or community health center.[37] Pool funds also cover the cost of drugs used during inpatient treatment as well as those distributed by hospital-licensed and CHC-licensed pharmacies.[38] Individuals qualify for full free care, for which 100 percent of their liability may be billed to the Pool, if their family income is at or below 200 percent of the federal poverty level. Residents with family incomes of 200 to 400 percent of the federal poverty level are eligible for partial free care (a portion of their liability is covered by the Pool).[39]

The Free Care Pool has three primary funding streams: an assessment on acute hospitals' private sector charges; a surcharge on payments to hospitals and ambulatory surgical centers by payers including HMOs, insurers and individuals; and an annual state appropriation. These mechanisms are mandated by state statute. Smaller sources of funding for the Pool that are not state mandated come from surpluses in the Medical Security Trust Fund (when available) and an intergovernmental funds transfer that allows

federal funds from the state's MassHealth research and demonstration waiver to be allocated to the Pool.[40]

In fiscal year 2002, funds in the Pool totaled $472 million.[41] The hospital assessment contributed $170 million to the Pool; the surcharge on payments to hospitals provided $100 million; and the state appropriation provided $30 million. The FY 2002 Pool budget had an additional $70 million in federal funds from the intergovernmental funds transfer; $90 million from the Medical Security Trust Fund and $12 million from the Tobacco Settlement Fund.[42]

Distribution of Pool funds is determined based on a formula reflecting the amount of free care costs a facility incurs for caring for the uninsured. Hospitals receive the majority of uncompensated care payments from the Pool. In FY 2002, almost two-thirds (62 percent) of Pool funds were used to pay hospital outpatient services for eligible patients and about 33 percent paid for hospital inpatient services. Boston Medical Center and the safety net hospital system just outside of Boston, Cambridge Health Alliance, received close to half of the Pool funds ($240 million combined) in FY 2002.[43,44]

Community health centers received only 4 percent ($23 million) of Pool funds for reimbursement for the year, based on the proportion of free care costs they incurred.[45,46] One percent of the Pool was used to finance demonstration projects for alternative approaches to health care for uninsured and underinsured.[47]

Demand on the Free Care Pool is expected to continue to rise. Between April 2002 and June 2003, the number of applications to the Pool rose 38 percent and hospital charges to the Pool increased 41 percent.[48]

Projected Free Care costs for FY 2002 totaled $504 million, putting the Pool in a $32 million shortfall for the year. In 2003, the Pool was also used to cover the health care costs of individuals who lost their insurance coverage when the state eliminated its MassHealth Basic Program. With an additional 36,000 uninsured residents needing health care, the deficit is expected to increase to over $163 million for FY 2003.[49]

DSH Programs

Massachusetts' Medicaid program also provides funding to care for the uninsured and underserved through disproportionate share hospital (DSH) payments. DSH Payments were implemented to ensure that state Medicaid programs provide adequate payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients. The state's Free Care Pool is part of the Medicaid DSH payment structure, which allows the state to draw down additional federal Medicaid matching funds.[50,51]

In 2001, total DSH payments to the four largest safety net providers in Boston stood at $147 million.[52] Boston Medical Center received the majority of the payment with $107 million, followed by MGH with $16.9 million. Beth Israel Deaconess Medical Center and Brigham and Women's Hospital received $12.8 million and $10.5 million, respectively.[53]

CenterCare

The Department of Public Health provides primary and preventive health care coverage to low-income, uninsured residents of Massachusetts through the CenterCare program. Available to residents who are patients at independently-licensed community health centers, the program is targeted to patients who are ineligible for Medicaid or whose care would not be covered by the Free Care Pool. CenterCare fully covers medical visits, social services, nutrition services, health education and on-site laboratory services at no cost to the patient.[54]

Participating CHCs have a designated number of slots for CenterCare patients, and enrollees can enroll in CenterCare at only one CHC at a time. That CHC becomes the patient's primary care provider. Eligible individuals must be residents of Massachusetts, have incomes at or below 200 percent of poverty, be at least age 19 and have no other form of health insurance.[55]

Children's Medical Security Plan

Children who do not qualify for MassHealth or CommonHealth[56] and who have no other source of health coverage may be eligible for the Children's Medical Security Plan (CMSP). Sponsored by the Department of Public Health, CMSP is available to children living in Massachusetts who are under the age of 19. The cost to families depends on income and number of children. Benefits include primary and preventive care.[57] Specialty care and hospitalization is provided through the Free Care Pool.

Pharmacy Programs

Boston residents may be eligible for a number of state and local pharmacy programs that help offset the high cost of medications. The *Boston Mayor's Neighborhood Pharmacy Plan* offers fixed discounts on prescription drugs to eligible disabled and elderly Boston residents.[58] Individuals qualify for the program if they are Boston residents, are 65 years old or older (or younger if they are Medicare disabled), and have incomes at or below 400 percent of the FPL. Thirty-seven pharmacies participate in the plan. In addition to fixed discounts on prescription drugs, the program provides free transportation to participating pharmacies and free home delivery if the transportation service is not available.

Citizens Health operates another pharmacy program available to senior citizens and uninsured, working families living in Massachusetts who have no drug coverage.[59] A member-based, health care savings and benefits plan, Citizens Health helps its members save on out-of-pocket health care costs. In 2001, Citizen's Health launched a prescription plan, CitizensHealth Rx, to maximize savings on prescription drugs by negotiating group discounts for its members and developing partnerships with pharmaceutical companies. The program offers significant discounts on prescription drug prices, access to medical information via a toll-free call line and management of prescription utilization. The program started initially in Southern New England and is now available nationwide; over 44,000 pharmacies, including national chains, participate in the program.

The *Prescription Advantage Plan* is a state-sponsored, discounted prescription drug plan that targets residents of Massachusetts who do not qualify for Medicaid. Members pay premiums, deductibles and co-payments at rates based on gross annual household income. To be eligible, individuals must be at least 65 years old, residents of Massachusetts, have gross annual income of no more than 188 percent of the FPL, work fewer than 40 hours per month and meet the disability requirements of CommonHealth.

The safety net assessment team conducted interviews with key stakeholders in the Boston health care community and visited safety net facilities during its assessment of the local safety net. The analysis of the Boston safety net was greatly informed by the interviews with safety net providers and other local stakeholders. Informants discussed important changes in local health policy and programs, emergency department use and crowding, issues relating to access to care, and significant barriers that patients face.[60]

Overview

Boston has a strong tradition of providing generous health benefits to its neediest residents. The city has an extensive health care safety net with far-reaching penetration in the community and generous financing mechanisms to cover the costs of serving uninsured and underserved individuals. However, recent state budget cuts and reductions in public insurance benefits and outreach activities are threatening the viability of the safety net and its ability to care for the city's most vulnerable populations. The cuts have reduced the resources that hospitals, community health centers, mental health facilities and other community providers rely on for treating the uninsured, while at the same time increasing the number of people without public health insurance coverage.

Emergency Department Crowding

Emergency department use is on the rise in Boston. The elimination of MassHealth Basic and reductions in psychiatric services and substance abuse programs, including emergency detox services for the uninsured and post-detox services for MassHealth adults, appear to have led to increases in ED visits.[61] Appointments in both inpatient and outpatient behavioral health programs are extremely limited, forcing patients to wait for needed care and turn to the ED when in crisis. Massachusetts General Hospital has seen a 49 percent increase in psychiatric patients in the ED and BMC has experienced a 20 percent jump since last year.[62]

Patients' perceptions of the quality of care in emergency departments also appear to contribute to use of ED services for non-emergent care. Our interviews indicate that patients believe that care in the ED is better and more convenient than care at a community health center or hospital clinic. Although wait times can be long, patients believe their care will be both comprehensive and of high quality. In primary care settings, patients are often required to see multiple providers at different times and locations, causing patients to perceive that care is fragmented and unorganized, and more difficult to navigate than the ED.

Additionally, barriers getting speciality care, limited pharmacy formularies, and the limited hours of operation at health centers contribute to visits to the ED, which is open 24 hours a day, seven days a week. These conditions exist in neighboring communities as well, causing residents outside of Boston to turn to Boston's hospitals and EDs for care.

Physicians' actions also add to the crowding problem. Providers sometimes refer patients to the ED for primary care treatable conditions, either because they lack the resources to help them or they do not want to be burdened themselves with treating them. Sometimes, providers send patients to the ED, believing it is the fastest route to an inpatient bed or because they know by law the uninsured must be treated in the ED.

The [recent state budget] cuts have reduced the resources that hospitals, community health centers, mental health facilities and other community providers rely on for treating the uninsured, while at the same time increasing the number of people without public health insurance coverage.

Reductions in Community Health Center Services

Boston has a large primary and preventive care network consisting of community health centers, school-based health centers and hospital clinics. Most of these facilities have high community awareness, good distribution across the city and significant penetration in the neighborhoods. If anything, problems may arise from an abundance of health centers in a given area, which could result in overlapping catchments and duplication of services. For the most part, however, health centers seem to effectively serve a specific population, and collaboration, especially within specific networks, helps eliminate inefficiencies.

Nevertheless, state budget cuts have put a strain on community health centers in Boston.[63] While most health centers are committed to continuing services, the cuts will affect wait times for appointments, availability of after-hours care and transportation services. These cuts will also reduce the number of slots available to CHC patients under CenterCare, the state-sponsored, CHC insurance program. Reductions in annual grants to health centers will result in cuts to outreach programs that target families and individuals who have trouble accessing health care.[64]

Limited Specialty Care, Dental Care and Pharmacy Services

Specialty Care: Despite the numbers of specialists in the Boston area, access to specialty care can be a challenge, especially for uninsured and underserved populations. East Boston is the only health center in the city that operates a clinic with primary care and comprehensive specialty care services. At the other sites, network partnerships between hospitals and community health centers, physician consultation and referral centers at hospitals facilitate access to specialties.

The city is experiencing a specialty care capacity problem. Many communities outside the city do not have adequate specialty services to serve uninsured and low-income populations. These patients come to Boston for care, because they know they will get timely, quality treatment. As a result, safety net specialty providers in Boston are taxed by use from safety net populations in other communities.

Dental Care: Dental care is also a serious problem for uninsured and underserved residents of Boston, especially since the elimination of dental care and dentures as a benefit for MassHealth enrollees in 2002. In addition, demand for dental services far outweighs supply in the Boston area. Few dentists are willing to treat Medicaid or uninsured patients, either because they have small practices that cannot afford to take on the low (or non-existent) reimbursement rates for these patients, or they simply prefer not to treat them.[65] As a result, dental problems go untreated and may end up requiring medical attention, frequently in the emergency department.

Pharmacy Programs: Getting appropriate medication is often difficult for uninsured patients because of the high cost of drugs. A number of hospitals and community health centers have subsidized pharmacy programs offering low-cost medications to patients, and the Free Care Pool subsidizes pharmaceuticals. However, the state is in the process of reducing the formulary available through the Pool, which will limit the drug options available to Free Care patients. This policy change will switch Free Care patients to older, less expensive drugs, a move that can be especially deleterious to patients managing mental health problems. In addition, in Boston only two health centers with pharmacies serve free care patients.[66]

Inadequate Behavioral Health Services

Resources for the behavioral health system in Boston are declining significantly. Much needed mental health and substance abuse programs in the city have been eliminated as a result of reductions in community health center funding and a $15 million cut in the FY 2004 Department of Mental Health (DMH) budget.[67] Providers funded by DMH have had to sharply reduce available appointment slots in both inpatient and outpatient programs. Many community mental health clinics have had to completely eliminate services for the uninsured. Hospitals are being forced to eliminate

beds for both psychiatric and detoxification patients because of reductions in reimbursement for these patients. Cuts to MassHealth have compounded the problem as well. Of the 36,000 people who lost their MassHealth Basic insurance and are ineligible for other programs,[68] close to 15,000 require psychiatric care.[69]

While patients already connected to the system may not yet be feeling the fall out of these cutbacks, patients trying to access behavioral health care for the first time are experiencing significant barriers. Statewide, about 20,000 patients are waiting for DMH services, not including those patients who were deemed ineligible for services, or those who need care but have not sought out treatment.[70] Reportedly, one health center in the Boston neighborhood of Roxbury turns away between 30 to 40 patients a day due to budget cuts.[71]

For children, the lack of mental health and substance abuse resources in the community is even worse.[72] Inpatient or outpatient behavioral health services for this vulnerable population are very limited. Parents often cannot obtain care for their children unless they are in crisis. Once in crisis, children are seen in the ED where they wait, sometimes for several days, for available inpatient care.[73] Outpatient programs for children are also hard to find in Boston and wait times for appointments are very long. Schools are relied upon as the safety net for kids, although schools may not have adequate personnel who are trained to deal with children with mental health or substance abuse problems.

Reductions in Insurance Coverage

Significant erosions to MassHealth benefits and other state public programs are undermining the safety net's ability to serve uninsured and underserved residents in Boston. Tens of thousands of MassHealth Basic enrollees became ineligible for public insurance when the program was eliminated in April 2003. This cut was one of many reductions in public programs affecting Boston's most vulnerable populations. The state has eliminated funding for detoxification and outreach programs, raised co-payments for medications, and cut most dental services for MassHealth enrollees. The state also capped enrollment for the Children's Medical Security Plan, leaving more than 7,700 children on a waiting list to enroll in the program.[74]

The impact of these reductions will likely continue to be felt despite the state's attempts to reinstate some benefits for FY 2004. Enrollment in MassHealth Essential has been slow and only about one third of eligible individuals have reapplied for benefits. Cuts in state funding for outreach staff and community-based outreach workers have likely contributed to low re-enrollment in the new program.[75]

The increase of newly uninsured individuals is particularly taxing on hospital emergency departments. Residents who lack insurance coverage are limited in the services they can access, especially for mental health and substance abuse, and have nowhere else to go but the ED for care. Uninsured residents who put off primary care until conditions become emergent often end up requiring more costly intervention in the ED. Reductions in public health insurance benefits will also ultimately take a toll on the Free Care Pool, which will cover payment for care of this newly uninsured population.

Lack of private health insurance also presents a growing problem for Boston residents. Escalating health care costs have led to higher private premiums, making it harder for employers to provide insurance benefits and for employees to afford premiums. As a result, the uninsured, working population is growing.

Threats to the Free Care Pool

The Free Care Pool is a vital part of Boston's health care safety net, providing residents ineligible for public insurance programs access to health services. The future of the Pool, however, is uncertain. A significant shortfall in 2002 and an even larger projected deficit for 2003 have caused the state to examine how the Pool works. Increases in the uninsured population and restriction to MassHealth eligibility are also likely to result in greater demand on the Pool.

The Pool is a contentious issue in the Boston health care community, pitting hospital against hospital.

While all hospitals are required to pay an annual assessment into the Pool, the bulk of funding is distributed to the handful of hospitals that provide the largest amounts of free care.

Thus, small community hospitals that pay into the Pool and are struggling to remain operational blame the Pool for their financial difficulties. Meanwhile, large safety net hospitals, which bear the biggest burden for caring for the uninsured, depend greatly on the Pool to allow them to fulfill their mission to serve all who are in need of care.

Governor Romney has proposed to restructure the Pool and a public hearing was held in September 2003 to discuss the issue with state officials and the health care community. Stakeholders in the industry agree the Pool needs to be overhauled, but caution that significant reductions to the program could cripple major safety net providers. With growing numbers of uninsured in the state placing additional demands on its resources, it is unlikely that the Pool will be able to continue in its present form.[76]

Barriers to Care

Despite a robust safety net system, uninsured and underserved residents still face significant obstacles obtaining medical services. Discontinuities in the system as well as lack of resources and logistical barriers make getting care difficult for uninsured and underserved residents. These barriers are amplified for immigrants.

Language and Cultural Competency: Immigrants' experiences with the health care system are complicated
by the language and cultural barriers they confront. Language is probably the biggest barrier, especially when dealing with complicated medical terminology. Although health centers hire bilingual staff, few provide interpreters for multiple languages. Hospital EDs are required to provide interpreter services and employ interpreters for a variety of languages; for example, BMC has a large interpreter services program with 35 full-time interpreters speaking a total of 17 languages. Nevertheless, providers continue to struggle with the issue of interpreter services. In most facilities, interpreters do not meet all the language needs of Boston residents. Increasing these services, however, would require additional resources.

Immigrants also face particular problems in navigating the health care system, accessing specialty care providers, and enrolling in appropriate health plans. Many immigrants lack a support system that can help them with complicated enrollment procedures and eligibility criteria. Cuts in funding for outreach activities have greatly increased the challenges faced by this population. In addition, close to 10,000 poor, unemployed immigrants lost their health care coverage with the elimination of MassHealth Basic.[77] Enrolling these individuals in other programs, including the reinstated MassHealth Essential, will be difficult.

Furthermore, immigrants may feel intimidated and overwhelmed by large health care networks that are not connected to their ethnic communities. Cuts to outreach programs have made it more difficult for organizations known to, and trusted by, immigrant populations to provide important information regarding access to health care resources in the community. Informants also note that ethnic providers are much needed in Boston hospitals and clinics to help build bridges between immigrant groups and the American health care system.

The safety net assessment team conducted three focus groups

with residents who receive their care from safety net providers in the Boston area. The focus groups were held on September 26, 2003, at Health Care for All and Boston Medical Center. Focus group participation was voluntary. Participants were recruited through the local community partner, Health Care for All, as well as other safety net providers and community groups. Recruitment efforts involved displaying flyers announcing the sessions and their schedules. Participants received $25 each in appreciation for their time and candor. A total of 29 individuals participated in the focus groups. One group was conducted in English, one was in Spanish and one was in Haitian Creole. Several of the participants were homeless at the time of the focus group.

The focus group discussions highlighted the difficulties that many uninsured and underserved residents have in accessing timely and affordable health services in the Boston area. Their comments addressed issues related to primary care and prevention, access to specialty and inpatient services, their use of the ED for emergent as well as non-emergent care, their understanding of the health care system and the opportunities that are available to them, and their feelings about the provider community.

Health Insurance Coverage, Access to Primary Care

In general, focus group participants were familiar with programs such as MassHealth and the Free Care Pool, having benefited from using them at points in their lives. Many of the uninsured participants reported they had a regular source of care, but not a regular primary care provider. Many said they received most or all of their care at Boston Medical Center. Despite having a regular source of care, they reported that they were less likely to seek routine screening services and physical exams, even though they said they would definitely go to a doctor or health center when feeling sick. Participants were satisfied with their primary care and health coverage. One participant with chronic conditions stated, "*I feel fortunate and lucky. What would I do if I didn't have this?*"

Many of the participants said that they were pleased with the care they received through the BMC clinics, such as those at the BMC campus and at Whittier, Mattapan and Codman Square. Several said they chose the locations that were most convenient to their homes. Other participants were not as pleased with the care they received at some of the clinics, saying "*Those places are mobbed. They're over-booked. You have to have a lot of patience even though they will treat you and it will be affordable.*"

Discussion about access to primary care for the uninsured led to further discussion about how community health centers, shelters, and other community organizations are having an increasingly difficult time finding enough funding to provide adequate services. Participants noted that there is a constant strain on the resources of charitable organizations because they rely on donations that are hard to come by in a bad economy. Participants noted that Massachusetts is a very charitable and generous state, but wanted the federal government to do more. One disabled MassHealth beneficiary stated, "*We can send a man to the moon and go to another country to have a war, but we can't pay for everyone to have health care.*"

Participants in the Haitian Creole-speaking focus group discussed differences between health care in the U.S. and their native country. The group agreed that health care is of higher quality here and easier to access than in Haiti, but not as accessible as they had believed it would be before coming here. One young woman noted that even though health care is better in the U.S., some aspects were unexpected: "*We're used to seeing movies with the doctors running down the halls to treat you. It's not like that. You have to wait. Even if you have an appointment, it could be two hours at these*

"We can send a man to the moon and go to another country to have a war, but we can't pay for everyone to have health care."

clinics." Participants agreed with this comment, but also agreed with another participant's conclusion: "*But, it's still much better here than in Haiti.*" All reported feeling comfortable going to health centers within the Free Care system and would not delay seeking health care due to being uninsured, because the Free Care program provided affordable services.

Haitian participants talked about the challenge of not speaking English in negotiating the health care system. They noted that there are interpreters available in clinics and hospitals, but they are often overworked and cannot spend more than 10-20 minutes per patient. Participants noted that interpreters are more readily available at Codman Square than at Whittier (two BMC Free Care locations). In some locations, there are Haitian doctors available, but it is difficult to get appointments with them. Participants stated that learning English is the best way to ensure access to quality care because even with an interpreter, it is often difficult to know if the doctor understands how the patient feels and if the patient truly understands what the doctor is saying.

Transportation is a barrier to care for many low-income people in Boston. Bus fares are $.75 and bus trips can be difficult for the elderly and disabled. Some MassHealth participants can get vouchers for services such as "Free Ride" or "The Ride" from their doctors. However, most participants felt that more transportation options should be available.

Prescriptions

Participants who are covered by MassHealth noted the increase in prescription co-payments in recent years. Participants said they used to pay $.50 per prescription, but fees have increased to $2, which can be especially onerous for individuals who use multiple medications each month. One participant who is on MassHealth and SSI stated that the homeless shelter helps her cover the prescription drug costs because her medications total between $20 and $30 each month. Another participant, an 83-year old woman covered by MassHealth and Medicare, told the group that her prescriptions total $120 each month. While she says she tries to budget for the increased drug costs, she also stated, "*Whether I eat or not, I have to pay what I can before they give me anything.*"

Hospital/Emergency Care

Participants were generally not willing to go to the hospital unless it was an absolute emergency. While participants understood that emergency departments are obligated to treat any patient regardless of coverage, all of the focus group participants were keenly aware that hospital bills are very high and patients are often held responsible for them whether they are able to pay or not. One Free Care participant stated, "*I know they'd take me, but I'm not trying to owe thousands of dollars that I can't pay back. That's why I stick to the Free Care system. I wait till I can get in to see them.*"

Haitian participants also stated that they would only seek emergency care in absolute emergencies. One participant of Free Care stated that because health care is so expensive, "*You pray so that you don't get sick. The hospital is only for when things are very serious.*" Another participant was surprised that people would consider going to the ER in anything but an emergency situation. She said, "*It's so crowded there. You should only go when it is a true emergency.*"

When asked which hospitals were preferable in terms of quality of care and treatment, participants agreed that most hospitals were satisfactory based on what they knew and what they had heard in the community. In one focus group, participants discussed how the quality of care at BMC has improved since its change to BMC from Boston City. One woman pointed out, however, "*BMC is much better. But even now with their remodeling and everything, they still don't have enough staff.*" Participants agreed this was a problem common to all area hospitals.

Participants believe that hospitals treat patients with private insurance more quickly than those who are publicly insured or uninsured. One MassHealth beneficiary stated, "*They look to see what you have and then*

they say, 'Let's go to the money first.' If you have no insurance, you'll wait longer than someone on MassHealth, and much longer still than someone with real insurance."

Dental and Vision Care

Participants stated that dental and vision care are not covered by MassHealth or the Free Care Pool. Vision screenings are available, but glasses are not, and those with eyeglasses reported that they got them for free from charitable organizations. Preventive or cosmetic dental care is not offered at all. Because of the expense, only one of the 29 participants reported getting regular dental cleanings. One uninsured woman reported that she receives annual cleanings at low cost at a local dental school. Some participants who were eligible for Free Care could get their teeth pulled if necessary, but services such as cleanings or dentures were "luxuries." Participants with small children worried about their children's access to dental cleanings under MassHealth.

Mental Health and Substance Abuse Care

In contrast to reports from providers and other key stakeholders, participants reported that resources for mental health care are available to MassHealth and Free Care beneficiaries, as well as in the community at large. Participants in one focus group discussed how mental health care is not as stigmatized as it used to be and treatment for depression or drug abuse is much easier to access.

One uninsured participant described a recent bout with severe depression. She reported that she felt suicidal and was afraid she would hurt herself or others so she went to the hospital. She said the doctors listened to her and took her claims seriously and worked with her to get her on medication instead of institutionalizing her. She stated that she was feeling better but thought she should pursue regular counseling to prevent future breakdowns.

Outreach and Information

Several of the participants were strong advocates for health care for the uninsured. They discussed ongoing efforts to raise awareness of the struggles of the poor in accessing health care and prescription drugs. According to some in the group, the low-income community in Boston needs more information about the health care resources in the area. Many participants noted that access to health care appears to be a function of how diligent a person is in finding resources and places to go. One participant commented, "*You have to fight. You have to learn.*" Another participant disagreed and said that many people cannot find the information they need to find out where to go. He reported that the government should be more upfront about the health care options for the poor. He stated, "*If you don't have the information, you can't get to these places. It's who you know. Tell us the truth about health care… Don't leave us in the dark if you know there's light outside the tunnel.*" Another participant agreed, saying, "*We here in this room know that there's money out there and places to go. But a lot of people have no idea where to go and they just never get care at all.*"

Overview

The emergency department plays a critical role in the safety net of every community. It frequently serves as the safety net's "safety net," serving residents who have nowhere else to go for timely care. Residents often choose the ED as their primary source of care, knowing they will receive comprehensive, quality care in a single visit. When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations and the accessibility of timely care outside of the ED. Whether it serves as a first choice or last chance source of care, the ED provides a valuable and irreplaceable service for all community residents, including low-income, underserved populations.

Problems arise, however, when using the ED leads to crowding and ambulance diversion. When the ED is too crowded, quality of care and patient safety can be compromised. Many factors cause crowding, including limited inpatient capacity, staff shortages, physicians' unwillingness to take call, and increased demand for services from uninsured as well as insured patients. It is important to focus on all these issues when trying to address the problem.

In this section of the report, we provide an analysis of ED use at Boston Medical Center. Using a profiling algorithm,[78] we were able to classify visits as either emergent or non-emergent. We were able to further allocate these visits to determine whether the emergent visits were primary care treatable, preventable/avoidable or non-preventable/non-avoidable. Communities should use this information to help understand the dynamics of health care delivery. These data, however, do not tell the whole story and should not be viewed as a comprehensive analysis of emergency department use in the community.

When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations and the accessibility of timely care outside of the ED.

The ED Use Profiling Algorithm

In 1999, John Billings and his colleagues at New York University developed an *emergency department use profiling algorithm* that creates an opportunity to analyze ED visits according to several important categories.[79] The algorithm was developed after reviewing thousands of ED records and uses a patient's primary diagnosis at the time of discharge from the ED to apportion visits to five distinct categories. These categories are:

1) Non-emergent, primary care treatable
2) Emergent, primary care treatable
3) Emergent, preventable/avoidable
4) Emergent, non-preventable/non-avoidable
5) Other visits not classified according to emergent or non-emergent status

According to the algorithm, ED visits are classified as either emergent or non-emergent. Emergent visits are ones that require contact with the medical system within 12 hours.

Emergent visits are further classified as either needing ED care or treatable in a primary care setting. Visits classified as "primary care treatable" are ones that could have been safely provided in a setting other than an ED. These types of visits are ones that generally do not require sophisticated or high-tech procedures or resources (such as CAT scans or certain laboratory tests).

Visits that are classified as needing ED care are classified as either non-preventable/non-avoidable or preventable/avoidable. The ability to identify visits that would fall in the latter category may offer opportunities to

reduce costs and improve health outcomes: patients who present with emergent but preventable/avoidable conditions should be treated earlier and in settings other than the ED.

A significant percentage of visits remain unclassified by the algorithm in terms of emergent status. Visits with a primary ED discharge diagnosis of injury, mental health and substance abuse, certain pregnancy-related visits and other smaller incidence categories are not assigned to algorithm classifications of interest.

The data from the ED utilization category must be interpreted cautiously and are best viewed as an indication of utilization rather than a definitive assessment. This is because the algorithm categorizes only a portion of visits and does not include any visits that result in an inpatient admission. For many hospitals, visits that result in an inpatient admission are not available in ED electronic databases. Presumably, since these visits warrant inpatient treatment, none would fall into the non-emergent category. Excluding these visits may inflate the primary care treatable (both emergent and non-emergent) categories. However, ED visits that result in an inpatient admission generally do not comprise more then 10-20 percent of total ED visits and would likely have a relatively small effect on the overall findings. A larger effect could occur if more visits were categorized by the algorithm. Since a sizeable percentage of ED visits remain unclassified, percentages or visits that are classified as falling into one of the four emergent or non-emergent categories should be interpreted as a conservative estimate and may understate the true values in the population.

ED Use at Boston Medical Center

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at Boston Medical Center for the period between July 1 and December 31, 2002. During that six-month period, there were 41,682 ED visits that did not result in an inpatient admission.[80] Table 6 provides information on these visits by race, coverage, age and gender.

Table 6 Demographic Characteristics of ED Visits

Race		Coverage		Age		Gender	
Black	50.7%	Commercial	7.4%	0-17	21.2%	Female	48.7%
White	22.2%	HMO*	25.5%	18-65	73.3%	Male	51.3%
Latino	17.4%	Medicaid	17.5%	65+	5.5%		
Other/Unknown	9.6%	Medicare	8.9%				
		Uninsured	39.3%				

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Boston Medical Center emergency department.
** HMO classification includes commercially insured patients as well as patients covered by MassHealth.*

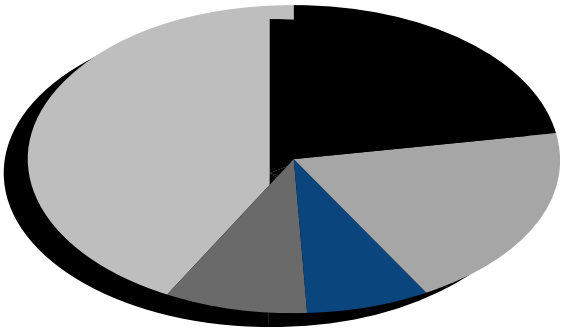
Key Demographic Characteristics of ED Visits

About half of ED visits at BMC were for black patients; 17 percent were for Latino patients. About 10 percent of visits were not classified by race/ethnicity.

Approximately four of ten visits to BMC were for uninsured patients.

Only about 6 percent of ED visits were for patients over age 65.

Figure 1 Visits by Emergent and Non-Emergent Categories



Non-Emergent	22.3%
Emergent, PC Treatable	19.4%
Emergent, Preventable	7.5%
Emergent, Not Preventable	8.7%
Other Visits	42.1%

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by Boston Medical Center emergency department.

A significant percentage of visits to the Boston Medical Center ED could have been treated in settings other than the ED. As Figure 1 demonstrates, 22.3 percent of ED visits at BMC were non-emergent and another 19.4 were emergent but primary care treatable. Thus, four of 10 ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.

Table 7 compares the rates of visits that were emergent, that required ED care, and that were not preventable or avoidable against rates for other categories of visits. For every visit that was in the emergent, not preventable category, there were approximately two and one-half non-emergent visits and over two emergent but primary care treatable visits.

These findings were fairly consistent across categories of visits by insurance coverage, race and gender. Medicare patients were less likely to use the ED for non-emergent conditions than were other patients, but even they used the ED at twice the rate they did for emergent, non-preventable visits. According to the analysis, uninsured patients did not use the ED for non-emergent conditions at significantly higher rates than did Medicaid or commercially insured patients.[81,82] Black patients had higher rates of ED use for non-emergent conditions, compared to patients of other races (2.81 vs. 2.23 and 2.37).

The largest variation in terms of use of the ED for non-emergent conditions occurred across age categories. Children were more than three and one-half times more likely to have used the ED for non-emergent conditions than for emergent, non-preventable conditions. Children were twice as likely as patients age 65 and older to use the ED for non-emergent conditions.

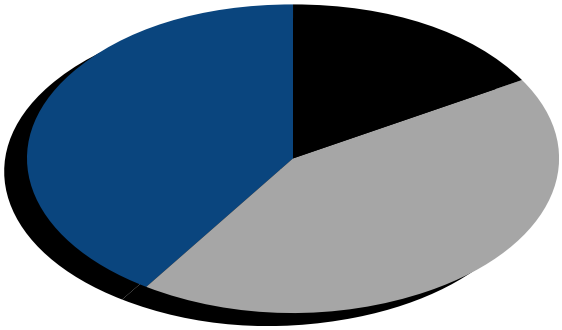
Table 7 Relative Rates for ED Visits at Boston Medical Center

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**2.56**	**2.23**	**0.86**	**1.00**
Insurance status				
Commercial	2.57	2.07	0.67	1.00
HMO	2.71	2.49	0.95	1.00
Medicaid	2.42	2.17	0.94	1.00
Medicare	2.10	2.02	1.19	1.00
Uninsured	2.60	2.16	0.73	1.00
Age				
0-17	3.66	3.63	1.29	1.00
18-64	2.40	1.99	0.78	1.00
65+	1.87	1.76	0.78	1.00
Race				
Black	2.81	2.42	1.00	1.00
White	2.23	1.87	0.70	1.00
Latino	2.35	2.22	0.88	1.00
Other/Unknown	2.37	2.14	0.53	1.00
Sex				
Female	2.52	2.22	0.77	1.00
Male	2.60	2.22	0.99	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by Boston Medical Center emergency department.

Most ED visits at Boston Medical Center occurred during the hours of 8:00 am to midnight. As Figure 2 illustrates, only about 16.5 percent of visits that did not result in an inpatient admission occurred between midnight and 8:00 am.

Figure 2 ED Visits by Admit Time to the ED



Midnight – 8 am	16.5%
8 am – 4 pm	42.8%
4 pm – midnight	40.7%

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Boston Medical Center emergency department.

Interestingly, many visits to the ED for primary care treatable conditions occurred during business hours that commonly coincide with physician and clinic availability. Table 8 illustrates the rates of use of the ED for emergent and non-emergent conditions according to three time periods—8:00 am to 4:00 pm; 4:00 pm to midnight; and midnight to 8:00 am. Patients used the ED for primary care treatable conditions at relatively comparable rates during "regular business hours" and the hours of 4:00 pm to midnight.

Table 8 Relative Rates for ED Visits at Boston Medical Center, by Admit Time to the ED

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**2.56**	**2.23**	**0.86**	**1.00**
Admit time				
8 am – 4 pm	2.65	2.27	0.83	1.00
4 pm – midnight	2.61	2.28	0.88	1.00
Midnight – 8 am	2.20	2.00	0.92	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Deparmtent of Health Policy application of the ED use profiling algorithm to data provided by Boston Medical Center emergency department.

These data support the assertion that patients are using the ED at Boston Medical Center for conditions that could be treated by primary care providers, at times during the day when primary care providers are likely to be available. This suggests that there are opportunities to improve care for patients in Boston while also addressing crowding in the ED at Boston Medical Center. While this analysis does not address ED utilization at other Boston hospitals, these findings are similar to other analyses of large urban ED populations and are likely to be similar to patterns occurring at other hospitals in the area.

Key Findings

After examining important components of the Boston safety net, the assessment team identified the following key findings:

Boston has an extensive health care safety net with far-reaching penetration in the community. Uninsured and low-income populations are served by Boston Medical Center (BMC) and a well-integrated community health center network. Public programs including Massachusetts' Medicaid program, MassHealth, and the Free Care Pool have enabled low-income residents to receive insurance coverage or subsidized care to address their health care needs.

After serving as a model for state-sponsored health insurance expansions and robust safety net services, Massachusetts has responded to a severe downturn in the economy with slow but significant erosions to its public support for safety net providers, outreach activities, and MassHealth services. These trends are likely to place additional burdens on the state's Free Care Pool as more residents become uninsured. Hospital emergency departments will be burdened as well, as many residents forgo care until their needs become emergent.

The Free Care Pool, which has served as the foundation for subsidizing health care for uninsured individuals, faces an uncertain future. New financing arrangements are being developed that will alleviate some of the financial stresses on community hospitals. At the same time, the redistribution of funds may impair the ability of large safety net providers, such as Boston Medical Center, to serve the growing uninsured population.

Cuts to the Massachusetts Department of Health and Human Services budget have eroded important aspects of the mental health safety net in Boston. These budget reductions have forced community mental health programs to reduce or eliminate services for the uninsured, and limit essential medications for mentally ill patients. In addition, the state's elimination of MassHealth Basic deprived a seriously vulnerable population of coverage for important mental health services.

Hospital emergency departments are feeling the backlash of reductions in MassHealth coverage and substance abuse and mental health care programs for adults and children. Without these public resources, patients are not getting timely care and ending up in crisis in the emergency department.

A significant percentage of emergency department visits at BMC are for patients whose conditions are non-emergent. Over one-fifth (22.3 percent) of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. Nearly another fifth (19.4 percent) were for patients whose conditions were emergent but could have been treated in a primary care setting.

Low-income and uninsured residents of Boston struggle to navigate the health care system. Coordinating care across multiple providers and insurance programs is a particular challenge to patients with little knowledge of the local safety net and limited English proficiency. The loss of funding for outreach programs has made it all the more difficult for low-income individuals, immigrants, and working, uninsured residents in Boston to negotiate the health care system.

Issues for Consideration

The *Urgent Matters* safety net assessment team offers the following issues for consideration:

Boston safety net providers must educate the health care community about the importance of preserving a Free Care Pool mechanism that does not place any additional burden on principal safety net facilities. Realistic reforms must be developed that will preserve this important funding mechanism.

Safety net providers, community-based organizations, faith-based institutions and other stakeholders should work together to develop strategies to reach out to uninsured residents of Boston and enroll them in the new MassHealth Essential program or other public insurance plans. Many eligible individuals do not have the means or knowledge to apply for benefits, and require help from outreach workers and other community groups. As the state appears to be withdrawing support from the safety net, it is even more crucial for the key players in the safety net to continue to collaborate in their efforts to address these issues and other local problems in access.

Hospitals, safety net providers and community-based organizations must agree to work together to build an adequately funded mental health care infrastructure. Significant reductions in Department of Mental Health funding have severely affected the ability of safety net providers to offer mental health services to Boston residents.

The Boston health care community must work together to increase funding for vital community health resources in Boston, including longer hours of service at community health centers, new points of access for uninsured and underserved residents, better transportation to and from key safety net facilities, and greater prescription drug availability in safety net pharmacy formularies. It remains unclear whether safety net providers can respond to the growing demand as low-income and uninsured patients in and outside the Boston area continue to seek specialty services, emergency care, and pharmacy assistance from Boston safety net providers.

Public awareness campaigns and outreach efforts should be employed to help poor and uninsured residents learn how to navigate the health care system. Boston is fortunate to have a well-integrated, progressive safety net system in place. Still, some residents are overwhelmed by the complexities of the system and uncertain how to access its services.

All hospitals in the Boston safety net should conduct analyses of the use of their emergency departments for emergent and non-emergent care. These studies would help determine whether area hospitals are experiencing trends in ED use similar to those seen in safety net hospitals. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in hospital EDs.

1 Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000), 21.

2 Boston Public Health Commission Research Office, *The Health of Boston 2003 (*Boston, MA: Boston Public Health Commission, 2003).

3 Demographic and economic statistics were calculated using data from the 2002 American Community Survey, a project of the U.S. Census Bureau. The ACS is a sample survey subject to sampling variability. It has a 90 percent confidence interval. The ACS universe includes only household populations and excludes populations living in institutions, college dormitories and other group quarters. See U.S. Census Bureau, *American Community Survey Profile 2002: Boston City, Massachusetts, Profile of General Demographic, Social and Economic Characteristics* (Washington, DC: U.S. Census Bureau, 2003), www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/index.htm

4 2002 American Community Survey.

5 2002 American Community Survey.

6 In 2003, the federal poverty level was $8,980 for an individual and $18,400 for a family of four. (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2003).

7 Boston Public Health Commission Research Office, *The Health of Boston 2003.*

8 National Association of Community Health Centers, Resources to Expand Access to Community Health (REACH) data 2002 (Bethesda, MD: NACHC, 2002).

The REACH data are based on Census Bureau data and provide estimates on the number of persons by poverty level, age, sex, race, and primary source of health insurance for each county in the U.S. in 2000. Estimates are based on the 2000-2002 pooled data from the Current Population Survey and the 2000 Census of the United States which are provided by the Bureau of Census.

9 Boston Public Health Commission Research Office, *The Health of Boston 2003.*

10 Ibid.

11 C. Wacks, *Access Update: Health Insurance Status of Boston Residents* (Boston, MA: Massachusetts Division of Health Care Finance and Policy, 2003).

12 J.H. Powell, "Caregivers Plead to Spare Aid," *The Boston Herald*, 28 March 2003, 36.

13 C. Wacks, *Access Update: Heatlh Insurance Status of Boston Residents*.

14 Ibid.

15 Ibid.

16 J. Billings and R. Weinick, *Monitoring the Health Care Safety Net Book II: A Data Book for States and Counties (*Washington, DC: Agency for Healthcare Research and Quality, 2003).

17 Figures apply to 100,000 persons who would be the provider's patient population. Adult primary care providers represent the number of providers per 100,000 individuals 18 years of age and older; pediatricians represent the number of providers per 100,000 children ages 17 and younger; ob/gyns represent the number of providers per 100,000 adult females.

18 Unpublished data from the Massachusetts Medical Society, "Massachusetts Healthcare Environment Evolution," 2002.

19 Unpublished report from the Health Care Finance Task Force, Mayor Thomas M. Menino's office, "Analysis of Boston Hospital and Physician Market," 2000.

20 I. Singer, L. Davison, L. Fagnani, *America's Safety Net Hospitals and Health Systems, 2001: Results of the 2001 Annual NAPH Member Survey (*Washington, DC: National Association of Public Hospitals and Health Systems, 2003).

21 Health Care Finance Task Force, Mayor Thomas M. Menino's office, "Analysis of Boston Hospital and Physician Market."

22 Singer, et al., *America's Safety Net Hospitals and Health Systems, 2001: Results of the 2001 Annual NAPH Member Survey*.

23 Health Care Finance Task Force, Mayor Thomas M. Menino's office, "Analysis of Boston Hospital and Physician Market."

24 Ibid.

25 S. Madden, *Data on the Uncompensated Care Pool*, Presentation to the Free Care Pool Working Group, 5 December 2003.

26 The number of community health centers in Boston is reported by the Massachusetts League of Community Health Centers. The figure includes both federally and non-federally funded centers, as well as some hospital clinics. The Bureau of Primary Health Care reports that Boston houses 15 federally qualified community health centers (FQHC) and look-alike centers. FQHCs are federally funded health centers that are designated to serve medically underserved populations. FQHCs are eligible for Section 330 grants from the Health Resources and Services Administration to offset the costs of care to uninsured patients. They also are eligible for enhanced Medicaid reimbursements. FQHC look-alikes receive no section 330 Federal funding but are eligible for cost-based reimbursement under Medicaid and Medicare and participate in the 340(b) Federal Drug Pricing program.

27 These data apply to health centers in Boston only. Unpublished report from the Health Care Finance Task Force, Mayor Thomas M. Menino's office, "Community Health Centers," 2000.

28 The Boston Public Health Commission is a quasi-public entity that serves as Boston's board of health. The agency reports to a seven-member board appointed by the mayor.

29 Non-qualified aliens, aliens with special status and aliens lawfully admitted for a temporary purpose such as students, visitors or diplomats are eligible to enroll in MassHealth Limited. Massachusetts Division of Health Care Finance and Policy, *Access to Health Care in Massachusetts* (Boston, MA: Massachusetts Division of Health Care Finance and Policy, 2002).

30 S. Rosenbaum, J. Lambrew, P. Shin, M. Regenstein, T. Ehrmann, D. Roby, *Health Coverage in Massachusetts: Far to Go, Farther to Fall* (Washington, DC: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Center for Health Services Research and Policy, 2002).

31 K. Quigley, A. Shelto, N. Turnbull, *MassHealth: Dispelling Myths and Preserving Progress* (Boston, MA: Massachusetts Health Policy Forum, 2002).

32 J. Saltzman, "Psychiatric Caregivers, Clients Celebrate Restoration of Funds," *The Boston Globe,* 13 February 2003, Globe West 1.

33 The National Alliance for the Mentally Ill of Massachusetts, Inc., "Budget Cuts to Health and Human Services Put Consumers and Families on Very Dangerous Ground," *The Connection* (Winter 2003).

34 Massachusetts Department of Medical Assistance snapshot data, 30 November 2003.

35 Information provided by Health Care for All. January 2004.

36 R. Seifert, *The Uncompensated Care Pool: Saving the Safety Net* (Boston, MA: Massachusetts Health Policy Forum, 2002).

37 Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool: PFY02 Annual Report* (Boston, MA: Massachusetts Division of Health Care Finance and Policy, 2003).

38 R. Seifert, *The Uncompensated Care Pool: Saving the Safety Net*.

39 Ibid.

40 The intergovernmental transfer is not technically part of the Free Care Pool. It is paid directly to the Boston Medical Center and the Cambridge Health Alliance (CHA) at the beginning of each state fiscal year. BMC and CHA use these funds to cover the costs of uncompensated care before turning to the Free Care Pool for payment. R. Seifert, *The Uncompensated Care Pool: Saving the Safety Net*.

41 Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool: PFY02 Annual Report*.

42 Ibid.

43 Percentages are from the Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool: PFY02 Annual Report*.

44 Total dollar amounts are from the *Uncompensated Care Pool: PFY 2002 Utilization Report.* L. Ruthardt, S.K. Dugan, R. Fitzmaurice, B. Gies, K. London, S. Madden, R. Safford, U. Swaminathan, G. Wong, *Uncompensated Care Pool: PFY 2002 Utilization Report (*Boston, MA: Massachusetts Division of Health Care Finance and Policy, 2002).

45 Percentages are from the Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool: PFY02 Annual Report*.

46 Total dollar amounts are from L. Ruthardt, et al., *Uncompensated Care Pool: PFY 2002 Utilization Report.*

47 Massachusetts Division of Health Care Finance and Policy, *Uncompensated Care Pool: PFY02 Annual Report*.

48 S. Madden, *Data on the Uncompensated Care Pool*, Presentation to the Free Care Pool Working Group, 5 December 2003.

49 Ibid.

50 R. Bovbjerg and F. Ullman, *Recent Changes in Health Policy for Low-Income People in Massachusetts* (Washington, DC: Urban Institute, 2002).

51 The Free Care Pool is the largest of six Massachusetts DSH payment programs from which hospitals can apply for reimbursement for care to uninsured and underinsured patients. Division of Medical Assistance, *Acute Hospital Request for Applications: Rate Year 2004* (Boston, MA: Division of Medical Assistance, 2003).

52 Centers for Medicare and Medicaid Services, *Massachusetts Total DSH Payments: FFY 2001* (Washington, DC: Centers for Medicare and Medicaid Services, 2001), www.cms.gov/dsh/madsh01.pdf

53 Ibid.

54 Massachusetts Department of Public Health, *CenterCare Fact Sheet* (Boston, MA: Department of Public Health, 2003).

55 Massachusetts Division of Health Care Finance and Policy, *Access to Health Care in Massachusetts* (Boston, MA: Massachusetts Division of Health Care Finance and Policy, 2002).

56 CommonHealth is part of MassHealth and provides coverage for disabled adults and children. See Table 5 in the report for information on its benefits and eligibility criteria.

57 Massachusetts Division of Health Care Finance and Policy, *Access to Health Care in Massachusetts*.

58 Ibid.

59 Ibid.

60 All information derived through interviews with informants was kept confidential. Many of the same questions were asked throughout the interview process. Opinions are included in the report only when they were voiced by several informants.

61 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

62 K. Lutz, "Mental Patients Turning to ERs: Cuts force many to try hospitals," *The Boston Globe*, 20 August 2003, B1.

63 When the state implemented emergency state budget cuts, community health centers received a $7.8 million reduction in direct appropriations. The governor eliminated $7 million in aid to distressed health centers, as well as $300,000 for the CenterCare insurance program. An additional $500,000 in annual grants to the health centers was also eliminated. See Massachusetts League of Community Health Centers, "$16.5 million in budget cuts place strain on health centers: Longer waits and reduced outreach predicted," *CenterLine* (Fall 2002).

64 Massachusetts League of Community Health Centers, "$16.5 million in budget cuts place strain on health centers: Longer waits and reduced outreach predicted."

65 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

66 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

67 E. Barry, "Mental Health Commissioner Named," *The Boston Globe*, 19 April 2003, B5.

68 These patients were ineligible for coverage prior to the re-institution of MassHealth Essential.

69 K. Lutz, "Mental Patients Turning to ERs: Cuts force many to try hospitals."

70 Ibid.

71 Ibid.

72 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

73 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

74 Health Care for All, Boston, Massachusetts, "Advocates halt excessive kids' health premiums by Romney Administration," 8 January 2004, www.hcfama.org/acrobat/HCFA_CMSP_reversal_01-08 (as of January 2004).

75 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

76 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

77 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

78 The algorithm presented here uses a methodology that has been replicated in numerous communities in the country to categorize emergency department visits data. The algorithm does not address the issue of appropriate use of the ED for non-emergent and/or primary care treatable conditions. This issue has been discussed extensively in the peer-reviewed literature. For a summary of these discussions see: L. Richardson and U. Hwang, "Access to Care: A Review of the Emergency Medicine Literature," *Academic Emergency Medicine* (Volume 8, no. 11, 2001): 1030-1036.

79 For a discussion of the development of the algorithm and the potential implications of its findings, see J. Billings, N. Parikh and T. Mijanovich, *Emergency Room Use: The New York Story* (New York, NY: The Commonwealth Fund, November 2000).

80 It is important to note that these findings refer to the allocation of visits across emergent and non-emergent categories and do not address whether uninsured patients use the ED in greater numbers than insured patients, per se. This assessment would not be possible in the absence of better data on ED use across many more hospitals in the Boston area to determine whether uninsured patients were using ED care at higher rates than insured patients.

81 This finding is consistent with recent research showing increases in the numbers of commercially insured patients relying on emergency departments for care. See P.J. Cunningham and J.H. May, *Insured Americans Drive Surge in Emergency Department Visits, Issue Brief 70* (Washington, DC: Center for Studying Health Systems Change, October 2003).

Urgent Matters Grantee Hospitals and Community Partners

Atlanta, Georgia
Community Partner: National Center for Primary Care, Morehouse School of Medicine
Project Director: George Rust, MD, MPH FAAFP
Grantee Hospital: Grady Health System
Project Director: Leon Haley, Jr., MD, MHSA, FACEP

Boston, Massachusetts
Community Partner: Health Care for All
Project Director: Marcia Hams
Grantee Hospital: Boston Medical Center
Project Director: John Chessare, MD, MPH

Detroit, Michigan
Community Partner: Voices of Detroit Initiative
Project Director: Lucille Smith
Grantee Hospital: Henry Ford Health System
Project Director: William Schramm

Fairfax County, Virginia
Community Partner: Fairfax County Community Access Program
Project Director: Elita Christiansen
Grantee Hospital: Inova Fairfax Hospital
Project Director: Thom Mayer, MD, FACEP, FAAP

Lincoln, Nebraska
Community Partner: Community Health Endowment of Lincoln
Project Director: Lori Seibel
Grantee Hospital: BryanLGH Medical Center
Project Director: Ruth Radenslaben, RN

Memphis, Tennessee
Community Partner: University of Tennessee Health Sciences Center
Project Director: Alicia M. McClary, EdD
Grantee Hospital: The Regional Medical Center at Memphis
Project Director: Rhonda Nelson, RN

Phoenix, Arizona
Community Partner: St. Luke's Health Initiatives
Project Director: Jill Rissi
Grantee Hospital: St. Joseph's Hospital and Medical Center
Project Director: Julie Ward, RN, MSN

Queens, New York
Community Partner: Northern Queens Health Coalition
Project Director: Mala Desai
Grantee Hospital: Elmhurst Hospital Center
Project Director: Stuart Kessler, MD

San Antonio, Texas
Community Partner: Greater San Antonio Hospital Council
Project Director: William Rasco
Grantee Hospital: University Health System
Project Director: David Hnatow, MD

San Diego, California
Community Partner: Community Health Improvement Partners
Project Director: Kristin Garrett, MPH
Grantee Hospital: University of California at San Diego
Project Director: Theodore C. Chan, MD