The Impacts of Chapter 58 Health Care Reform on Immigrant Health Providers in Massachusetts

A Case Study of The Dorchester House

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ABSTRACT: This paper explores the impacts that Massachusetts' 2006 landmark Chapter 58 healthcare reform has had on community health centers (CHCs) that provide services to immigrant communities. This analysis is presented through an in-depth case study of one such immigrant CHC, the Dorchester Multiservice House, in Dorchester, Massachusetts. Following background sections on immigrant populations in Massachusetts, their health challenges, and on the history of Chapter 58 reform, I present three chapters of analysis to show how Chapter 58 has impacted the Dorchester House's patients, providers, and the organization as a whole. I find that, at each level, Chapter 58 has posed significant challenges to Dorchester House, which, in turn, have compromised its ability to provide care to immigrant patients. I follow these chapters of analysis, I present a conclusion that links some of these challenges to specific provisions in Chapter 58 and identify areas of recommendation on the topic of how health care policy can be adjusted to better provide equal access to immigrants and to the health care providers who serve them both in Massachusetts and, with increasingly relevancy, in the United States as a whole.

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Introduction

In an office in downtown Boston, overlooking the old State House and the plaza at Government Center, Judy Meredith, a veteran health care reform lobbyist and Director of the Public Policy Institute explained to me what seeking health care could mean for immigrants today, "Just imagine" she began, "You came from the old country, your husband's dead here, you're living with your son, here's your daughter-in-law, a bunch of teenagers who don't speak your language… You're there in this little isolated place, and you feel a lump in your breast."

Judy went on to tell me that she had met the woman described by this story at a Chinese Women's Benevolent Society rally for expanded immigrant health care coverage in February of 2005. Across the state there was growing talk about pushing forward on a proposal for universal health coverage in Massachusetts, a policy that- if implemented- would be the first of its kind in any US state (Belluck 2006). Though representatives and lobbyists had been kicking around the idea of a universal coverage program for years, talks had grown more serious at the beginning of fiscal year 2005, as a five year contract with the Executive office of Health and Human Services (HHS) that had been funding the majority of Massachusetts' Medicaid program, called MassHealth, was drawing to a close. As these talks sped up, lobbyists like Judy Meredith wanted to make sure that the immigrant voice was included in these plans, and, hopefully, to use this new reform as an opportunity to abolish some of the restrictions on immigrant access. And so, on that day in February, Judy had walked to the State House to join the Chinese Women's Benevolent Society as they addressed their councilman, Senator Sal DiMasi, and asked him to vote on behalf of their coverage.

The woman described by Judy Meredith, who introduced herself as Mrs. Lao, explained with the help of a Cantonese translator that she had turned to the politicians because her health center could not pay for her breast cancer treatment. Though Mrs. Lao was legal, she did not fall into an eligible category for state coverage, and despite the technical availability of care, without the aid of the state, she was entirely alone.

On the day that Mrs. Lao made this plea it happened to be the Chinese New Year. Less than a mile away in Boston's Chinatown, the drums and firecrackers for the parade were already beginning. As Mrs. Lao finished her story, she handed a red envelope to Senator DiMasi and explained that it was a gift for the Chinese New Year- a token of hope that he would support the reform that would help her access the physicians she so badly needed. As each member of the Chinese Benevolent Society left, they put a red envelope on Senator DiMasi's desk. Judy Meredith recalls the image she was left with, "If that doesn't bring these issues to life. I don't know what does."

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That anecdote was from 2005: one year before a universal health insurance mandate titled "An Act Providing Access to Affordable, Quality, Accountable Health Care" or "Chapter 58" for short was put into place by Massachusetts legislators. This reform was lauded as "ground breaking" (Belluck 2006); it significantly changed the rules in Massachusetts's health care system, including those regarding the access and rights of immigrants. Unfortunately, three years down the road, is has become increasingly clear these reforms did not help Massachusetts' immigrants as Mrs. Lao and Judy Meredith had hoped (MIRA 2008) (National Immigration Law Center 2009). Today, lobbyists and health policy researchers are still grappling with Chapter 58 reform as it applies to immigrants, while health centers, still reeling from the various

logistical and service delivery-related adjustments that resulted from Chapter 58, have yet to even begin assessing this issue within their own clinics.[1]

I have chosen to address this information gap in my research by exploring some of the changes community health center providers who serve immigrants have experienced since the implementation of Chapter 58. As a group that has had the opportunity to monitor the health seeking behaviors[2] of immigrants over the course of these policy reforms, health care providers and administrators represent an invaluable perspective. Further, as suggested above, providers are a relatively under-researched group in the area of immigrant health studies and thus represent an important information gap to consider in judging the impacts of Chapter 58 reforms.

I have centered my research at one community health center in particular, the Dorchester House Multi Service Center (referred to henceforth as Dorchester House), which is located in the Dorchester neighborhood of Boston, a densely populated immigrant community. My aim in this case study was to gain an intimate understanding of how Chapter 58 reforms have affected community health centers serving immigrant communities. In the case of Dorchester House, this meant exploring the what changes the organization has incurred as a result of Chapter 58 reforms, what the nature of the these changes are, and how these have affected the position of Dorchester House as a health resource for immigrants in the Dorchester Community. A case study analysis focused on these questions will bring to life a new voice and add

[1] It is important to note that while MassHealth reform occurred in 2006, most of its implementation occurred in early 2007, and was followed by major reforms as recently as Fall 2009. Thus, Chapter 58 reforms are continuing to have important effects that are not yet captured by public health studies and data (Ku et al 2009).

[2] By "health seeking behaviors" I mean how patients interact with their providers and their health clinics: how likely they are to report medical problems, to comply with follow up, to express hesitations. These are all activities that providers are able to observe first hand.

valuable empirical evidence to the current understanding of the impacts of Chapter 58 reforms on immigrant health care providers (including administrators and non-medical health care professionals) as well as the patients they serve.

Furthermore, as the United States moves to implement landmark federal health care reforms passed into law this spring (March 2010), my analysis will serve as an important case study for how immigrant health care providers may soon be experiencing changes and challenges across the nation. With a structure and mandate similar to that of Chapter 58, federal reform represent a radical step in redressing the government's role in the United States health care system. By focusing on some of the challenges Massachusetts immigrant health care providers have faced during this transition at a state level, my research can be seen as offering an important empirical perspective on areas where national policy may fall short for immigrant patients in the coming years, and on those areas that policy-makers might look to as targets for reform.

The first chapter of this research project will offer a background on immigrants in Massachusetts, health challenges faced by immigrants, and how access to health care fits into these larger issues of disparity among in immigrant populations. The second chapter sets Chapter 58 health care reforms in a context of immigrant health policies in the United States and Massachusetts, specifically. I then map the policy changes created by Chapter 58 and its subsequent reforms and show how these reforms have impacted immigrants, according to current public health literature. I will follow this with a methods section that includes a description and history of Dorchester House and the Dorchester Community along with my full rationale for using Dorchester House as a case study. Following my methods sections I will present my findings in three separate chapters of analysis, based on personal interviews I conducted with providers. These

chapters seek to show how Chapter 58 has impacted the Dorchester House's patients, providers, and the organization as a whole. My findings will show that, in each case, Chapter 58 has posed significant challenges, which, in turn, have compromised Dorchester House's ability to provide care to immigrant patients. My finding will be followed by a conclusion that links some of these challenges to specific provisions in Chapter 58, and, thus, seeks to identify areas of recommendation and consideration on the topic of how health care policy can be adjusted to better provide equal access to immigrants and to the health care providers who serve them both in Massachusetts and, with increasingly relevancy, in the United States as a whole.

CHAPTER 1: IMMIGRATION BACKGROUND

Immigrants in Massachusetts

Massachusetts has always been defined by a rich immigrant culture. From the early American colonists, to the Irish potato famine refugees, to later European migrants during the post-WWI era, Boston's seaport has historically been a haven of asylum for populations in search of a new life. Over the past two decades, however, the profile of immigration to Massachusetts has changed drastically, following the changing trends of immigration into the United States as a whole. Below is a statistical summary of immigration in Massachusetts today in terms of its size, ethnic background, and legal status. I present this data in a manner that incorporates a statistical description of immigration in United States as a whole to illustrate the position of Massachusetts as the context for my research.

For instance, it is important to note that while Massachusetts ranks comparably with the rest of the United States in its immigrant population's growth, ethnic, and legal composition, its relative share of immigrant population is notably higher. Like the rest of the United States, Massachusetts has seen a general rise in immigration since the mid-1980s. However, Massachusetts' particular growth occurred with a distinct rapidity and size. The proportion of immigrants living and working in Massachusetts has doubled over the last 25 years with immigrants making up 14.2% of Massachusetts' total population and 28.6% of the population of Boston (Kaiser State Health 2009). Both of these ratios are higher than the US average of 12.6% (Kaiser State Health 2009). With over 950,000 foreign-born residents, Massachusetts ranks as having the 9th largest immigrant population in the nation (FAIR 2006).

Regional trends in migration have, however, matched the pattern in the United

States as a whole. Whereas immigration to the US in the 19th and first half of the 20th century was dominated by Western European migrants, today the majority of immigrants in the US come from South/Central America and Asia; the top ten sending countries are almost exclusively Asian or South/Central American (with the notable exception of Canada, ranked eighth) and nearly a quarter of US immigrants come from Mexico alone (Pew Center 2009). Massachusetts' regional patterns are similar, with the majority of immigrant arrivals- approximately 74%- stemming from non-European countries; Latin Americans make up 30% of Massachusetts' overall immigration and Asians make up 26% (FAIR 2006).

In terms of specific national origin, however, the immigrant community in Massachusetts is fairly unique. As of 2006, Massachusetts' top receiving countries were Brazil, China, and Portugal respectively (see **Appendix A, Figure 1** for a list of Massachusetts' top ten foreign born populations, by country of origin). In addition, Massachusetts has seen an influx of significantly large populations of Vietnamese, Haitian, and Cambodian refugees. This diversity amongst its immigrant population sets Massachusetts apart from other states as having a uniquely complex cultural composition of immigrants, with vastly different linguistic needs (Bloemrad 2006).

Adding to these cultural complexities in both Massachusetts and the United States as a whole is a growing population of undocumented immigrants. Though gathering accurate demographic information on undocumented populations is difficult, reports estimate that there are approximately 11.9 million undocumented immigrants living in the United States, constituting about 4% of the nation's total population. In Massachusetts surveys have estimated a roughly similar makeup with reports varying from 190,000 to 225,000 undocumented immigrants living and working in

Massachusetts, which represents approximately 3.4% of the state's total population (Pew Center 2009). In both cases, researchers agree, these populations are on the rise. Both in Massachusetts and at the national level statistics indicate that the highest proportion of undocumented immigrants has national origins in Central and South America, while the second largest group has origins in Asia, and the third in the Caribbean Islands (Pew Center 2009).

Thus, like trends in population growth and ethnic background, Massachusetts' trends in undocumented immigration generally follow those in the rest of the United States. This is important to consider in analyzing the general applicability of an analysis of Massachusetts' health care policies for documented and undocumented immigrants. By the same token it is important to note the ways in which Massachusetts' immigrant population is unique- namely, that it is highly culturally diverse and, compared to other states, fairly large in size. As I illustrate below, as a socially and culturally complex population, immigrants importantly shape the public health terrain as well as the nature of health disparities in Massachusetts, as well as the United States as a whole.

Challenges in Immigrant Health

In a study of the poorer health outcomes suffered by immigrants in the United States, Kandula (2004) described this trend by what he called a "healthy immigrant paradox". This, he explained, was a well-documented trend of steady decrease in immigrants' relative health status as they spent more time living in the US. Kandula noted that this decrease occurs over a life time, as well as between first and second generation immigrants. Studies have found significant increases in negative health markers such as obesity, diabetes, serum cholesterol, tobacco smoking, alcohol use,

illicit drug use, mental illness, suicide, and death by homicide, among others (Ortega 2007).

These disparities hold true in Massachusetts where a study in relative health outcomes have shown that children of immigrants are more than twice as likely as children of native-born residents to meet health criteria that indicate that they are in "fair" or "poor" health (immigrant children- 9%; native born children 4%) (Capps 2001). This study demonstrated how these differences widened when one focuses on low-income populations: 12% of immigrants' children age five and younger are in fair or poor health, compared with only 5% of children of native born populations. These numbers translate to adult populations as well. This same study found that 2% of native-born children report having parents in poor health as compared to 9% in immigrant children (Capps 2001). Furthermore, immigrants are over represented in the Massachusetts Lead Poisoning registry and are, overall, more likely than natural born citizens to incur both fatal and non-fatal occupational injuries (Davis and Souza 2007). Clearly these gaps represent significant and unequal health outcomes that cannot be explained by foreign-born status differences alone.

Causes of Poor Health and The Need for Access to Care

Literature on immigrant health has highlighted a number of social determinants within immigrant populations that are central in producing these poorer health outcomes. Because my research is centered on policies that regulate health care access, my discussion of social determinants mostly focuses on a discussion of the impacts of health care access in causing health disparities, and the challenges immigrants face in accessing appropriate care. However, I have provided a brief description of other social

and environmental factors influencing immigrant health to illustrate both the imbedded nature of immigrant health disparities and immigrants' need for appropriate access to care.

Poverty

The Immigrant Learning Center estimated in a recent report that 14.5 percent of immigrants in Massachusetts were living below the poverty line in 2007 versus 11.1 percent of natives. Further, nearly a third, 32.4 percent of immigrants were living below 200% of the poverty line versus 22 percent of natives (Clayton-Mathews et al 2009). Poverty has far reaching implications for health seeking behaviors and has been shown to be a risk factor for poorer health outcomes. Health indexes show direct inverse correlations between socio-economic status and morbidity and mortality rates. Individuals living below the poverty line have been shown to have higher rates of almost every disease as well as higher rates of mortality overall (Adler 2008).

Housing and Built Environment

Immigrants in the US are more likely to live in poor or substandard housing and in neighborhoods with higher crime, violence, and pollution rates. All these factors lead to poorer health outcomes (Adler 2008). In Massachusetts, case studies of immigrants in Boston's Dorchester and Chinatown neighborhoods have shown the prevalence of elevated blood lead levels among immigrant children to be more than twice that of U.S.-born children. Largely, researchers suspect this comes from environmental exposures such as exhaust from motor vehicle traffic, dust from construction projects, and poorly maintained home and piping systems (Eamranod and Hu 2008).

Poor Working Conditions

Immigrants are more likely to participate in high-risk occupations such as agriculture, construction, industry, and other temporary or seasonal forms of manual labor. These jobs are often dangerous- among non-agricultural immigrant Latino workers, the average occupational injury rate was 12.2 per 100 full-time workers, compared to an expected 7.1 in the U.S. population as a whole (Eamranod and Hu 2008). Further, they offer little formal structures of support such as paid sick leave, health care, and vacation time, and generally do not provide steady payrolls. All these factors contribute to higher stress levels in immigrants, which in turn can be linked to poorer health (Adler 2008).

Immigration Status and Fear

Researchers have found that some immigrants defer seeking medical care because of issues of fear about their immigration status. Qualitative researchers have found that, even in communities where health centers perform active outreach and promote their services amongst immigrants, immigrants report feeling mistrustful of the US health system and hesitant to seek care (Holmes 2006). In Massachusetts, health care enrollment organizations have noted that this occurs in both documented and undocumented populations. Specifically, undocumented immigrants worry that they will be reported to immigration enforcement officials and potentially deported, while naturalizing immigrants fear that being diagnosed with chronic or serious illness will affect their immigration eligibility (Health Care for All, Interview, 2009). Research has found that these levels of fear in Massachusetts have increased as immigration

enforcement issues gain increasing media attention, and that, subsequently, health seeking behaviors amongst Massachusetts immigrants, regardless of their status, have decreased (ICH 2009).

Access to Care

All these factors put Massachusetts immigrants at risk for poor health outcomes and underscore the need for health care in this vulnerable population. There is little question amongst public health experts that in populations with greater risk and burden of disease and poor health, the single most important factor in improving health disparities is the adequate and continuous access to health care. In this case, "adequate and continuous" can be defined as quality health care that is physically, financially, as well as culturally and linguistically accessible (Adler 2008).

The linguistic and cultural piece of this description is particularly challenging in Massachusetts where Creole, Portuguese, and Vietnamese are often needed in health care settings. According to the Massachusetts Department of Public Health's Primary Care Office (the regulatory body responsible for monitoring Massachusetts' physician workforce) the Massachusetts health workforce is facing increasing challenges to meet the linguistic needs of its patients (Dyck 2007). Though state efforts have worked to increase interpreter services and health professionals with secondary language skills, unless immigrant patients have established regular translation services or appointments with specific doctors, often culturally and linguistically appropriate care cannot be ensured (Dyck 2007). Along with causing direct problems in diagnosis and treatment practices, language barriers play a significant role in adding to the problems of fear that immigrants feel about seeking care (Devi 2008). Thus, even amongst immigrants who

are insured or who may have access to care, it cannot be said that appropriate or adequate health care is available.

For many, however, the most pressing problem regarding access is the fundamental issue of uninsurance. The efforts of the Obama administration to reform our national health care system has underscored both the importance of accessible health care and the great gap that the United States faces in offering this to all of its citizens. According to the United States Census Bureau, 46.3 million Americans remain without health insurance as of 2008, and accordingly do not seek regular primary care or preventative screenings and are typically diagnosed at later stages of disease (US Census Bureau 2009). Accordingly, uninsured are four times more likely to use emergency rooms as their regular source of care and are 30-50 percent more likely to be hospitalized for an avoidable condition (FAIR 2006). According to a recent Harvard Study by Wiper et al an estimate 45,000 preventable deaths occur in the United States every year due to lack of health insurance (Wiper et al 2009).

For immigrants, the likelihood of being uninsured is almost double that of the native born population (FAIR 2006). This is a direct result of the United State's limited policy on public health care. Unlike in Canada or the United Kingdom, US citizens must purchase their own private insurance plans, receive health care from an employer, or enroll in public programs for individuals with low incomes such as Medicaid, State Children's Health Insurance Program (SCHIP), or, for those over the age of 65, Medicare. Because immigrants are disproportionately below the poverty line and often work irregular, part time or temporary jobs, they are much more unlikely than native-born citizens to obtain affordable health care from private sources (Capps 2001). Further, many immigrants do not qualify for Medicaid or Medicare because of policy

restrictions that prevent individuals from enrolling without full citizenship status. Thus, immigrants often fall into coverage gaps and are forced to seek the type of limited, emergency care that, as described above, exacerbates the pathology of a given disease and lowers health outcomes overall. Indeed, this is true in Massachusetts, as elsewhere in the United States.

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In the following chapter, I will outline the health care policies that have defined immigrants' rights and access to care in the United States and in Massachusetts specifically. This will include a detailed description of the policies defined under Chapter 58 and how current literature has shown these reforms have impacted immigrants' access to health. Combined with the information presented above on the impact of uninsurance and access to care, this discussion will illustrate the complex problem facing health care providers such as The Dorchester House in Massachusetts that are seeking to provide appropriate access to immigrants.

CHAPTER 2: POLICY BACKGROUND

I will begin by locating my analysis of health care policy in the larger context of

policies that affect immigrants in the United States, and to make a distinction between Immigration and Immigrant policies. **Immigration Policy** refers to the set of regulations that dictates statutes about who is allowed to enter the United States, who is allowed to stay (for how long and under what conditions), and who is required to leave (MacPherson 2007). These policies are established and regulated at the federal level by the United States Congress and, similarly, enforced by Immigration Customs Enforcement (ICE), which operates under a federal mandate.

Immigrant policy, on the other hand, does vary at a local and regional level. These are the set of laws and regulations that address immigrant populations already living in the United States. This may include welfare, public health care programs such as Medicaid and Medicare, Social Security, or any other type of public policy that contains clauses directly relating to immigrant populations. The legal frameworks of these policies are set at a federal level. It has already been noted, for instance, that the federal policies regarding Medicaid and Medicare prevent individuals without full citizenship from accessing these programs. However, supplemental policy amendments and funding may be made at the state level. As I will show, in the case of Massachusetts a number of state-based public policy reforms included in Chapter 58 have had significant implications for immigrants' access to health care. As a result, my analysis will focus predominantly on immigrant policies at the state level, rather than the federal policies that regulate immigration practice.

History of Immigrant Policies in the US

Having made this distinction, it is important to note that immigrant policies have, historically, been heavily influenced and intertwined with the immigration policies

in the United States. A highly regulated immigration system based on intensive federal regulation and economic protectionism, has informed the nature of the both policies and cultures surrounding immigrant benefits, especially on matters of health.

The first national immigration laws were passed in 1790 in response to the growing wave of Western European immigrants who had left the receding economy in Europe in search of new opportunity in America. Politicians came to fear that Boston and other new cities were being "flooded" with Irish, French and Scottish immigrants who as, described by a Massachusetts congressmen of the time, were seen as little more than a "common class of vagrants, paupers, and other outcasts from Europe" (Meckel 1985).

Many of these doubts and fears about immigrants were colored by concerns about the threat they posed to the nation's health (Baldwin 2005). Indeed, Dysentery, Head Lice, and Cholera were common diseases amongst European immigrants of the mid-nineteenth century who often entered the country with diseases they had contracted from their boat journeys to America or who became ill under the poor living and sanitation conditions of immigrant tenants. According to one historian:

> "[Occupants' severely strained existing housing supplies and sanitary facilities and led to overcrowding, squalor, and consequent high rates of mortality, especially among the immigrants and their children…Packed into teaming back-alley tenements or hastily converted commercial structures, immigrants found themselves inhabiting an environment where unsanitary conditions were the rule, where disease festered and was rife, and where death held powerful sway" (Meckel 1985).

At this time, the United States had not yet established a basic hospital network, let alone a national health care system. Medical care was offered by local and family physicians on a pay-per service basis for those who could afford it (Baldwin 2005). Those, like the majority of the impoverished immigrant class, who could not afford care fell to the care of charity and public aid organizations for the poor. As a result, early

immigrants in Boston and other epicenters came to be seen- not only as diseased and dangerous outsiders- but also as individuals who required public aid: a burden to the American tax-payer and average working citizen (Fairchild 2004).

This sentiment was codified as official US policy in 1879 in *An Act to Prevent the Introduction of Infectious or Contagious Diseases into the United States and to Establish a National Board of Health.* The Act's stated purpose was twofold: first, to prevent the introduction of contagious diseases brought from foreign countries and second, to contain the financial burden of American taxpayers in caring for these new residents. This law, as well as the history which preceded and prompted its implementation, set in motion a legacy of polices that have intertwined economic protectionism with immigrant entrance policies and which have importantly linked health to immigrants' eligibility by these standards. This basic premise still defines immigration and immigrant policies today.

The most notable example of this is a measure (whose original components were added not long after the initial Act of 1879) that bars immigrants from entering who can be considered an economic liability or "public charge" on the basis of pre-existing health conditions (USC 8 § 1182). This means that naturalizing immigrants may be deported if immigration officials determine that they do not have sufficient funds to pay for pre-existing medical conditions. Further, today's policies state that immigrants may be denied entrance or citizenship if they have a contagious disease such as TB, HIV, or various STDs (42 CFR Part 34). Thus, immigration policies today serve to reify the historical trend of linking immigration to health status, and maintaining health status as a category that colors how our nation defines immigrants' rights to accessing social benefits, including health care.

Types of Immigrants

In particular, in the United States, as in most other countries, health care and other social benefits policies often have vastly different applications amongst immigrant groups according to immigrants' type or category.[3] As determined by the World Health Organization (WHO) the general definition of an immigrant is "an individual who leaves their legal place of origin and crosses international boundaries (WHO 2003)". Past this very basic definition, further distinctions may be made based on origin, age, length of stay, and one's reason for leaving, amongst other factors. Generally, however, immigrants are broadly discussed as fitting into one of two groups- documented or undocumented- a dichotomy that has already been highlighted in my discussion of varying immigrant health outcomes and risk factors. Below is a more detailed explanation of these two categories:

Documented migrants are those whose entry and residence in a host country has been registered by state authorities and who, accordingly, may be eligible for health care and other social benefits depending on their status. Below, I have listed several categories of documented migrants relevant to discussions of immigrant policies in the US and my analysis of Chapter 58 reforms.[4]

Types of Documented Migrants

[3] Thus, it is interesting to note that while health care and other social benefits fall under the category of immigrant policies, they are inherently linked with immigration policy as well.

[4] Note that I do not include asylum seekers or refugees in my chart. This is because both of these represent groups that have been awarded special status by the US government and which receive (often extensive) social and health care benefits specifically tailored to their needs (MacPherson et al 2007).

Qualified Migrants	Individuals who have been a legal permanent resident for 5 years or more and who hold a valid green card; or individuals who are granted citizenship under asylum or refugee status
Person Residing in the US Under Color of Law (PRUCOL)	Individuals residing in the US who have express, written documents from the US government stating that the government knows of this person's presence in the US and does not plan on making them leave. Though these individuals do not qualify for U.S. citizenship, they are considered to have the same rights as U.S. citizens for welfare and state benefits eligibility purposes.
Aliens With Special Status (AWSS)	Immigrants who have had legal, permanent status for less than 5 years and have been approved by the US as eligible for certain social benefits, but without assurance of residency. This may include individuals who are in the process of applying for naturalization or refugee status.
Nonimmigrant	Individuals who have legal status under a state-issued visa (work, student, or otherwise) issued for a specified, limited time. These individuals may be in the US with the intention of applying to naturalize or they may intend to return to their countries of origin.

Undocumented migrants are those whose current presence is unregistered by host countries and immigrant officials (WHO 2003). Though this category may include individuals who entered countries illegally, it may also include visitors or workers who were once legal but who overstayed their authorized entry period (WHO 2003). As a group without officially recognized political status, undocumented immigrants are not- for the most part- directly included in health care and other public benefits programs. Though, as I show below in my discussion of health care policies in Massachusetts, this does not keep undocumented immigrants from still being significant affected by the provisions and changes in immigrant policies.

Massachusetts Health Insurance Policies prior to 2006

Though my particular focus is limited to health care, a full analysis would include a range of state and federal level policies (such as welfare, food stamp, and housing programs) that impact social and health services available to immigrants in Massachusetts. Here, however, I have chosen to focus specifically on only the most recent health care policy reforms and how these have changed access to care for immigrants in Massachusetts.

Prior to Chapter 58, Massachusetts already had a highly regulated health care system with extensive public benefits (McDonough et al 2006). Its Medicaid program (MassHealth) was expanded in 1997 through a federal grant that legislators had been awarded from the HHS. This additional funding expanded MassHealth eligibility guidelines to include coverage for individuals with incomes at 150% of the federal poverty level (FPL), whereas before the cut-off was set at only 100%. To provide some idea of what this means, the FPL is defined by the bureau of population statistics as the minimum amount of money necessary for an individual to maintain an acceptable standard of living, and for a single adult in the United States, is set at $10,830. (see **Appendix A, Figure 2** for official 2009 FPL chart) (HHS 2009). This grant, called the MassHealth Waiver, was authorized for an initial five-year period and then given a secondary extension through 2005. Over time this bumped MassHealth enrollment from 670,000 to 1,038,000 and helped reduce Massachusetts' uninsurance rate from 11.7% to 9.8% in 2005 (Commonwealth Fund 2009). This ranked Massachusetts as having the fifth lowest uninsurance rate in the country (Commonwealth Fund 2009).

Supplementing this extensive Medicaid funding was a unique and extensive state-funded free care system called the Uncompensated Care Pool (UCP). The Pool,

first established by Massachusetts legislators in 1985, reimbursed hospitals and community health centers (CHCs) for care provided to lower-income (defined, in this case, as 200% below the FPL) and uninsured patients (Commonwealth Fund 2009). Though this money was dispersed throughout the Massachusetts health system, particularly large grant stipends were set-aside for two particular hospitals and their affiliated CHC networks that were deemed by the state to treat a Disproportionate Share of uninsured patients.[5] These Disproportionate Share Hospitals (DSH) were the Cambridge Health Alliance and the Boston Medical Center, with which Dorchester House, my particular case study, is affiliated.

The UCP was financed by a mix of federal, state, hospital, and third-party payor dollars and used a reimbursement system based on block grants (EEOSS 2007). In other words, CHCs and hospitals would calculate their twelve-month averages in free care spending and receive UCP funds based on these (Ku and Jones 2009). Thus, leading up to reform in 2006, Massachusetts was already contributing a great deal of state resources and policy effort to addressing health insurance and health access.

However, for legislators and lobbyists in Massachusetts, these efforts were not enough. Beginning in 2004, state legislature talks- led by Governor Mitt Romney (Rep) and Senate President Robert Travaglini (Dem)- on the topic of universal health care coverage in Massachusetts had begun. These talks came in light of steadily increasing state costs to the UCP and MassHealth system, and the looming knowledge that the MassHealth waiver was due to expire in 2006. Additionally, for the lobbyists and politicians who had- for over a decade- fought to put Massachusetts at the forefront of public health care policies, the prospect of a universal health care overall meant much

[5] This was defined as 63% or more. It is also important to note immigrants represent a large number of these uninsured patients (DHCF 2008).

more; it was an opportunity for reformers to prove that a universal health care was possible and for Massachusetts to be the state that proved this.

2006: Chapter 58 Health Care Reform

Thus, in April 2006, Governor Mitt Romney closed a two-year long legislative process by signing Chapter 58 of Massachusetts General Court: *An Act Providing Access to Affordable, Quality, Accountable Health Care. This* marked the first statewide bill explicitly aimed at achieving universal coverage. The major components of this bill are described below

1. Individual Mandate: To enforce the push for universal care, a mandate was included requiring all Massachusetts residents 18 and older to purchase an affordable[6] health care plan by December 2006 or else pay a tax penalty in 2007 roughly equivalent to $219 per person.
2. Employer Mandate: This ensures that all employers with more than ten employees offer at least partially subsidized health insurance packages to their employees or else pay a tax fee of $295 per employee, per year that they do not offer a health insurance plan.
3. Establishment of the Massachusetts Health Connector (*The Connector*): This independent public authority was created by Chapter 58 reform to regulate the

[6] The definition of affordable varies with income. At one extreme, adults with family income at or below 150% of the FPL are assumed to be unable to afford any payments for insurance coverage, while, at the other extreme, those with incomes 600% of the FPL or higher are deemed able to afford coverage because of their income status. For those in between, affordability definitions range and follow a sliding scale according to family income. See appendix for full affordability scale.

sale of private insurance plans to residents of Massachusetts and to ensure that individuals were being linked with affordable and appropriate coverage. For individuals and small businesses who, under the mandate, were required to purchase private or partially subsidized insurance (see Commonwealth Care below), the Connector[7] serves as the primary resource through which they can access and be linked to affordable private health insurance plans.

4. Expansion of MassHealth: Chapter 58 allocated a significant amount to maintain eligibility standards that had been initially achieved through the MassHealth waiver. Thus, state funding was used to maintain the 150% of the FPL eligibility level; for children, eligibility was raised from 200% to 300% of the FPL.

5. Creation of Commonwealth Care (CommCare): This program was created for individuals who do not qualify for MassHealth, but who cannot afford the full cost of purchasing private health insurance. Commonwealth Care offers state-subsidized health insurance to individuals with incomes below 300% of the FPL. Individuals enrolled in Commonwealth Care must pay small premiums and co-pays according to a sliding scale that is based on income and determines the amounts. These plans are offered through five private managed care organizations (MCOs)[8] who signed contracts with the state, and whose services are regulated through the connector to ensure comprehensive and affordable care.

6. Creation of the Health Safety Net (HSN): Federal and state funds that had been provided under the UCP system were significantly cut under a new free care

[7] Accessible online via www.massconnector.com.

[8] The five plans are BMC HealthNet Plan, Fallon Community Health Plan, Neighborhood Health Plan, Network Health, and the most recently added, CeltiCare Health Plan.

system called the Health Safety Net. These cuts were made in exchange for the extra funds being channeled into MasssHealth and CommCare, with the rationale that a great number of patients would shift their coverage from the UCP to one of the newly provided state plans. In addition, the HSN added new cost-sharing provisions such as sliding scale co-pays and deductibles for individuals with incomes below 400% of the FPL. These changes were accompanied by a requirement that hospitals and CHCs shift to billing the HSN on a pay-per-patient basis rather than in a block grant system as they had done under the UCP. Finally, extra-funding to DSH hospitals was also significantly reduced.

Source: Health Care For All. 2009. Public Programs Fact Sheet. www.hcfama.org

Impact of Chapter 58 Health Care Reform for MA Immigrants

In terms of statewide uninsurance numbers, there is little question that Chapter 58 reforms have had a significant and positive impact. Between the fall of 2006 and 2008 uninsurance among working-age adults in Massachusetts dropped from 13% to 4%, a reduction of 70% and an average almost five times lower than the national average uninsurance rate of 19.7% (KHF 2009). Greatest reductions in uninsurance occurred in individuals with incomes less than 300% of the federal poverty level. These individuals experienced a drop in uninsurance rates from 24% in 2006 to less than 8% in 2008 (KHF 2009). However, these figures do not accurately reflect the experiences of Massachusetts' immigrant population. In fact, the same reports that have found large decreases in statewide uninsurance rates, have also reported that those in Massachusetts who remain uninsured are disproportionately likely to be immigrants (KHF 2009)

(Commonwealth Fund 2009). Current reviews and public health literature indicate that immigrants have been, at best, left out of Chapter 58 reforms and, at the worst, restricted by it (MIRA 2008) (ICH 2009). Detailed below is an analysis of how various provisions of Chapter 58 reform have done this. These descriptions will serve, mostly, as an overview through which to familiarize the reader for further discussion in my analysis chapter. Specific consequences and subsequent arguments about these reforms are reserved for the providers with whom I spoke and for further discussion of the care of Dorchester House in particular.

CommCare and Changes Under CeltiCare

Initially, CommCare represented an improvement in coverage for Massachusetts' immigrant community and was praised by activists like Judy Meredith, who had hoped that Chapter 58 would offer expanded rights for immigrants. In its original provisions, CommCare included state-subsidized coverage for AWSS immigrants- a population that had previously been ineligible for public funding under Massachusetts policies prior to Chapter 58. What this meant was that an entire subset of immigrants- those who held green cards, but who had not yet been in the country for a five full years- were made eligible for state funding and subsidies, whereas, previously they had been treated the same as undocumented or provisionally documented immigrants. Had these provisions remained in place, it is possible that discussions surrounding Chapter 58's coverage for immigrants today might be much less critical (Public Policy Institute 2009).

However, this has not been the case. In July 2009 state legislators voted to eliminate AWWSS immigrants from inclusion in CommCare in an effort to close

statewide budget shortages. As a result, nearly 31,000 legal immigrants were cut from CommCare insurance. Not surprisingly, immigrant advocates and health care centers immediately responded to this budget cut with outrage, demanding that health care coverage be reinstated for these individuals (Community Partners 2009). In response, Massachusetts' Governor, Deval Patrick (Dem)[9], pledged 70 million dollars to piece together an interim coverage package that could offer AWWS immigrants some limited coverage until state funds had recovered enough to redress the question of full CommCare coverage.

The interim plan, offered only to AWWS immigrants who had previously been enrolled in CommCare, was called Commonewealth Care Bridge (the Bridge program) and was brokered with a new, out of state MCO entrant in the Massachusetts insurance market called Celticare (HCFA 2009).[10] Unlike the other four contracts signed to CommCare through the connector, Celticare is a for-profit MCO and is located out of state. Because of this, the Bridge program utilizes a much more limited network of physicians than other plans on CommCare, and does not cover services offered in the two largest state-funded hospitals in Massachusetts- Boston Medical Center and the Cambridge Health Alliance (Community Partners 2009). Further, because the CommCare Bridge program was designed to be low cost and temporary it does not include all the same services that were available under the CommCare program. For instance, dental, vision, hospice, and skilled nursing are not covered in the new plan and there is no sliding scale system to help determine co-pay or deductible level (HCFA 2009). As a result, some individuals will see a rise in personal costs for the CeltiCare

[9] Elected in 2008, following the completion of Romney's term.
[10] CeltiCare, like the other four HMOs, has been chosen and approved by the Massachusetts connector.

option. The Bridge program was implemented in October 2009 and as of November 2009, approximately 21,400 of the immigrants have enrolled in the new, lower-cost plan operated by CeltiCare; legislators have yet to begin talks on reinstating full CommCare to the 31,000 immigrants who had been cut.

MassHealth Limited

While a large number of MassHealth services were supported by Chapter 58, relatively few of these dollars were made available for immigrants. Following the previously upheld federal Medicaid guidelines, full access to MassHealth was only offered to low-income PRUCOL and qualified immigrants (green-card holding) who could prove that they have lived in the US for more than five years (HCFA 2009). For all other low-income immigrants who were documented provisionally (that is, not in the process of applying for green cards), an auxiliary version of MassHealth (MassHealth Limited) was created that offered funding only for emergency hospital visits and acute services (see **Appendix A, Figure 3** for a full comparison of MassHealth Standard and MassHealth Limited) (McDonough et al 2006).[11] This coverage is highly restrictive; under MassHealth Limited, a patient might be covered for the cost of their transportation to an emergency room, but then be charged with hundreds of dollars of medical bills upon being admitted to the hospital or upon returning for follow-up services. Further, this plan leaves significant gaps in coverage for primary care and preventative services, non-emergency drug prescriptions, non-emergency doctor visits, dental and eye care, and long term medical care (HCFA 2009). Thus, MassHealth

[11] "Emergency" is defined by MassHealth mandate as "a medical condition that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in: (a) placing the member's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (Massachusetts Law Reform Institute 2009).

reforms left Massachusetts' provisionally documented immigrants all-but-uninsured. Regardless of their legal status, they, like the estimated 200,000 undocumented immigrants living in Massachusetts, must rely exclusively on the HSN.

Health Safety Net

Because of the various restrictions in MassHealth and CommCare, many immigrants have had to rely disproportionately on the HSN for primary care and general hospital services. To summarize, this includes low-income undocumented immigrants, provisionally documented immigrants and, following the change to the Commonwealth Care coverage, any green-card holding immigrant who has been in the US for less than five years.[12]

The impact of the HSN's implementation occurred at both the individual and organizational level. For patients who had been receiving care via the UCP, the switch to the HSN represented an increase in personal costs for walk-in visits, appointments with primary care physicians, as well as for pharmacy and prescription costs. As described above, this is because the HSN requires individuals to provide co-pays and deductibles based on a sliding scale system. Though the poorest patients are exempt from all personal costs, most individuals using the HSN have begun to see co-pays ranging from 1 to 50 dollars, depending on their procedure and length of stay.

For health centers that serve uninsured immigrant patients (CHCs), the move to the HSN and elimination of block funding has resulted in major shifts and, often, losses in funding. As mentioned above, the shift to the new HSN system was made with the intention of reducing overall state funding for free care services in lieu of the expanded

[12] This does not, of course, include those immigrants who were eligible to be transferred to the Commonwealth Bridge Program. However, it may include individuals who *would have* been eligible for the Commonwealth Bridge Program but did not (for whatever reason) register for it after being cut from Commonwealth Care.

services and eligibility offered under MassHealth and CommCare. When Chapter 58 was implemented in 2006, legislators estimated that enrollment in these state programs would cause free care costs to fall from $610 million to $320 million by 2009 (Kaiser Commission 2009). While enrollment in MassHealth and CommCare did serve to shift state costs somewhat, demand for free care services did not fall proportionately to what was expected. As shown above, MassHealth and CommCare represented imperfect coverage systems with gaps for many services and types of patients, especially immigrants (Massachusetts Executive Office of Health and Human Services 2007). As a result immigrants and other low-income patients have continued to rely on the HSN system, and the clinics who serve them have been left to cope with financial gaps. This was particularly true in the case of CHCs such as Dorchester House who were affiliated with one of the two DSHs who lost their extra funding from state and federal Sources (DHCFP 2008).

In my analysis chapters, I will explore further how the implementation of this new step and the increase in paperwork for undocumented immigrants and the providers who serve them, has been problematic.

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In the next chapter I will present my research methodology, including a detailed background of Dorchester House and why its health care providers represent a relevant case study through which to examine the impacts of Chapter 58's impacts on immigrant health services. I will follow this by presenting my findings, highlighting the ways in which the aforementioned financial and legal reforms have affected the practices and structure of health care providers at Dorchester House.

CHAPTER 3: METHODS

My study centers on interviews with 11 professionals whose work impacts the health services provided at Dorchester House. These professionals were chosen to represent a range of perspectives and professional roles associated with the Dorchester House; a full list of my interview participants and their professional titles may be found below:

Name	**Position** ***Organization***	**Second Language**
Joel Abrams	CEO, Director *Dorchester House*	
Pat Egan	Medical Director, Family Medicine Physician *Dorchester House*	
Judy Meredith	Board Member *Dorchester House* Executive Director *Public Policy Institute*[13]	
Michelle Nadow	Policy Director *Dorchester House.*	
Julita Mir	Internal Medicine Physician, HIV/AIDS Specialist *Dorchester House*	Spanish Portuguese
Bich Phuong Do	Adult Case Manager *Dorchester House*	Vietnamese
Marika Hewes	Family Case Manager *Dorchester House*	
Allison Diamond	Family Medicine Nurse Practitioner/ Women Health Specialist *Dorchester House*	
Pedro Sanches	Insurance and Registration *Dorchester House*	Spanish
Kathryn Bicego	Education and Enrollment Manager *Health Care for All*	
Dayanne Leal	Outreach Manager *Health Care for All*	Portuguese

[13] The Public Policy Institute is a non-for profit organization whose mission is to help Massachusetts nonprofit and community organizations working for positive policy change build their organizational capacity and political power. The Public Policy Institute has done a great deal of work around health care reform campaigning, focusing on, among others, those who fall under Chapter 58. They have also opened a health insurance helpline service, similar to HCFA, to which Dorchester House patients are referred.

Health Care for All (HCFA) Interviews and Participation with the Institute for Community Health (ICH)

The last two listed participants, Kathryn Bicego and Dayanna Leal, represent important exceptions in my case study in several respects, in that neither is directly affiliated with the Dorchester House. Rather, both Bicego and Leal work for Health Care for All (HCFA), a non for- profit organization which works to provide universal, consumer-based health care to residents of Massachusetts through activism, education and outreach. One of HCFA's most important activities is running a health insurance "Helpline" which Massachusetts residents can call[14] to contact health insurance counselors to receive free information about health insurance and health insurance enrollment. Helpline counselors also provide the vital service of enrollment facilitation, working with uninsured individuals to fill out state applications over the phone. Both Kathryn Bicego and Dayanna Leal work on the Helpline project, answering questions and enrolling uninsured individuals in state programs. Often, these women report, they work with immigrants from all parts of the state and city, including the Dorchester Area (HFCA interview). This is especially true for Dayanna Leal who is a native of Brazil and speaks Portuguese fluently. In that respect, Bicego and Leal represent individuals who are highly experienced with the state health insurance policies and reforms that apply to immigrant communities, as well as, generally, the clinics and health centers that serve them. I found their discussion of these topics highly informative and accessible sources of information about what is needed in today's policy climate to get access to state insurance.

[14] The helpline also uses an online format which can be found at: http://www.hcfama.org/index.cfm?fuseaction=Page.viewPage&pageId=523&grandparentID=496&parentID=767.

The second way in which Bicego and Leal represent an important exception in my research is methodological in nature. These are the only two participants that I did not interview and audio record in person. Rather, these women were interviewed and audio recorded by researchers Jocelyn Chu and Jonathan Takahashi as part of the Immigrant Health Project at the Institute for Community Health (ICH). The research project for which this interview was conducted is titled, "The Impact of Enhanced Immigration Enforcement on Immigrant Health" (Principle Investigator, Karen Hacker) and is set to be completed in the spring of 2010. The study focuses on the dynamics of immigration enforcement, fear, and health impacts amongst immigrants in Everett, Massachusetts.

After learning about the Immigrant Health Project from my academic advisor, Linda Martinez, and seeing how closely it tied in to my own interests on policy challenges affecting immigrant health, I began volunteering with the ICH research team in October of 2009 to gain a greater understanding of how researchers were approaching these types of questions in the specific context of immigrant communities in Massachusetts. I mostly worked in their offices, located at the East Cambridge Health Alliance, transcribing interviews with certain policy Stakeholders, including individuals like Bicego and Leal who work to enroll immigrants in insurance programs. Before my volunteer position ended with the ICH in December of 2009, I also helped researchers begin to develop a qualitative code to use in their analysis of these transcribed interviews. Accordingly, though I did not interview Bicego and Leal firsthand, I did serve as the primary transcriber on this interview and have studied it in great depth both for my own research coding, and for researchers at the ICH.

I have included in my field notes a description of a research meeting that I attended at the beginning of my volunteer period at the ICH in which I describe being introduced to individuals who later became my research colleagues. These notes provide a helpful reference in explaining how my work at the ICH dealt with crucial information about the climate and perceptions of Boston immigrant communities, especially those surrounding issues of policy enforcement and health care. After working closely with the Bicego and Leal interview, I was granted permission both from the ICH projects' PI as well as from Bicego and Leal themselves, to use this interview for analysis in my own project. I have found it incredibly helpful in elucidating some of the more complex policy questions of immigrant enrollment under Chapter 58 reforms.

Interviews

My own interviews were performed over a 5 month period (September 2009 – January 2010) and took place at the Dorchester Community Health Center, located at 1353 Dorchester Avenue in Dorchester MA. Each interview was approximately an hour long and audio recorded. All participants were asked to sign a consent form (see **Appendix B** for a copy of the consent form) prior to the interview and audio recording process, which fully informed participants of any potential risks, harms or benefits of my research. I later transcribed these interviews to analyze their contents using qualitative methods, described in greater detail below. In total, I obtained 65 pages of typed interview notes.

Sample

As stated above, as opposed to much of the previous literature on the topic of health care reform and immigrant communities, I have chosen to focus my research on the provider, rather than the immigrant or community perspective. My decision to focus on providers reflects my desire to speak with individuals who have had a wide range of

immigrant patient-provider interactions over a long period of time in the state of Massachusetts. While immigrants are able to comment on their own personal experiences, providers are better suited to make generalizations about the effects of policy on a range of patients with a diversity of legal statuses, coverage levels, and cultural backgrounds. Further, while many studies have focused on the impacts of policy reforms on the receiving end of the health care system, few have addressed the numerous other actors that mediate the translation of policy into practice such as providers and health clinic administrators. It is this understudied group on which my research is focused.

With this in mind, the participant sample was selected to reflect a range of professional relations to, and perspectives on, immigrant health care within the Dorchester House. That is, I wanted to interview individuals who think about issues of health care reform at the administrative and organizational level as well as individuals who have had to adapt to hands-on changes in various clinical settings as immigrant health care providers. Additionally, I wanted my study to include an examination of providers who worked both with medical and social services. I have created a chart which clusters my participants based on these various perspectives so that the reader may get an idea of how I built a conceptual framework for my research. However, it should be noted that most of the individuals whom I spoke to did a great deal of interfacing between these various professional domains. An example of this is Dr. Patrick Egan, Dorchester House's Chief Medical Director, who works both with immigrant patients and, as medical director, is responsible for managing and understanding clinical challenges faced by other physicians. Thus, the chart below represents a simplified explanation of my participants' contributions, which will

hopefully be rectified by my research's description of their highly nuanced roles and challenges as immigrant health care providers at Dorchester House

Professional Perspective	Name
Administrative/ Organizational	Joel Abrams Judy Meredith Patrick Egan
Health Insurance and Policy Work	Michelle Nadow Pedro Sanches
Hands on Medical Services	Julita Mir Allison Diamond
Hands on Social Services	Marika Hewes Bich Phuon Do

Before I go on to discuss, briefly, the content of my interview guide, I will note that one other participant, already mentioned in this paper, stands out as somewhat different from the rest of this group: Judy Meredith, a board member of Dorchester House, who also works as a health care Lobbyist for the Public Policy Institute. As mentioned in the introduction of this paper, my interview with her took place at her offices at the Public Policy Institute, located in downtown Boston. I included her interview both because she is a long time veteran of health care policy reform lobbying in Massachusetts and because she, more than any other individual who I talked to, offers a perspective that places the experiences of Dorchester House in a larger context of how reforms have affected other immigrant health care providers in the state of Massachusetts.

Interview Format

The interviews I conducted were unstructured and thus did not follow the same format each time. Nevertheless I attempted to follow a core set of questions that established interviewees' 1) Role and relationship to Dorchester House; 2) Interactions

with immigrants in Dorchester house; 3) Experiences with health care reforms; and 4) Perspectives on how these experiences had reflected changes in interactions with immigrant patients (See **Appendix C** for a full copy of my interview guide). At the end of each of my interviews I asked participants to offer suggestions as to how they thought specific challenges faced by Dorchester House providers or the organization as a whole could be addressed at both policy and organizational levels. I asked this question both as a way for my interviews to offer some reflexive benefit to my study participants, and also to help build my understanding and analysis of possible strategies(both provisional and long term) that would help Dorchester House face some of the new challenges posed by chapter 58. The breadth of my participants' responses both to my four core areas of inquiry and to my prompt for suggestions, reflects their range of experiences, and allowed me a broad understanding of how the role of Dorchester House has changed since Chapter 58 was put in place.

Nature and Selection of the Case Study

My research presents a comprehensive analysis of one specific immigrant community health center's experience with Chapter 58 reforms. This represents an important addition to current empirical data on the impacts of Chapter 58 in Massachusetts and allows for the extrapolation of analyses on larger trends and challenges that have resulted from Chapter 58 reforms.

Given proper time and access, my study of the effects of Massachusetts' health reform might have included a broad range of health centers and immigrant communities both inside Boston and in other areas of the State, such as Worcester and Lawrence, which have large immigrant populations affected by these reforms. This type of larger, more qualitative-oriented survey of several CHCs was not logistically feasible given my

funding and time framework, and represents an important area for future research on the differential impacts of Chapter 58 amongst Massachusetts' immigrant health care providers.

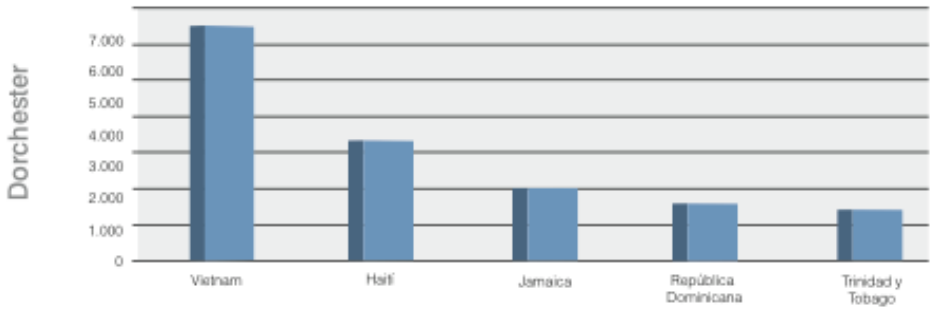
Why Dorchester House?

My decision to focus on Dorchester House as a case study was based on several important features of the organization, the most important of which was its extensive involvement with immigrant patients and, specifically, the immigrant community in Dorchester. Although many community health centers work with a large number and proportion of immigrant patients, few centers in the state of Massachusetts have established an immigrant care identity as strongly as The Dorchester House **(Hewes, personal interview, 2009)**. In part, this is because of its historical backing. Dorchester House was originally established as a settlement center for new arrivals in Boston; its early mission was based on helping new families with social services as they moved into the Dorchester community. Since then, the Dorchester House has continued to maintain its high level of outreach to new arrivals and foreign-born citizens in the Dorchester Community, adapting to the shifting needs of this group as its demographic has changed over the past century.

All the providers I spoke with reported that immigrants made up a significant portion of their patients- some estimated as much as 60%- and all referred to Dorchester House as being a health center that specialized in immigrant health (Sanches, personal interview, 2009). Though Dorchester House does not record exact statistics on the national origin or citizenship status of its patients, racial breakdowns of its patients give some indication of the organization's patient diversity. The following data is taken from Dorchester House's 2008 annual report:

Race	Percent
Asian or Pacific Islander	24.8 %
Black	25.6%
Unreported	13.7%
White	19.9%
Hispanic	11.8%
Other	4%

From my interviews and fieldwork, I learned that Vietnamese represent the single largest immigrant population served by Dorchester house, followed by Latinos and Brazilians. Several providers also noted a growing Cape Verdian population, and subsequent increase in Portuguese-speaking patients. Generally, patient demographics described by providers reflect the reported demographics of the Dorchester Community. According to a 2007 report conducted by the city of Boston (Lima, Boston Redevelopment Association), Dorchester has the second-largest immigrant population among Boston neighborhoods, with close to 30,000 immigrant residents; this means that more than one third of Dorchester's residents are foreign born. The following chart illustrates the top five countries of origin amongst Dorchester's foreign born community.



Again, these statistics highlight the prominent role of the Vietnamese in Dorchester. In fact, Dorchester is home to more than 7,000 of Boston's 10,000

Vietnamese residents (Lima 2007). Throughout my study and analysis I was careful to note where providers' experiences with immigrant patients were colored by the specific nature of this population, and how this might change the overall experience of Dorchester House relative to other health centers in Massachusetts. Overall, I did not feel as if the specificity of the Vietnamese population served as a skewing factor, and that generally, the experiences of providers at Dorchester House represented a diverse immigrant patient population.

While finding a clinic with a significant immigrant patient profile was the most important consideration in choosing my locus for case study, it was also important to me to select a clinic that performed a diverse range of patient services and programs. This was necessary in acknowledging that a complete model of health care involves much more than primary care and medical services; it also may include outreach, education and prevention, mental health, and social service programming. Following from this model, it is necessary to examine the full scope of Chapter 58's impact on all of these areas.

Indeed, as a Multi-Service Center, Dorchester House provided a highly relevant case study. Primary care services make up the core of Dorchester's model, wherein patients make consistent appointments with primary care physicians and can make referrals for further testing and medical services as necessary. In addition to these core services, Dorchester House also offers secondary medical services such as Behavioral Health, Oral Health, Eye Care, Radiology and Pharmacy. These medical services are offered along side a range of community services such as education and family programming, after school classes, finance classes, as well as public health services such as fitness and nutrition classes, HIV and sex education, addiction services and support

groups. One of the most vital aspects of this varied model is a case management unit that works with patients, staff, and physicians to align and monitor these various aspects of care. Included in this is a team of financial managers that works specifically with issues of insurance and a team of legal advisors that work with issues of immigration status and also with issues of policy. This integrated approach, coupled with the specific attentions given to issues of insurance and policy, made Dorchester house a highly relevant case study through which to address the multi-tiered effects of Chapter 58 Reforms on all aspects of care.

Finally, Dorchester House represents an interesting case study based on its role as a Federally Qualified Community Health Center (FQHC, referred to here as simply CHC) and its long-standing affiliation with the Boston Medical Center (BMC). Federally Qualified Community Health Center is a designation given by the Health Resources and Service Administration (HRSA) to community health centers that provide health services along certain guidelines established by Sections 1861(aa)4 and 1905(I)(2)(B) of the Social Security Act (HRSA) (HRSA 2009). This designation identifies the Dorchester House as an organization that offers care to under-insured and low-income patients; 52 such organizations exist within the state of Massachusetts (HRSA 2009). Though each of these CHCs has a unique patient population and scope of services, they are bound by a high level of involvement with public programs and uninsured populations. Accordingly many of these CHCs work with a high number of immigrant patients (Dyck 2006). Thus, this designation suggests the Dorchester House serves as a good model on which to examine the impacts of state reforms to these programs more generally.

Dorchester House's affiliation with the BMC also represents a feature that is typical of many Massachusetts CHCs (especially those in Boston). Though mentioned above briefly, this affiliation can be described as comprising a referral system through which specific secondary and tertiary services that patients cannot receive at Dorchester House are referred out by physicians to BMC testing centers, physicians and facilities. As mentioned above, this network has been highly affected by the Chapter 58 reforms; whereas the BMC used to receive additional federal and state money as one of two "disproportionate share" hospital systems (the other being the Cambridge Health Alliance), these additional block grant funds were all but cut in lieu of the switch to a pay-per-patient services system under the new HSN billing system. Thus, Dorchester House represents an example of an institution that has had to cope with major financial cuts and shifts following Chapter 58 reform, and, accordingly, places it at the center of current insurance policy debates.

Field Work

All in all, I made 7 separate visits to the Dorchester House to conduct interviews or perform on-site observations. I came to know the clinic and its desk staff with some familiarity, though by no means did I develop an insider-role such as ethnographer or full time field researcher might. I did, however, get to become very familiar with the facility and the general ebb and flow of life there. These are described in XX pages of field notes, which I performed over 15 hours of field observations. These observations usually took place before and after my interviews with providers at Dorchester House, in various public spaces around the clinic. I spent the majority of my time observing interactions between patients and providers in the waiting rooms. I took note of

conversation topics, body language, and demographics of both providers and patients. I also took note of the clinics' surroundings and settings, including individuals who I saw directly outside of the clinic.

Final Note on Methods

Using interview and field observation methods in tandem was crucial in my ability to construct a comprehensive understanding of the social function and atmosphere of Dorchester House. While interviews allowed me to ask directed questions and hear providers reflect on their relationships with patients and Chapter 58 reforms directly, observations enabled me to put these reflections in a meaningful context and to feel familiar with the settings I was hearing these individuals describe. This familiarity has directed the analysis I present in the following chapters to highlight the issues that are most important to the patients, providers, and to the overall institution of Dorchester House.

CHAPTER 4: EXPERIENCE OF DORCHESTER HOUSE PATIENTS

Providers generally described two types of challenges that they have seen patients facing as a result of Chapter 58. The first type are barriers to enrollment- wherein provisions or details of the Chapter 58 law have made it difficult or prevented patients from enrolling in state insurance programs. The second type of barriers described by providers are a range of challenges that patients have begun to face once they become enrolled in MassHealth. In both cases, physicians reported one of the biggest factors to be issues of complexity in the reform process and limited accessibility for of information for immigrant patients. Ultimately, providers report that these new challenges and barriers have, at the very least, increased anxieties and doubts amongst immigrant patients, and, at the worst, reduced their health seeking behaviors.

The Challenges of Immigrant Patients

In describing problems with enrollment in state insurance programs, providers noted many of the challenges that immigrant patients inherently pose to health care reformers as a population that is hard to reach both linguistically and culturally. Bich Phuong Do, a Vietnamese Adult Case Manager at Dorchester House, emphasized experiencing this in her work with Vietnamese patients at Dorchester House:

> "I work with a lot of immigrants, and especially, I'm Vietnamese and in Dorchester area there's a lot of immigrant coming from Vietnam and they also run into that problem: the language barrier. I have to say that it's really a hard time for them…No language no job. Most of the jobs are at least requiring some language, you know, have to know a little bit of English, and the Vietnamese population, I have to say they're actually educationally limited, probably because of the war back then…"

Dr. Julita Mir, a Spanish speaking Internist at Dorchester House, echoes Bich Phuong Do's concerns about linguistic barriers, and expands on a theme that Bich

Phuong Do introduced in mentioning the issue of immigrants' lives back in Vietnam. Namely, Dr. Mir speaks to the issue of acculturation barriers amongst immigrant patients, and how this can make linking immigrant patients to the health system and services at Dorchester House difficult, regardless of issues of insurance:

> "Now other issues that are not language related, it's obviously the cultural competency… most patients even if they speak basic English, they come from other countries and have different views of how health care works….just to give you an example, Haitians are people who for reasons that I don't know and I don't have a lot of experience with Haitians or with the Haitian cultural way of seeing America, they come with a lot of fear…Fears that we're always trying to do some sort of investigation with them and that there's some sort of secondary gain to a recommendation. Things like that…. So I think they come with some beliefs already and some cultural background that we can't change. That makes them see the system with some sort of concern. I think part of it is because they get approached from a lot of different sides asking them to make choices, and maybe in their country they're not offered so many choices or they're not used to the fact that there are so many choices so that's a bit different. And then because the system is so complex, that to go get an x-ray you need to register and like 3 different points in the hospital, people get… it seems very overwhelming. It causes mistrust. (MIR)

Dr. Mir's comment reflects the ways that providers clearly acknowledge that, even without the added challenge of introducing health care reforms, immigrants represent a vastly complex and diverse population- both in terms of linguistic and cultural background- that is hard to integrate into the health care system.

Enrollment Issues

According to Dorchester House Providers, the fact of this challenge has been wholly mismanaged and ignored by Chapter 58 reforms. Letters informing patients of changes to state MassHealth policies and insurance plans, as well as all notices of eligibility, and appeal forms associated with Chapter 58 changes, were sent out only in Spanish and English (HCFA interview). Thus, these forms ignored the 28+ languages that Massachusetts' immigrants are reported to speak, and importantly missed

Portuguese, Creole, and Vietnamese: the most highly represented languages amongst Dorchester's patient population, besides Spanish. Even though Dorchester House's Case Management, Registration and Legal Advising departments provided translation support for patients with enrollment questions, it was still obvious that many were, as Joel Abrams, the CEO of Dorchester House, explained it, "because of linguistic issues, falling through the cracks." Enrollment experts at HCFA explained a scenario in which this might occur:

> "And we have called a couple of times with Portuguese speaking callers from our help line to help them find out who their doctor is and find out where there is a doctor who speaks their language and we are told 'we have to call you back, we don't have an interpreter or translator that speaks Portuguese' and then we never get a call back. So people are really falling through the cracks…"

Indeed, it is not hard to imagine how an individual already feeling isolated and unsure of the health system, perhaps even mistrustful of the health system as Dr. Mir described above, would be quick to opt out of following up with their health center or a state insurance provider, when they cannot communicate comfortably or understand the issues at hand. Chapter 58's lack of basic translation services played a large part in creating this rift and subsequent barrier to enrollment. Equally formidable, however, was the reform's overall inaccessibility for the general population. Dr. Patrick Egan, Dorchester House's medical director, for instance, describes- like most of the providers I spoke with- the frustration he felt after first seeing the state's notice of enrollment following Chapter 58 reform:

> "All of the correspondence was mailed out in English, it was VERY dense, I mean it was stuff that between Joel and me, we would have to compare notes as we went through this two and a half page letter or page and a half letter that was, sort of, you know, very little white space on this letter. So that was the point where this stuff is tricky…But the administration by the connector wasn't

set up to give people, particularly who don't have good English, the extra accommodation that they really did need to make informed decisions."

Here, Dr. Egan refers directly to the Connector, the state body that was established by Chapter 58 reform for the express purpose of serving as an administrative body to help Massachusetts' uninsured population enroll in new State and private options. Dr. Egan's remarks suggest that by not providing information or administrative support that was able to accommodate immigrants and non-English speakers, the state's attention to immigrants in the reform process was blatantly inadequate.

Re-enrollment

Another major issue raised by providers is the fact that, even if immigrant patients are able to navigate the complexities of the state program's enrollment initially, they are still prone to be lost in the process of re-enrollment, which is required each year for all state programs. Providers report the same kinds of problems with language and cultural competency during re-enrollment processes as were described above. Accordingly, immigrant patients are especially likely to become uninsured because of failing to comply with this re-enrollment requirement. Family Case Manager Marika Hewes reports that this is a fact that some of her patients at Dorchester only discovered after coming in for a procedure:

> "With all the re-certification and all the paperwork that Mass Health sends out and that CommCare sends out, people get lost, they get kicked off, then they're out a visit and they don't have insurance so they've got a sick kid but they have to go see the financial counselor before they can have their appointment, so they can re-apply for their health care you know, and stuff like that. That affects people all the time."

Re-enrollment, however, is only one example of an area where providers are seeing chapter 58 policies leaving immigrant patients behind once they have already entered into state programs. The next section of this chapter explores other areas where providers have noted that chapter 58 policies have simply failed to meet immigrants' health care needs.

Post Enrollement Issues

Provider Shift

One of the most problematic issues providers have seen immigrant patients experience since the onset of Chapter 58 has been dealing with provider shifts under the state's new terms of covered care. As described above, as a result of the switch to Commonwealth Bridge, coverage guidelines for patients were redrawn according to contracts that CelitCare's brokers signed with local CHCs and hospitals. As an independent CHC, Dorchester House was included in this contract, and thus, patients who were transferred to Commonwealth Bridge did not experience shifts in their primary care coverage at Dorchester House.[15] However, the BMC, Dorchester House's umbrella medical network, was not signed under Celticare contract. Thus, patients have had to transfer all their referral services to a new series of medical facilities and physicians that are signed with Centina. Dorchester Physicians reported that they have already started referring patients to the Caritas Hospital system for a number of basic medical services including colonoscopy, endocrinology, hematology, oncology, and obstetrics. Policy Director Michele Nadow explains how this is impacting Dorchester's Patients:

[15] Had they been patients at the Cambridge Health Alliance, which does not have an affiliation with the Boston Medical Center, however, this would not have been the case.

> So we have women who are pregnant on CeltiCare who for all intents and purposes should be delivering at one of our delivery hospitals—Brigham or BMC—and will now have to figure out how to get to St. Elizabeth's [a Caritas Hospital]….So their midwife that they've had here training them, cannot deliver their baby. So that's just messy to say the least. And there's all situations like that. There's a variety of wonderful hospitals in this city that folks with CeltiCare will not be able to connect with unless they pay out of pocket.

As suggested by Nadow, this shift in referrals is proving to come at a heavy cost for patients. A major component of this shift as described by her is that patients are forced to disconnect from physicians with whom they have established significant relationships. This is especially difficult for immigrant patients, who represent such a unique set of linguistic and cultural needs. Almost all providers I spoke with agree that these needs were far better met by the BMC network than by Caritas.

The overall impact of this provider shift was best expressed by Dr. Mir, the Spanish speaking internist, who had just finished explaining to me that, as a Spanish speaker, she often found herself playing a particularly critical role in her patients' lives and social support network. She explained that for many of her patients who have been transferred to Commonwealth Bridge, this switch has been devastating:

> "Yeah, it's complicated. It's complicated, and these people, again if they finally find a provider they trust it's really hard. It takes a long time to gain that trust if you're not from there…So it's really hard to even start telling them that they have to break a relationship they have in one hospital with a specialist or something and that they need to go somewhere else. I bet that a big chunk of patients will not make the transition and we'll just hope that at some point this changes and they can go back to their doctors."

Dr. Mir's fear of patients "not making the transition" is another way of stating a fundamental failure Chapter 58 health care reforms: that, as a direct result of these new policies, immigrant patients are seeking less care. Indeed this sentiment was echoed by several other Dorchester House providers, often in tandem with discussions of the logistical barriers that provider shifts under the Commonwealth Bridge have caused.

Though Caritas hospitals are still located within Boston, they are significantly harder to access for Dorchester residents. Allison Diamond, a Women's Health Nurse Practitioner, explains how she has seen this as a particular challenge amongst her immigrant patients:

> "It's far if you don't have a car. It's not that big a deal for me, or for people who are used to… who speak English and who've driven around this city. But like, you don't have a car, you don't speak English, and you're taking the bus to Alston or Brighton it's kind of a pain in the butt." (AD)

According to Dr. Egan, the result of this new complexity amongst his own patients being referred out to Caritas Hospital is clear. In this case, he was referring to patients following up on blood testing referral: "[If] it's harder, fewer people will do it."

Affordibility

The problem of provider shift, as described by Dr. Egan and his colleagues, is specific to immigrants who have been enrolled in the Commonwealth Bridge program. Of course, Dorchester House also sees a number of immigrant patients who do not qualify for this program or who, though qualified, failed to enroll in CommCare. Most of these patients access services at Dorchester House through the HSN. Here too, providers have seen a number of growing complexities since the initial reforms of Chapter 58.

One issue providers noted is that for some immigrant patients, the new cost-sharing provisions under the HSN were simply unaffordable. In particular, providers noted heavy burdens for patients who have chronic diseases and who have seen increases in pharmacy costs and co-pays for doctor's visits. Policy Director Michele Nadow explains:

"I think people get concerned about paying out of pocket costs. So there are co-pays, which are minimal to you and I, you know, five dollars, whatever, prescription costs. When the governor proposed to increase those costs for Mass Health, that's a shocker. Because we have people with chronic health conditions who not only go to their primary care doctor, but get referred to a specialist and need three different kinds of drugs. And so any dollar amount increase on that is really going to affect them."

Dr. Allison Diamond offered an example of where she might see an immigrant patient experiencing new pharmaceutical costs. Diamond made a point to explain that even in instances where these new costs were affordable to patients, they may still represent significant sources of stress:

> "If someone's diabetic and has high blood pressure and they're on ten different medicines, then they're like, you know. Ten different medicines, even if it's two dollars apiece for a co-pay is twenty dollars a month that they have to come up with. And before when they were on free care they didn't have to do it. So you know it's twenty dollars, and they may be able to do it, but it's something that they didn't have to do before and it kind of stresses them out a little bit."

This example, like Michelle Nadow's above, highlights certain cases where new HSN costs will significantly affect patients, who, previously, were receiving reliable and comprehensive care. Though these costs will raise the burden for all of Dorchester House's patients, they may be particularly stressful amongst its immigrant patient population, as immigrants more often lack steady income and have access to fewer formal financial support systems (welfare, disability pay, etc) to compensate for these new costs (Egan, personal interview, 2009).[16]

Changes in Coverage

[16] For further discussion of the effects of Chapter 58 reforms on the HSN, see Chapter 6's analysis the impacts of new billings and funding structures on organizational costs. billing

In other cases, providers reported experiences with immigrant patients who incurred financial burdens because they did not realize or understand that their insurance plan had been changed under the provisions of Chapter 58. Allison Diamond described a particularly shocking example of this in which a patient, who had believed she was enrolled in MassHealth, was denied surgery for breast cancer, after having had the appointment booked and scheduled for several weeks. The morning of her mastectomy, she was informed by doctors that her insurance status had changed and that the hospital could no longer perform her surgery unless she paid out of pocket. In a frenzy, this patient called Allison Diamond, who immediately placed a referral to a hospital that was covered under the new coverage terms of MassHealth. When I asked Allison Diamond to explain how it could happen that this patient could go for months with a growing cancer, not knowing that her scheduled treatment was not covered, her response implicated the state's inability to communicate the terms of Chapter 58 reform:

> "Because she didn't know, because I think it got changed and there were probably letters sent out but maybe not in the language they speak. So a letter in English telling you that we switched your insurance is not particularly helpful."

Diamond informed me that, even as we spoke, this patient, who spoke little English and whose family had been calling practically non stop since her new referral, would still have to wait several months for her approved surgery.

Dr. Mir reports that instances such as this, as well as the general climate of volatility that has surrounded state insurance programs, are leading both her and many of her patients to uncertainty in pursuing follow-up care:

> "So you can find some of these immigrant patients that have had different insurances at different times. So at some point they may have been on a safety net, the old free care system, and then at some point maybe they got a letter that they qualify for some sort of limited Mass Health thing that's a different name…So I feel that now these patients again have a fear that they're being left

behind, and they're very unsure whether they're covered. And they're very afraid of getting bills. So I find that they're much more reluctant now to get any specialties, x-rays, things like that because they'll say "are you sure I'm not going to get a bill for this MRI?" and I can't promise that. Because if my office makes an appointment in the wrong hospital and this group of patients who are just signed up to CeltiCare, well, I hope no one makes a mistake on the way but if the guys ends up getting an MRI in the wrong hospital, he's going to get a bill."

Both Dr. Julita Mir and Allison Diamond provided me with examples in which their patients' health and health seeking behaviors were limited by changes Chapter 58's changes to MassHealth. But it is also important to note that the consequences related in these stories are not isolated. In interviews, providers described seeing many immigrant patients who hadn't personally experienced problems with their insurance, but felt hesitant to seek care or, in fact, sought care less, due to fears that their coverage had changed or been revoked under Chapter 58. Most frequently, these fears centered on the issue of incurring unexpected financial burdens as a result of lack of coverage. In the most drastic cases, CEO Joel Abrams speculates, following the onset of Chapter 58 reform, a handful of Dorchester's immigrant patients entirely stopped seeking health care; unable to understand the information coming in from the state, they simply presumed that they were uncovered and subsequently, that they could not receive care without incurring huge debts.

During our interview, Dr. Patrick Egan discussed the impact of this phenomenon within the context of the inherent health risk that denying medical treatment poses to immigrant patients.

> "People are way more willing to take those health risks than they are to take on this debt. Medical debt is crushing…It's a huge impact on particularly people who don't have a lot of income, taking on the debt. You know a few hundred dollars here or there might not have a big impact on me but it's nearly what they'll earn in a week or in a month..."

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This chapter has served to demonstrate that, according to providers, chapter 58 has had significant restrictive impacts on immigrant patients. Whether this because of the significant barriers immigrants face in enrollment under Chapter 58 or because of the various restrictions immigrants meet once enrolled in the new state programs, Chapter 58 has created new challenges and barriers that have, at the very least, increased anxieties and doubts amongst immigrant patients about their insurance status, and, at the worst, interrupted their access to primary care and reduced their health seeking behaviors.

CHAPTER 5
EXPERIENCES OF DOCHESTER HOUSE PROVIDERS

The experiences of providers is inherently linked to that of their patients. Patients' social, medical, and legal status background all serve to shape the challenges that medical providers face when dealing with each patient's unique medical concerns. As shown in the last chapter, amongst immigrant patients, health insurance status plays a significant role in this process. This chapter explores how the medical providers at Dorchester House have experienced these insurance-related challenges amongst their immigrant patients following Chapter 58 reforms. Specifically, I will show how Chapter 58 reforms have created an increased need for immigrant health care providers to engage with financial and insurance issues. I will also explore some of the ways in which immigrant health care providers have re-adapted their treatment strategies in response to Chapter 58 reforms. In both areas of analysis, I found that changes in response to Chapter 58 reforms represented challenges to physicians' ability to provide care that they considered adequate, meaningful and crucial for immigrants in the Dorchester Community.

Equal Care

In order to qualify for federal funding as a Federally Qualified Community Health Center (CHC) as it successfully does each year, The Dorchester House is bound to uphold a certain set of service and practice guidelines. One of the must fundamental federal requirements for CHC qualification is an adherence to an equal care principle: that a CHC must provide equal quality care and services to all of its patients, regardless of their insurance status or ability to pay (HRSA 2009). This principle of equal care is tied into Dorchester House's mission statement as an organization and lauded on their official website and public materials in language similar to this passage from their list of

core values[17]: "Access to our services regardless of ability to pay is the underlying principle of our mission" (Dorchester House Website, 2009).

Having spoken with individuals at a variety of levels of service at Dorchester House, I have found that this equal care model is far more than a written motto or legal designation. Rather, it is an important part of how health care providers conceptualize their work and role at the Dorchester House. This sentiment was best captured by Dr. Egan, in his description of how he, as Medical Director, perceives the importance of this issue:

> "Certainly among the providers, and I think our whole staff generally feels this way, and it sounds a bit Pollyannaish but all we really worry about is whether or not people are getting good care. It's really, really true, all the angles…. In spite of the state financial stuff, one of our jobs, one of our most important jobs is to make sure people have access to care."

Dr. Egan's ability to speak confidently about his staff as a whole, and his comment that he felt providers "really worry" about these issues, indicates that the model of equal care is a crucial part of Dorchester House providers' professional roles. Also imbedded in Dr. Egan's remark is a statement that gets at the heart of the issue discussed in this chapter: namely, that state policies can pose significant challenges to health care professionals seeking to provide this equal care model.

A significant part of this challenge is based in health care providers' extrapolation of the equal care to a more general philosophy of prioritizing patients' health above all other issues of medical care. Dr. Egan describes seeing this amongst his provider team as they have dealt with understanding and implementing Chapter 58

[17] Full list available at: http://www.dorchesterhouse.org/?page_id=90.

reforms: "The providers, to their credit, aren't interested in the larger scale." Providers, he explains, only want to know "What does it mean for the patients?"

Thus, Dorchester House physicians' philosophies and priorities in providing care imply a separation of spheres and purposeful distancing from financial and insurance issues in the doctor's office. However, since Chapter 58 reforms, providers have increasingly had to engage with financial issues in ways that are both new and troubling for their mission as equal care providers.

Provider Education

At the most basic level, providers have increasingly engaged with financial issues via their own educational experiences and their responsibilities surrounding health care policies. Providers are discovering that, as the rules changed under Chapter 58 and became more complex, they had to greatly increase their understanding of MassHealth guidelines. On the one hand, providers have had to do this to serve as a resource to their patients who have seen losses or changes in their insurance status. As described above, immigrant patients face significant barriers in understanding the language and complexity of health care reform. Providers across all spectrums of services and specialties in Dorchester House have described receiving new types of questions from immigrant patients who had heard that their insurance had changed, but who were not aware of how or what this meant. Family Case Manager Bich Phuong Do explained that until Chapter 58 reforms, her engagement with state policy and her personal set of policy knowledge has primarily focused on state welfare programs such as the Supplemental Nutritional Assistance Program and housing assistance programs. However, she explained that now she often sees patients asking questions about insurance:

> "I found it's just really hard for them, not only in the Vietnamese community but I found that also the Spanish community…the patients are like, "why is all this thing changing...is my benefit cutting? Am I still going to come to here? Am I still going to get my service?" They're really concerned about that, it affects them a lot. I'm seeing that a lot now."

Dr. Julita Mir described seeing a similar upward trend of concerned immigrant patients in her office. In our conversation about the dynamics of these discussions, she explained to me how serving as an informed resource on MassHealth and the insurance system has built her role as a medical professional:

> "It's not just helping them with their medicines or how to get them, it's how to get health insurance, helping them understand where they want to go for different things, how things happen in this country, so I would say that the interaction with that group, you know that when people think doctors are just doing medicine or prescribing medication, the interaction with these patients goes beyond that….

Though Dr. Mir spoke about her self-education process surrounding issues of MassHealth and her increasing role as an insurance counselor as just another part of her responsibilities as a medical provider, for some providers, this process has been both a surprise and a challenge. When I asked Nurse Practitioner Allison Diamond at what point she realized that understanding insurance was going to be a part of her career as a physician she responded, with more than a hint of frustration:

> "They don't teach that, and it's so aggravating. … it's just lots and lots of busy work, and that's not why anyone went into health care – to be looking up dosages of stuff. I think people are frustrated by that."

Similarly, in a discussion of how his work as a physician has changed since the beginning of Chapter 58 reforms, Dr. Patrick Egan explained to me that, "One of the things I've actually had to do is learn how to talk to people about their insurance status". These words revealed that engaging with insurance issues, as he has since Chapter 58, was not something Dr. Egan had expected to do as a physician and something that he had ever done so directly in his career before. Further, his comment

reflects the breadth of the new type of education providers have had to adopt to serve as a resource to their immigrant patients, and the ways this has expanded their roles as compared to the past.

Providers as Information Resources

To understand the full significance of this new, direct engagement with patients on financial issues, it is important to understand why patients have been reaching out to health care providers more so than others. A fuller description of this disproportionate balance will be addressed in the following chapter, which examines the impacts of Chapter 58 on Dorchester House as an organization. The heart of my findings on this question, however, most fundamentally relates to the role of direct care providers.

My interviews revealed that a disproportionate amount of responsibility in informing and counseling immigrant patients has fallen to physicians, because, more than most other groups in the medical service umbrella, physicians represent a highly trusted resource to immigrant patients. This fact was made evident by the great number of instances that providers reported where patients felt comfortable relying on them to give legal advice and support about their immigration and/or insurance status. Additionally, many providers also spoke directly with me about the issue of trust related to their special status as physicians; this became a major theme in our discussion about the challenges and differences in working with immigrant patients. According to Allison Diamond "Most cultures trust you automatically because you have the status of being a provider….they'll automatically trust you and your judgment just because of your position."

As Diamond suggests, cultural habits may play a highly important role in building immigrants' trust in physicians.[18] Current sociological and public health research supports this observation in noting how the unique role and status associated with doctors translates strongly cross-culturally, even when concepts of medicine or medical systems do not, and thus, endows doctors with certain "automatic" authorities (Portes, Light 2009). This fact is especially significant given patients' increased levels of anxiety and fear about health care insurance following Chapter 58 reform; as doubts about immigrants' rights and role in the US health system increase amongst immigrant patients, those such as physicians who are seen by the immigrant community as a steady source of trust become even more critical as a resource for health insurance counseling.

Impact on Patient-Provider Relationships

This also means that health care providers, and physicians in particular, are under an increasing pressure to know the health system intimately and get their information right. However, as illustrated in my discussion of Chapter 58's complexity, especially in its provisions on immigrants, it should come as little surprise that, for providers, "getting it right" has become a lot harder. Several providers talked about how they felt that this paradox presented by Chapter 58 reform has fundamentally changed their ability to offer accurate and guidance for their immigrant patients. Dr. Julita Mir explained this to me:

> "I'll start by saying that the big change for us, you know if you just think about it, as the provider, not even if you agree or disagree with the changes, that the most important thing that has added a level of complexity is that, in most instances, you can no longer coach the patient in any way. In the past, years ago, you could tell people what you thought was the best way to do insurance, or which kind of insurance would be best for them. So you really can't advise them anymore because you don't understand all the details and the ins and outs. So

[18] It is important to note that physicians and medical providers should be distinguished here from Dorchester House as an organization and the medical system as a whole.

one of the most important things for us that has happened is we now don't feel like we have a handle on the insurance and who qualifies for that."

Thus, despite their attempts to keep up with keep up with all current insurance changes and to understand the new levels of complexities that have been introduced with Chapter 58, providers are still finding that their best efforts at providing effective counseling to their patients are falling short. Following from providers' comments about the importance of trust with immigrant patients, and the special relationships that they work so hard to establish, this inability to provide reliable information to patients - including information about what types of treatments they might be able to afford under their insurance status- and their inability to provide the type of support that patients are asking for may come at a considerable cost for patient-provider relationships.

This fact highlights a fundamental problem which underlies the trend, as I've described it above, of providers' increased need to engage with health insurance issues in their professional roles. Namely, that since Chapter 58 reforms, providers' relationships with patients have increasingly been defined by financial and insurance issues. This directly contradicts the goals of Dorchester House physicians to serve under an equal care model that considers patients' health, above all other issues and especially the ability to pay, to be the basis of a health care model. Thus, Chapter 58 has created challenges to patient-provider dynamics that have limited providers' ability to offer the kind of care that they feel in important for immigrants.

I will close this analysis section with a quote from Allison Diamond that encapsulates both these new challenges and the frustration and tension that, she feels, Chapter 58 has caused for her, as an immigrant health care provider:

> "I like to just give the care that I want to give. I don't want to have to think about someone's insurance, or whether or not they… it's not the care we're supposed to give. You're supposed to give the best care you can to people and

not have to… Money's not supposed to be important. Clearly we can't live like that…"

Treatment Practices

Beyond this increased integration of financial issues in providers' relationships with their immigrant patients, providers also report having to adapt their treatment practices in light of new and complex restrictions in coverage that have impacted many immigrants under Chapter 58 reforms. In particular, providers discussed problems in relation to MassHealth pharmaceutical guidelines and in relation to referral services on occasions when they wish to refer patients for further testing or procedures that have made it increasingly difficult to provide immigrant patients with effective care.

Pharmaceutical Guidelines

An example was given to me by Allison Diamond in describing changes to prescription drug coverage under Chapter 58. She explained that after the reform, some medications were removed from coverage while others were not, seemingly without following any particular guideline. Further, she explained to me that within one type of medication, a certain dosage might be covered by MassHealth, while another was not. For example, MassHealth will cover the prescription cost for the common antacid drug Prilosec, but will not cover Prilosec Controlled Release- the exact same drug and dosage, but which uses a different type of coating for the pill. This example was given to me by Dr. Julita Mir, while discussing some of the more exasperating aspects of Chapter 58's new guidelines. Similar nuances were reported in the availability of other various pharmaceutical brands.

These changes represent new details that both physicians have had to learn in order to ensure that their patients are actually able to access and afford appropriate treatment. Allison Diamond explained how difficult this process could be:

"I mean I try to when I'm prescribing look at what their insurance is, and be like, ok, well I know if they have this insurance then I can't prescribe that medicine. I have to remember that I have to prescribe a similar version, but I have to remember to prescribe this one otherwise they're going to come back in half an hour and it's going to create more work for them and more work for me."

Beyond Allison Diamond's basic assertion that adapting her treatment practices to the pharmaceutical guidelines is a difficult and complex process, this statement also highlights the significant impact that some of the changes described here have had on physicians' already busy schedules and scarce time. Because Chapter 58's regulations are, as described above, complex and nuanced and lacking in any concise set of rules or guidelines, providers have had to learn to adapt their treatment practices through a process of trial and error. As illustrated by Allison Diamond, this may involve seeing patients multiple times in one day to figure out a correct prescription, placing additional phone calls to patients or family members who have questions about insurance, or simply spending extra time in the office with patients to figure out and explain the terms of their insurance and any recent changes. All of these are challenges that doctors are having to face now at a volume that they have not encountered before, and which, has undoubtedly added challenges to the already complex task of providing care for immigrant patients.

This was something I personally witnessed several examples of in my observations at Dorchester House. The following is an excerpt from my field notes which took place over the course of approximately 15 minutes, describing the same dance between the clinic and the pharmacy that Allison Diamond described above:

"Across the waiting room, the man with dark black skin and knit, red sweater who has been standing by the reception, lifts his hand, motioning to one of the receptionists. An Asian nurse wearing pink scrubs who is standing behind the desk notices him first and says something in Vietnamese to the receptionist, who is also Asian. The Receptionist looks up and says, "Can I help you?"

The man extends a small piece of paper out to her, "They tell me come back again." He has a strong accent, which I guess to be African.

"Again?"

He holds up three fingers. I get the impression that he is hesitant to speak English.

"You need three prescriptions?"

"Three times. They say no. They say insurance."

"You've been down to Pharmacy three times?"

"Yes."

"Okay, I'll page a doctor to take a look at this." She takes his prescription sheet from him. "Did you have an appointment today? Who was your doctor?"

By all accounts, learning how to cope with Chapter 58 pharmaceutical changes and its other complex policies has largely been a process of trial and error for physicians. However, it should be noted that the situation I described above represents perhaps one of the best-case scenarios when a physician prescribes a medication outside health insurance guidelines. This is because the pharmacy is located within Dorchester House, the doctor was still available, and the staff were willing to coordinate the necessary linkage with the doctor. Although certainly frustrating and time consuming, problems that can be addressed within the Dorchester House premises and on the same day as a medical visit are often, ultimately, addressed, and patients are likely to leave the clinic having received effective treatment by the end of their visit. Issues become more complex for providers and their patients when insurance problems move outside the Dorchester House facility.

Referral Services

Providers explained that, following Chapter 58, they had to work hard to learn which hospitals had signed contracts with MassHealth, and how these medical landscapes differed from the previous system. For example, with the change to Celticare, providers had to learn where the Caritas clinics were, and, further, what services were available at each hospital. Providers also noted having to take into

account the facility and service cuts under the changes to the HSN. In recounting the debacle of Allison Diamonds' breast cancer patient in Chapter 4, I have already presented an example of a scenario where a misunderstanding of the insurance coverage for referral services can produce ineffective care for patients. Stories such as these underscore how much is at stake as providers are having to learn and adapt to Chapter 58 reforms in seeking to provide effective care.

A separate issue with referral services has arisen for physicians with patients who, following Chapter 58 reforms, were cut from their insurance policies. This group includes a large number of immigrant patients who lost their coverage under the reforms to CommCare. Dr. Patrick Egan described this to me in the context of having to learn a new process of negotiating the need for medical care in a way that would minimize his patients' costs:

> "And again, these folks who get booted off their insurance and we would still see them. And then we'd have to negotiate: "Well, do you think you can get to the consultant or buy this medicine or do this other thing that might cost you money?" And folks would strategize around it somehow. "What about some cheaper medicine that maybe won't be as good but might get me halfway there?" Or, "how about if I see the heart specialist after January 1 when my insurance kicks back in?"

This type of negotiation is typical of the new ways that providers are having to think about both their prescribing and referral services for immigrant patients in light of Chapter 58 reforms in order to ensure that their patients are receiving effective care. As with many of the examples physicians gave in describing having to adjust their treatment strategies to Chapter 58's new pharmaceutical regulations, Dr. Egan's statement illustrates an example of a provider offering a referral based on a patients' insurance coverage rather than their primary medical need. Thus, because of Chapter 58 reforms physicians have had to re-frame their treatment strategies in a way that they

would not otherwise consider best medical practice- whether that means using trial by error to find a medication that fits a patient's plan rather than being able to simply prescribe preferred and familiar medications or asking a patient to wait to get a much needed medical test.

Like providers' increased engagement with financial issues, this changes treatment practices represent a direct contradiction to the equal care model. In both instances providers are adapt their practices for some patients and not others, and having to base these changed practices on patients' insurance statuses. As illustrated by Allison Diamond above, these changes represent troubling and frustrating challenges to the Dorchester House providers' mission of equal care. Thus, as a result of Chapter 58 reforms, Dorchester House providers have had to compromise their practices in a way that limits the type of care they both want to provide, and which they feel is paramount to ensuring the health of immigrants in the Dorchester Community.

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In my next chapter, I will continue to explore what this trend means for the Dorchester House an organization, building towards producing recommendations for addressing these new challenges in my final, concluding chapters.

CHAPTER 6: IMPACT ON ORGANIZATION

The past two chapters have been concerned with, respectively, the experiences of immigrant patients and immigrant health providers in dealing with the changes and challenges that have arisen with the implementation of Chapter 58 health care reforms. As patient and providers' contribute to every aspect of Dorchester House's services and performance, these analyses have been critical to forming an understanding of how Chapter 58 has impacted Dorchester House as an organization. Making use of the context supplied by the analysis in the earlier chapters, I will now provide a description of the various ways providers report experiencing change at an organizational level.

My analysis will focus on both financial and non-financial challenges posed by Chapter 58, and will be accompanied by descriptions of the various impacts these new dynamics have had on Dorchester House at an institutional level. Specifically, I will show how, in both areas

For the organization as a whole, changes under Chapter 58 have resulted in barriers to providing services and, in some ways, stand to threaten the reputation of Dorchester House as a trusted immigrant health care provider and resource within the Dorchester Community.

Financial Challenges

Though the successful performance of a CHC is linked to a number of diverse factors- not the least of which is the delivery of quality medical care- at the most fundamental level, the continued operation of any CHC depends on its ability to be financially sustainable. Though issues of health insurance prices and billing can be

highly complex and nuanced, as has been seen, the logic that guides financial sustainability of a CHC can be boiled down to a simple cost/profit[19] formula.

In this model, each patient represents a number of potential costs and profits for the organization. Disregarding marginal costs or other non-proximate externalities, costs can be measured in terms of services used by providers to treat patients. These may be thought of both in terms of specific medical tests (blood work, pap smear, e.g.) and in terms of providers' direct service time with patients. Profits can be thought of in terms of reimbursement for these procedures and for patient visits. Reimbursement comes, primarily, through health insurance[20], which, at Dorchester House, is most frequently a state program such as MassHealth or HSN. Simply, the operation of Dorchester House can be said to be financially sustainable if its profits- or health insurance reimbursements- offset its costs for services to patients. As I will show in my analysis below, though the impacts of health insurance reforms have yet to be fully analyzed by administrators at Dorchester House[21], Chapter 58 has disrupted the financial stability of Dorchester House both by raising its costs, and, via changes in HSN billing methods, reducing its profits. Though specific financial challenges varied amongst the providers I spoke with, the following represent the two components of Chapter 58 reforms to the HSN that I found to be most problematic for Dorchester House as an organization.

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[19] Used here, the term profit should be understood in terms of the nonprofit organizational model, under which the Dorchester House operates. This means that all financial profits above and beyond basic operating costs are channeled back into the organization (rather than towards new investments) to expand its existing services and goals (DHCFP 2008)..

[20] Patients' direct contribution to reimbursement most frequently occurs through co-pays as part of an established insurance program.

[21] This is because of how recent the implementation of Chapter 58 reforms has been and because, given much of the organizational strain I define in these paragraphs, few resources have been available for in-depth research projects..

Under-Compensation

As explained in my background chapter, a major component of Chapter 58 reform was a shift in state funding to support the newly expanded MassHealth and CommCare programs. This shift has already been implemented to a large extent at the Dorchester House.

During our interview, Policy Director Michelle Nadow showed me a document on her computer that illustrated the change in patient insurance sources over time. She highlighted a point in 2007 where the numbers of patients enrolled in CommCare and MassHealth showed a sharp increase, while those billing the HSN turned slightly downward. She explained that this exchange reflected the intention of Chapter 58 reform:

> "So this is what they wanted to have happen. They wanted people to get off the free care pool, and get on one of these two products, or private insurance, that would be a regular set of benefits."

Of course, this is only half of the story. Accompanying this shift in state programs enrollment, was a major shift in state funding. This shift is illustrated in the following two charts from Dorchester House's annual financial reports. The first chart is from 2006 (Figure 1, Pre-Chapter 58) and shows 13% more funding being channeled into Dorchester House via free care than in 2008 (Figure 2, Post-Chapter 58). In 2008, on the other hand, the chart illustrates that free care funding was reduced and MassHealth and CommCare (called "subsidized care" in the chart) was increased by nearly 10% as compared to 2006.

Fiure 1 (Pre-Chapter 58): Annual Report: 2006

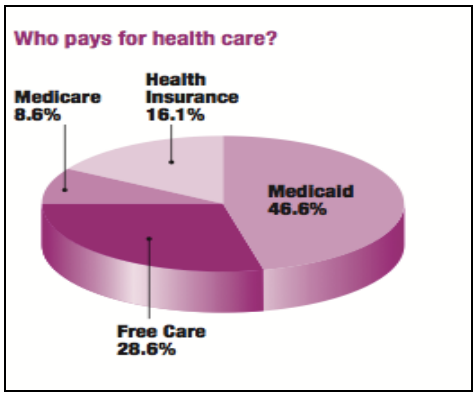
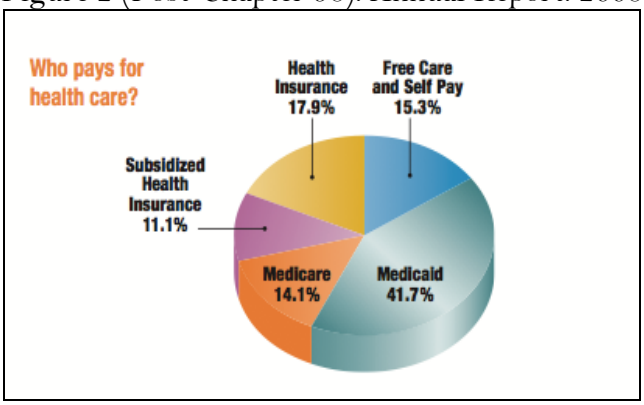


Figure 2 (Post-Chapter 58): Annual Report: 2008



As discussed in my background chapter, this reduction in state funding for Free Care services was done with the intention that, as the number of patients paying through MassHealth and CommCare increased, health centers would subsequently need to rely less on reimbursement delivered through the HSN. In other words, the state's model assumed that this shift in funds would ultimately even out in CHCs' bottom lines.

At Dorchester House, however, this has not been the case. As I discovered in talks with administrators, including the aforementioned interview with Policy Director Michele Nadow, the decrease in funding to the HSN has not been offset by a sufficient increase of funds from MassHealth and CommCare patients as the state expected it to be. CEO Joel Abrams explains this result:

> "[The state plan] sounds good but what with the state's economy and even the original design of how the Commonwealth Care health coverage was going to be subsidized, and how that money was going to flow between the needs of the

safety net providers, to still access some form of safety net pool and to pay the premiums or part of the premiums of people enrolling in CommCare-- just didn't add up even from the beginning. At least it didn't add up to the same level of funding that the safety net providers had before. But it just hasn't been enough."

According to Mr. Abrams, the state's plan miscalculated the utilization needs of HSN providers in the case of Dorchester House. Fewer patients at Dorchester House have utilized MassHealth and CommCare than funding strategies had predicted and more patients have continued to rely on HSN services.

Though these financial strains reflect the utilization patterns of all patients at Dorchester House, given the analysis I have presented providing evidence for enrollment barriers to and exclusions from many state services, it would not be surprising if Dorchester House's significant immigrant population represents the population whose participation in state programs was not charted and accounted for by state funding. In other words, at Dorchester House, immigrants represent a significant HSN population that was restricted from enrollment in the new state plans, and while Chapter 58's intentions may have been appropriate for CHCs where a sufficient number of HSN patients were actually able to enroll in one of the new state plan, they did not prove to be appropriate for Dorchester House.

Many of the administrators whom I spoke to illustrated this by emphasizing that they knew of other Massachusetts CHCs that had not suffered financially from Chapter 58 reforms as had Dorchester House. Medical Director Dr. Patrick Egan explained to me how Dorchester House differed from these CHCs as an urban health center because of its large number of patients who rely on free care services:

"Once Chapter 58 happened, all of those people who were in the free care pool were shifted into one of the new products. So that one of the sort of benefits that a lot of health centers got was actually people came out of the woodwork who had not been getting care for a while because they had no insurance and all of a sudden they were bumping up their numbers and the demand for services went

up. And that didn't happen here….I don't mean to begrudge them, but the health centers that are further out all of a sudden had a much bigger bump… one of the expectations on the part of the state was that we'll make sure everyone's insured and then we're going to see all of these places doing better. That didn't happen in Boston."

Here, Dr. Egan groups Dorchester House with other CHCs in Boston. None of these Boston CHCs, he explains, saw a bump in numbers of patients using MassHealth that was significant compared to the number of patients who still needed to rely on the HSN. Patients, did not, as with the CHCs that were located in more outlying areas, "come out of the woodwork". When I asked why Dr. Egan thought this might be the case, he explained that he believed that these imbalances were a reflection of the patient populations specific to Boston who continued to have problems accessing MassHealth under Chapter 58 reforms. As my earlier analysis indicates, the most notable population in this category is immigrants.

Thus, the failure of Chapter 58 funding plans to recognize the needs specific to urban CHCs and, particularly, those that serve immigrant populations, represents a significant shortcoming on the part of the state. What has resulted from this is a significant under-compensation of funds to support Dorchester House's free care services, which previously represented a financially sustainable way for the organization to provide otherwise uninsured immigrant patients with free health care.

Change in Block Grant System

In addition to reporting general problems with under-compensation for HSN services, providers pointed to financial challenges that have arisen specifically from the switch to pay-per-service charges. As mentioned in my background chapter, the pay-per-service system was implemented in place of the block grant system as a mechanism through which to introduce cost sharing provisions for HSN services. Along with

compensatory enrollment in state programs, pay-per-service billing for the HSN was the second major provision of Chapter 58 that was implemented to support funding cuts for free care services. Contrary to what some health care activists believed prior to this provision, the individual costs that have resulted from these cost sharing provisions have been felt somewhat minimally by patients. Indeed, providers have been somewhat pleasantly surprised by how willing and able patients are to buy into this new pay-per-service system. At the organizational level, however, the shift to this new system has not gone as smoothly.

The elimination of the block grant has represented yet another way that the changes to the HSN billing system have limited Dorchester House financially. CEO Joel Abrams explained to me that financial limitations largely stem from the reduced flexibility of organizational profits that arises with this billing system:

> "[Now] We get paid per encounter. But when the payment doesn't really fully cover the cost of the encounter, we come up short on every visit…So when we got paid in a block format on the free care pool, that helped cover those shortages from other insurers."

This issue reveals the extent to which free care reimbursement from the state supported Dorchester House's sustainability above and beyond its application to the services the organization provided as a free care organization. In this statement, Joel Abrams highlights the problem of under-reimbursement at Dorchester House: that some services are reimbursed at a level less than their actual cost by private and state insurers. Typically, providers explained to me, under-reimbursed services tend to be social work and outreach programs. For instance, due to poor insurance reimbursement the behavioral health department at Dorchester House loses between $3,000 and $4,000 each year (Nadow, 2009).

Until Chapter 58 reforms, these costs were offset by the non-specified HSN block funds allotted from the state for free services. As Mr. Abrams points out, now that dollars are being channeled through service-specific pipelines at Dorchester House, this type of cross-service flexibility in funding within the organization is not feasible. This has left Dorchester House with a pile of unaccounted-for costs.

Another way that Chapter 58's pay-per-service billing system has represented new costs for the Dorchester House is through increased organizational error in billing processes. Costs arising from organizational error for billing are not a new phenomenon at Dorchester House. However, the frequency at which these organizational errors have occurred since Chapter 58 reforms is new and, indeed, problematic for Dorchester House's financial stability. Mr. Sanchesz? explained that errors in billing have risen a great deal due to the increased level of complexity and restriction in Chapter 58's changes to HSN billing:

> "The billing has become a lot tougher…when there was the free care pool, it was almost like they could bill everything to the free care pool and now they put a lot more restrictions on what you can bill so the billing has become a lot more complicated."

Mr. Sanches further drew on his own experiences with these new restrictions and complexities under the HSN to explain how they result in billing errors:

> "And then as far as us, sometimes, because they put all these rules and restrictions… sometimes you bill something thinking it's the correct way but "no no, that's not…" then they send it back, then by the time, you figure out how it's really supposed to be done, you send it back, it's past the time."

In my interview with Registration Assistant Pedro Sanches, he explained that the state is often unwilling to reimburse bills that were registered incorrectly or that were not registered in a timely way. The protocol for reimbursement, he explained, is that claims must be submitted within 90 days from the date of service. After this period,

the clinic cannot amend bills to the state. At the same time, they are unable to bill their patients for these services, as the patients were treated under the representation that they would receive free care. Thus, Dorchester House has no option but to incur these costs.

This dilemma exemplifies how the increased confusion about terms of billing and subsequent need to communicate with state agencies to understand and correct individual bills has resulted in increase organizational costs. In this case, these costs are felt in terms of bills that cannot be corrected within the 90 day window allowable for reimbursable claims. Approximately 7% of billing does not get paid for this reason at Dorchester House; other CHCs report numbers closer to 20% (P. Sanches, 2009). Thus, both because of reductions in accounting flexibility and because of complexities in billings processes, the shift to pay-per-service billing has resulted in new costs for the Dorchester House that have strained its financial stability.

Impact of Financial Challenges

Because of these various, new financial strains, administrators have, painfully, had to cut back some of Dorchester House's programs and services. In particular the organization has had to reduce programs that are not typically reimbursed (or that are under-reimbursed) by private and state funding and which can no longer be fully reimbursed due to changes to block grant funds (as described above). In particular, providers cited reductions in case management programs, preventative services, Teen Center programs, and reduced funding for interpreter services. Case Manager Marika Hewes gave an example cuts made to a diabetes prevention program that she worked for with the Case Management department. Following the switch to Commonwealth Bridge, several patients in this diabetes program lost their insurance coverage for

Physical Therapy services which were, until then, a vital part of the program. Fearing inequality in treatment amongst these patients, administrators then made a policy decision that Hewes explained in the following way:

> "[Administrators] ended up deciding that that part of the program, the weekly PT, wasn't very efficient and it wasn't going to work on a clinic basis if there is this problem with peoples' insurance. So we ended up changing our program and eliminating the weekly physical therapy visits because of this issue."

As in the case of the physical therapy program for diabetes patients[22], many of the cutbacks and changes to programs since Chapter 58 have particularly affected immigrants. According to CEO Joel Abrams, this is not only because of the restrictions to immigrants' benefits under Chapter 58 (though in Hewes' description this was the case). Rather, Abrams explained, immigrants are being disproportionately affected by the organization's cutbacks because many of the services that Dorchester House has built to target immigrant patients' diverse health needs are social and outreach services. Abrams explains as follows, using the term "wraparound" to mean all those services that cover health needs outside of the doctor's office:

> "The cut in free care funds has caused us to start to look at ways of cutting back on services and when you start cutting back on the wraparound services, that affects immigrants."

Abrams went on to give examples of what this has traditionally meant at Dorchester House:

> "[We] reach out to our immigrant population to provide linguistically appropriate care, to provide services to pregnant women and women who have just had children for the first time, and all kinds of support services."

Though cutting these types of programs has significant impacts on the immigrant patients who are experiencing these reductions firsthand, it also has

[22] Recall that CommCare Bridge enrollees are exclusively immigrants: Aliens with Special Status who were cut from CommCare
unfinished footnote here

important repercussions for Dorchester House's reputation as an institution. Providers described the difficulty they have had in explaining to patients that Dorchester House's services and capacities have been reduced, while knowing that the patients view Dorchester House as a constant and stable source of care. Joel Abrams explains this in the context of reductions to Dorchester House's dental program, which, like the behavioral health department, has struggled to remain financially stable following Chapter 58's elimination of block grant funds.:

> "Over the years we built up expectations that you could come here and get virtually free dental care. Well that, when health reform happened, that really changed things. We had to start operating our dental unit more carefully, let's say, with regard to what we can charge and what we couldn't charge to patients directly. And I think people would get angry…it was certainly a hard thing for us to explain to people why we have to change our way of operating."

Case Manager Bich Phuong Do supported this statement in discussing working with patients directly. She noted that patients felt particularly frustrated when they did not understand the language or reasoning behind their insurance status:

> "I know of patients that have gotten really angry with receiving a bill from here for co-pays and they don't understand why they have to pay that when they didn't before."

Here, Patients identify Dorchester House as the agent who bills them and enforces changes in their insurance status, rather than at MassHealth or the law-makers who set the terms of Chapter 58. They direct their anger and frustration at Dorchester House accordingly. This fact, coupled with the reductions Dorchester House has made to some of its services and programs in light of reduced funding, has the result of threatening the reputation of Dorchester House as a reliable and consistent source of health care in the Dorchester Community.

Non-Financial Challenges

Though financial sustainability underlies the most basic function of a CHC, it is most often the services, patient experiences, and patient relationships that define the role and reputation of CHCs in their community. In the paragraphs below, I detail how the implementation of Chapter 58 has impacted Dorchester House's involvement with patients around financial and insurance issues, focusing on issues of education and outreach as well as shifting departmental roles within the organization.

Increased Engagement with Financial Issues: Education and Outreach

Just as providers have had to increase their personal engagement with health insurance policies and MassHealth guidelines (described in Chapter 5), so too has Dorchester House as an organization. This has occurred both in their self-education efforts within the organization and in their outreach and public education efforts in the community.

CEO Joel Abrams explained to me that, as patients encounter more complexities, reductions, and changes in their insurance, Dorchester House must respond with an increased organizational focus on education around these issues. The statement below highlights how organizational engagement with financial issues has had to increase in light of the new changes to the HSN, described above:

> "We'd put them in some category of free care and then we would worry about everything else, how we wrote their care off to free care, how we got reimbursed from the pool for that part of the care that we can get paid for, what part if any they had to pay, all done within the health center. Once health care reform passed and the connector got involved, letters started going out to people saying "you must enroll in some plan somewhere" and so began a very complicated part of their lives. That just upped the ante for us to work with our patients and reach out to them in here and educate them on this process. We got to be educated, they got to be educated."

Mr. Abrams describes Chapter 58 reforms as having "upped the ante" for Dorchester House to provide accurate and reliable information to their patients. As he suggests, a major part of this is education within the organization. Registration Assistant Pedro Sanches explained to me that both the Billing and the Registration departments have had to increase their efforts to stay abreast of state reforms since 2006. Both departments have implemented monthly meetings and electronic bulletins on policy reforms and have even held several insurance-specific seminars in efforts to keep all providers sufficiently and equally educated on state policies. Though none of these meetings has focused specifically on immigrant insurance issues, they have helped Dorchester House providers gain a better understanding of Chapter 58 reforms as a whole.

"In addition the increased focus on education surrounding policy and financial issues, Dorchester House has also had to shift its goals as an organization to include more focus on health insurance education and outreach for their patients. Dorchester House has worked particularly hard to provide these services to immigrant patients. Attribution needed here"

In our interview, Policy Director Michele Nadow discussed some of these new efforts both in and outside of the clinic. In particular, she cited health educators from Dorchester House increasing their attendance at community events (such as health fairs and local festivals); new efforts at providing educational health insurance material to parents at local public school; and the institution of community meetings with business owners to work on integrating them into, as she framed it, "a larger outreach strategy" for Dorchester House's services and enrollment activities. The clinic has also worked to promote the availability of insurance helpline services offered through Board Member Judy Meredith's affiliated advocacy organization, the Public Policy Institute. This helpline service works to answer patients' questions about health care reform and

insurance eligibility. This service, along with the other outreach efforts mentioned above, pays special attention to immigrant populations by providing educational material in a variety of different languages. Judy Meredith explains how a variety of languages are integrated into the helpline service for Dorchester patients:

> "we've got five languages up there, so if an immigrant or someone calls in and says, "I just got his letter, what does it do?" And I'll ask them, what's the date of the letter? And then I'll put them on the phone with someone who can speak their language who translates the letter…"

Inside the doors of Dorchester House, aggressive multilingual health insurance education campaigns were adopted after Chapter 58 reform. This included posters that showed pictures of MassHealth applications and signs in a variety of different languages at the registration areas: " Have you received a letter saying that your insurance status is changing? Ask us how we can help".

While these posters and other community efforts represent particularly visible and tangible examples of the organization's efforts to redirect their focus, Board Member Judy Meredith also suggested to me that Dorchester House has created changes in their resource management strategies. Here, she explains new organizational challenges in the context of the problem of redirecting immigrant patients who were cut from CommCare:

> "We've had to spend a lot of our resources, I don't know how to calculate it and I'm sure Joel doesn't either, to personally contact all those folks, and say, "come in here, you're now going to be working with this hospital"…[We've had to] deal with those people, and get them new doctors, and make sure that folks with diabetes or folks with coronary disease or folks with other chronic problems are taken care of. So it's a big burden and it's been very confusing for everyone.

Judy Meredith highlights the fact that reorganizing social services to accommodate for the changes under Chapter 58 has required a great deal of time, effort,

and, indeed, a strain on the part of Dorchester House as an organization. This energy spent reorganizing outreach services supports the general feeling amongst providers that as, an organization, the Dorchester House has adopted a new focus on health insurance issues. Thus, like new increases in fiscally-oriented self-education, this changing focus of community outreach represents a significant institutional change that Dorchester House has had to adopt in response to Chapter 58.

Impacts of Non-Financial Challenges

Though integrating issues of health insurance into public education campaigns and outreach services was a necessary step for Dorchester House to be able to continue providing service to many of its patients, these efforts have also proven to be somewhat problematic in the context of immigrant care. Dorchester House has always been hesitant to establish a reputation that is tied to matters of policy and insurance enforcement or other areas of health care that might possibly create misconceptions or fears amongst immigrant patients. These concerns are supported by the findings of current literature in the field as well as Dorchester House providers' own experience of noting that immigrants avoid seeking care for fear of legal or financial repercussions due to their status as noncitizens. Dorchester House wants to be seen, primarily, as a patient-centered organization that functions under the free care model. Providers feel that pushing legal and health insurance-based issues threatens this reputation amongst immigrant patients.

Michele Nadow discussed this issue with me in describing why Dorchester House has not pursued more aggressive public campaigns amongst immigrants to bring new patients to use Dorchester House's insurance enrollment support services:

> "We thought, "well what if we had an open house one day, and people come in with all your questions about immigration?" And we all thought that would be great, but we've said we would not get a single person in here. Because people would think it would be like a covert raid operation."

This highlights the fine line that the Dorchester House must uphold between ensuring immigrant patients comprehensive information and coverage, and continuing to send them the message that their relationships with Dorchester House are not built on legal or insurance-based issues. In this case specifically, Nadow explained that publicizing community events centered on insurance registration could raise red flags for immigrants who fear being grouped based on their immigration status. Potentially, this could result in immigrants avoiding seeking health care altogether. Thus, as with the financial-based changes following Chapter 58, non-financial changes represent a significant challenge to the reputation of the Dorchester House as an immigrant health care institution and, accordingly, jeopardize its ability to provide care.

In response to this problem, Dorchester House has had to find non-public strategies of health insurance education and counseling. As described in my previous chapter, this responsibility has disproportionately fallen to physicians and direct medical providers. Michele Nadow explained how, after finding a mass-mailing outreach system ineffective, a provider-based insurance education approach was encouraged:

> And so we just decided that we didn't want to make people nervous by sending everybody a postcard because then some people wouldn't be affected by it, but they would get anxiety…So that's the tricky thing: how we interact with immigrants, legal or illegal, or undocumented, is that, it really has to be by a case to case basis because you really have to go in and reach them…And I think they're not afraid of their doctor, or if their doctor had suggested it to them, which is how we try and get folks to talk about the legal process and the legal services that are available."

Though no formal strategies or guidelines have been set by the Dorchester House to encourage providers' discussion of insurance with their patients, Nadow's comment shows that an emphasis on physician-patient outreach has been acknowledged and emphasized, at least informally, at an institutional level at the Dorchester House. Following from the analysis I presented in the previous chapter, these types of new financial counseling activities have proved to be time consuming and, often, a struggle for providers to integrate with their practice.

While, at the provider level, this may manifest in frustration and stress related to the lack of time, at the institutional level, professional strain results in lowered productivity. Joel Abrams explains the larger repercussions of how providers' work impacts the organization as a whole:

> "We hope that the providers don't have to get into that. But invariably this stuff creeps into the relationship between the providers and the patients because they're carrying all that with them…the providers are doing social work which slows them down, it slows down our productivity as an organization, which also has financial consequences, and so it's a vicious circle."

This statement illustrates just how closely linked various sectors of providers are within the Dorchester House. When one area is forced to compromise or cut back its services, all other areas must work to accommodate these changes and make up the difference. This interconnectedness highlights both the uniqueness and the fragility of Dorchester House as a community health center: that it manages to maintain a diverse range of services despite a relatively small group of providers and a particularly high-need and complex patient population. This model requires that Dorchester House maintain a delicate balance of both financial and non-financial factors at an organizational level to continue to function smoothly and successfully. The analysis above has shown how, according to providers, Chapter 58 reforms have impacted both

financial and non-financial functions of Dorchester House at an institutional level and, in doing so, begun to compromise its status as a reliable immigrant health care resource in the Dorchester Community.

This organization-wide perspective represents the final level of analysis I have drawn from my interviews of providers relative to the overarching impacts of Chapter 58 reforms. The trend that I have hoped to show in this three-tiered perspective is that, whether at the patient, provider or institutional level, Chapter 58 reforms have created barriers that challenge Dorchester House's role and function as an immigrant health care provider. As I move on to my next and final chapter, I will attempt to highlight recommendations that could be adopted at a broad level, by policy-makers at the state level, and, importantly, by providers at Dorchester House, to address some of the challenges and barriers that have impacted immigrant health care in the wake of Chapter 58 reforms.

RECOMMENDATIONS & CONCLUSION

Over the course of the year that I spent researching and writing this thesis, a

landmark battle to pass a universal health care bill was fought and won in the United States Congress. After nearly two years of debate and political maneuvering, the House passed the Patient Protection and Affordable Care Act (PPACA) by a margin of seven votes on March 21, 2010. Two days later, in an interview with Boston Public Radio, John McDonough, the president of HCFA, said "There is absolutely no doubt Massachusetts was the overwhelming conceptual structure for this federal program" (Brady-Myerov 2010).

Like Chapter 58 reform, the PPACA includes a universal mandate that every resident have health insurance. As in Massachusetts, those who do not enroll in a health insurance plan by a certain date will incur a tax penalty, as will employers who do not offer affordable insurance packages to employees. Also similar to Massachusetts' current structure is the PPACA's significant expansion to Medicaid coverage, as well as a provision for the creation of state-subsidized insurance plans.

Because of these similarities, these reforms will not bring a great deal of change to Massachusetts, at least at the individual level. At the state level, however, this federal reform will represent a new and welcome source of funding to supplement state health insurance plans. Under the PPACA, Massachusetts will receive $2 billion in Medicaid assistance over 10 years, beginning in 2014. Importantly, the PPACA reform has included a provision which allows qualified immigrants to be covered under this federal funding for Medicaid. Again, while this will not change the terms of eligibility for immigrants in Massachusetts (qualified immigrants were already covered under MassHealth), it will allow the state more dollars to fund immigrant-specific care.

The passage of federal reform has two important implications for my research. The first, in concert with the new funding being made available at the state level, is that

Massachusetts will now have access to additional resources to improve health insurance coverage and gaps that exist under Chapter 58. In particular, the provisions which extend federal funding to qualified immigrants, will allow policy-makers to redistribute the state dollars that were previously being used to fund this group, to other needy populations, potentially even to other immigrant groups who remain uninsured or to CHCs such as Dorchester House who work with immigrants and other uninsured populations. This availability of funds helps provide a mechanism through which many of the recommendations I provide below can be executed.

The second important repercussion of the passage of federal health care reform on my research relates to the potential scope and implications of my findings and analysis. The nationwide translocation of policies and reform processes similar to those experienced by Massachusetts under the transition to Chapter 58 means that lessons and recommendations I have drawn will now apply to a much wider range of health care providers. Issues experienced by Dorchester House are shared not only by other immigrant health care providers in Massachusetts, but also, potentially, by immigrant health providers throughout the United States. Accordingly, my analysis of the dilemmas faced by Dorchester house can be seen as offering an empirical perspective on areas where national policy may fall short for immigrant patients in the coming years, and on those areas that policy-makers might look to as targets for reform.

Recommendations

In the preceding three chapters, I have presented an analysis which explores the various changes that Dorchester House has incurred as a result of Chapter 58 reforms, as well as how these changes have affected the Dorchester House's ability to deliver care to immigrants in the Dorchester community. At every level that my analysis identified- patient, provider, and organizational- I discovered new and troubling challenges arising from Chapter 58, which have led to compromises in Dorchester House's services and care for immigrant patients.

In this conclusion, I seek to identify the most salient characteristics of these challenges so that they can be linked to linked to specific provisions of Chapter 58 policy. In doing so, I will suggest ways that Chapter 58 policy could be changed to better support the needs of immigrant health providers. My recommendations will be presented as proposed charges to policy-makers, along with explanations of how these changes would reduce the challenges and obstacles faced by immigrant patients, health care providers, and immigrant health care organizations. I have chosen to focus on three topics: the yearly re-enrollment requirement, the nature of Chapter 58's language and complexity, and the new billing structure for HSN reimbursement.

Re-enrollment

Though my analysis focused on several specific provisions of Chapter 58 that had components that were particularly problematic for immigrants, I found few to be as directly disruptive to immigrants' access to health care as the yearly requirement to re-enroll with the MassHealth system. Providers noted experiencing frequent problems

when patients lose insurance coverage because of failing to re-enroll in MassHealth. Often, this loss of insurance coverage follows long and hard-fought efforts on the part of providers to have linked immigrant patients with appropriate enrollment information and support services in the first place,; providers often exerted time and effort to extend insurance services to patients, and frequently even made specific claims about patients' rights and eligibility for insurance, only to have those efforts defeated by those who failed to re-register because they were unaware of the re-enrollment requirement.

While it is important to maintain up-to-date patient information, especially for immigrants who may qualify for greater benefits as they spend more time residing in the United States, this priority should not be enforced via threats to continued coverage. Rather, the state should recognize the difficult and often complex process it may take to enroll immigrant patients in state insurances programs, and focus on maintaining individuals who are already enrolled. Currently, the largest hurdle in maintaining enrolled immigrants is the cuts individuals face when they do not fulfill the re-enrollment requirement. My recommendation to policy makers on this matter is simple: remove these strict cuts in eligibility for individuals who fail to re-register; strategies to update patient information need not include threats to current coverage.

Complexity

One of the most common themes in my research was the problem of over complexity in Chapter 58 policies. Providers felt that neither they, nor their patients, had an accurate understanding of the exact rules and regulations of Chapter 58. Accordingly, the impacts of Chapter 58's unnecessary complexities were felt at the patient, provider, and organizational level.

For patients, problems with policy complexity manifested in barriers to enrollment and confusion about health insurance policies even after registration had taken place. Any effort to reduce these problems should include a push to disseminate accessible information about health insurance enrollment and eligibility for immigrants throughout Massachusetts. As my analysis shows, accessibility should be thought of in terms of both content and in terms of ready availability. That is, not only should state authorities work to disseminate educational materials on health insurance, they should also work to ensure that these materials are being presented in a way that is easily comprehensible for populations whose primary language and cultural understandings may span a wide range. This means that information should be available in a wide variety of languages and should be presented in basic terms. As reflected by my analysis, information should emphasize the association of one's legal status to their level of coverage above and beyond all other factors.[23] Within this framework, coverage plans should then be explained with explicit lists of common procedures that are not covered. Similarly, co-pay prices should be made explicit for those that are partially subsidized.

Increasing explanations of insurance eligibility and guidelines in this manner will cut down on cases where immigrant patients incurred financial burdens because they did not realize or understand that their insurance plan had been changed under the provisions of Chapter 58. Such an improvement would help foster a culture of trust among immigrant patients with regard to being able to safely use and rely on the health system. The less frequently immigrant patients experience instances like that of the

[23] Current public education materials emphasize income level and the FPL above immigration status. This is misleading, as immigration status supercedes income level as a category of eligibility.

breast cancer patient described in Chapter 4- either personally or amongst friends or family- the more they will feel that the health care system is a reliable resource to which they have equal entitlements. This will help raise levels of preventative and non-urgent medical visits amongst immigrants in Massachusetts and ultimately ensure a healthier community.

For providers, complexity manifested as challenges to understanding coverage guidelines, both generally, in terms of eligibility and, more specifically, in terms of which pharmaceutical and specialty care services were covered under each insurance plan. Thus, along with educational information that provides adequate guidelines on patient eligibility (as described above) the state should develop educational information targeted to providers that includes a comprehensive list of medications and medical services covered under each level of state health insurance plan.

Descriptions of medications should include specific dosages and brand names that are covered and should be updated frequently[24] because, according to my research, provisions guiding precise pharmaceutical coverage tend to be particularly complex and often volatile. Similarly information on specialty care services should include not only a full description of tests that are covered under MassHealth, but also an easily updatable list of hospitals where these are covered. As shown in my interviews, even when patients have already scheduled dates for treatment or testing procedures, hospital coverage is subject to change and can result in delayed procedures and extra work for providers.

Providing comprehensive and up-to-date lists such as the kind described here would allow providers to make fewer mistakes in their prescribing and referral

[24] An easily accessible online system might be most effective for this.

decisions. This would help reduce the time providers spend on self-education (often in order to offer advice to their patients), and the time they must spend fixing referral or prescription errors that are not in keeping with state insurance plans.

Eliminating or reducing the time that providers spend on issues of insurance would, in turn, help increase the productivity of the organization as a whole. This is supported by my institutional-level analysis, which highlights how the tight interlinking of Dorchester House's departments has meant less productivity for the organization as a whole, as providers have had to integrate the challenges of working as both health care suppliers and financial advisors.

Similarly, if the state became more proactive in providing comprehensive information to patients, Dorchester House would have to focus less on integrating financial and insurance information into its outreach and educational services. This would allow Dorchester House to maintain a primary focus on health issues and patients' well being and would avoid some of the tensions that providers feel are being generated amongst immigrants in the community in associating Dorchester House with legal, rather than health based functions.

Finally, providing more easily accessible guidelines would help reduce the financial losses that Dorchester House has incurred because of billing errors. According to providers, this could help bolster Dorchester House's bottom line by as much as 7%.

Billing Structure

According to providers, while the new billing structure of Chapter 58 reforms has worked for some CHCs, it has created new gaps in funding for others, including Dorchester House and many other urban CHCs. As highlighted in my analysis, these

funding gaps are a result of the state's underestimation of the number of patients that would switch from HSN services to MassHealth and/or CommCare at these affected CHCs. I argue that it is not an accident that funding gaps have disproportionately affected CHCs with large number of immigrant patients, but rather a reflection of Chapter 58's lack of consideration for immigrant health care coverage on the whole.

Accordingly, the state should invest efforts in reassessing the differential financial needs of rural vs. urban CHCs and, given that many of the unaccounted-for gaps in registration may represent immigrant patients who are ineligible for MassHealth, these assessment efforts should also include heavy consideration the number of immigrant patients served by individual CHCs. Those with a high number of immigrant or other patients who continue to be ineligible for state health insurance programs should be awarded extra state dollars. These compensatory funds should be continually adjusted to match patient populations and reduced accordingly as state coverage expands and more patients switch from HSN coverage to MassHealth or CommCare.

In addition to these compensatory funds, the state should provide provisional block grant funding for CHCs that have, like Dorchester House, traditionally served a large number of patients under the free care system. This recommendation comes in light of the significant cutbacks to "wraparound" services (case management, behavioral health, e.g.), which have lost their funding with the elimination of the HSN block grant system. I speculate that even minimal amounts of additional, non-specified funding at the Dorchester House during these past two years (as both its patients and registration staff have transitioned to the pay-per-service system) would have prevented the organization from having to cut back and even eliminate some of the social and support

services that are so vital to the Dorchester community, and especially its immigrant patients.

Like the recommendations above, this provision would help Dorchester House maintain its focus on patient health and wellbeing, as well as its position in the community as a reliable immigrant health care provider.

RECOMMENDATION SUMMARY

1) *The state should remove cuts in eligibility for individuals who fail to comply with MassHealth re-enrollment requirements. Instead, develop strategies to maintain up-to-date patient information that do not threaten current coverage status.*

2) *The state should invest more resources in disseminating accessible information about the terms of Massachusetts's health care policies as they have been restructured under Chapter 58. This effort should emphasize:*

    a. *Information targeted to patients that is easily comprehensible for non English speakers both in terms of language appropriateness and level of information;*

    b. *Information targeted to providers which includes comprehensive guidelines on pharmaceutical coverage as well as lists of hospitals where services are covered under various MassHealth plans across the state;*

3) *The state should reassess the differential financial needs of CHCs and provide additional funding for CHCs where:*

    a. *A high numbers of patients using free care remain ineligible to register for MassHealth and CommCare;*

    b. *Significant funding has been lost due to cuts in the HSN block grant system.*

In both cases, this funding should be provided along with clearly indicated provisional guidelines which allow funds to be adjusted as CHCs become more reliant on state or other funds to fill these current funding gaps.

As I draw this piece to a close, I would like to return to the story of the Chinese Women's Benevolent society that Judy Meredith related to me, and to the plea that Mrs. Lao made to her Senator in 2005 asking him to vote for MassHealth expansions which would help pay for treatments for the cancer growing in her breast.

Five years later, has Mrs. Lao received the financial assistance to receive the medical attention she so desperately needed? If so, has her plan provided enough coverage so that follow up and palliative treatment was affordable and accessible? Was she able to access providers who understood her unique linguistic and cultural needs and who helped her understand the terms of her insurance plan?

When I asked Judy Meredith what had become of the case of Mrs. Lao, she told me that, regrettably, she did not know; she had not kept in touch with the Chinese Women's Benevolent Society after their collaboration in 2005. Taken together, the observations of the many interviewees in this project, who represent involvement at all levels of a network of legal, policy, financial and direct care providers, offer little data which would cause us to feel hopeful on Mrs. Lao's behalf. Mrs. Lao's very obscurity is symptomatic of one aspect of the difficulties immigrants face in having an uncertain status in the system of health care entitlement. And further, as my research has illustrated, Mrs. Lao's story is one of countless such stories—a mere drop in the bucket of the battles immigrants are still fighting today to receive affordable and accessible health care.

My research at Dorchester House has illustrated some of these complex challenges from the perspective of a health care organization that has struggled to provide consistent and adequate care despite the challenges that Chapter 58 reform has

posed for its patients, providers, and for the organization as a whole. Not surprisingly, my research found that despite its strong efforts to not let insurance and other financial issues affect its level of care, Dorchester House has had to compromise its services and reputation as an unwavering source of care for immigrants in the community.

Reducing the capacity and function of an organization, such as Dorchester House represents a significant blow to the already limited health resources for immigrants in Massachusetts. Thus, despite Massachusetts' stated intention to provide affordable and quality health care to all of its citizens, it seems that Chapter 58 reforms have only served to widen health disparities with regard to its immigrant populations.

This is a reality that neither state nor federal policy makers can ignore as they monitor the implementation and outcomes of their first attempts at universal health care reforms. My research has provided an empirical perspective on the challenges immigrants face in accessing health care, and has reached recommendations, which, I argue, could allow policy makers to shape a health care system that is truly experienced as universal, both by our nation's growing population of immigrants and by the health care providers who are committed to serving them.

APPENDIX A

LIST OF ACRONYMS

Community Health Center	CHC
Department of Health and Human Services (Federal executive authority)	HHS
"An Act Providing Access to Affordable, Quality, Accountable Health Care"	Chapter 58
Dorchester House Multi Service Center	Dorchester House
Federation for American Immigration Reform	FAIR
Kaiser Health Foundation	KHF
Institute for Community Health	ICH
Health Care for All	HCA
Immigration Customs Enforcement	ICE
Tuberculosis, Human Immunodeficiency Virus Sexually Transmitted Diseases.	TB, HIV, STDs
World Health Organization	WHO
Aliens With Special Status	AWSS
Person Residing in the US Under Color of Law	PRUCOL
federal poverty level	FPL
Uncompensated Care Pool	UCP
Disproportionate Share Hospitals	DSH
Executive Office of Health and Human Services (Massachusetts executive authority)	EEOSS
Commonwealth Care	CommCare
Massachusetts Health Connector	The Connector
Managed Care Organizations	MCO
Creation of the Health Safety Net	HSN
Massachusetts Immigrant and Refugee Advocacy Coalition	MIRA
Commonwealth Care Bridge	The Bridge Program
Institutional Review Board	IRB
Boston Medical Center	BMC

Figure 1
STATISTICS OF FOREIGN BORN IN MASSACHUSETTS
(2006)

Foreign-Born in MA Top Ten Countries as of 2006		
Rank	**Country**	**2006**
1	Brazil	74,931
2	.China	66,920
3	Portugal	62,604
4	India	40,044
5	Canada	34,974
6	Vietnam	33,933
7	Italy	25,769
8	El Salvador	24,706
9	Russia	21,744
10	Ireland	16,206
	Total	401,831

Source: Federation for American Immigration Reform. 2009. Foreign-Born in MA Top Ten Countries**.** Accessible at: http://www.fairus.org/site/PageServer?pagename=research_research4e13

Figure 2
FEDERAL POVERTY LEVEL GUIDELINES

Persons In Family	Poverty Guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

Source: Department of Health and Human Services (HHS) 2009. Official 2009 Federal Poverty Level Guidelines. Accessed from HHS official website on 4/02/10 at http://aspe.hhs.gov/poverty/09poverty.shtml

Figure *3*
COMPARISON OF MASSHEALTH PROGRAMS

MassHealth Limited	MassHealth Standard
*Inpatient and outpatient emergency care *Labor and delivery services, *Emergency visits to the emergency room *Pharmacy services to treat a medical emergency *Other emergency services, including dental care and mental health care *ambulance transportation for a medical emergency	*Inpatient and outpatient hospital services *Doctor, nurse practitioner, nurse midwife, and clinic visits *Well-child visits including immunizations *Early intervention *Pharmacy services *Long-term care in a medical facility *Mental health and substance abuse services *Audiologist services *Vision care including eyeglasses and magnifying aids *Chiropractor services *Podiatrist services and orthotics *Prosthetic services *Abortion and family planning services *Rehabilitation and therapy services (physical, occupational, speech) *Renal dialysis *Home health care *Personal care and private duty nurse services *Hospice services *Smoking cessation services *X-rays and laboratory work *Medical equipment and supplies *Oxygen and respiratory equipment *Adult foster care, adult day health care, and day habilitation services *Dental services for children and adults *Ambulance and transportation

Source: Health Care For All. 2009. Public Programs Fact Sheet. www.hcfama.org

APPENDIX B
CONSENT FORM

TUFTS UNIVERSITY
Department of Community Health
CONSENT TO PARTICIPATE IN RESEARCH STUDY
Error! Contact not defined.

Senior Thesis Candidate
25 Upland Rd
Somerville MA, 02144
Tel:773 339 0623 Email: talya.peltzman@tufts.edu

STUDY TITLE: *The Effects of Massachusetts Health care Policy Reform on Immigrant Health: Health Providers' Perspective*

Purpose: This study involves research on the effects of recent changes in MA's health care policies on MA immigrant communities. I am interested in understanding how you have experienced these changes in your clinical and work environments.

Procedure and Duration: I will ask you a series of questions about your work experiences and environment as well as your experiences with immigrant patients. This study will take no longer than 1 hour of your time.

Risk and Discomfort: There are no foreseeable risks or discomfort associated with this study. If you feel uncomfortable you may ask to stop or skip a question at any point during the interview.

Benefits: Results will help to inform future clinical interventions for improving immigrant health and health care services.

CONFIDENTIALITY: The results of this study may be published in a scholarly book or journal, presented at professional conferences or used for teaching purposes. However, your name and other identifiers will not be used in any publication or teaching materials.

WITHDRAWAL OF PARTICIPATION: Your participation is voluntary. Should you decide at any time during the study that you no longer wish to participate, you may withdraw your consent and discontinue your participation.

REQUEST FOR MORE INFORMATION: If you have any additional question at any time, You may contact the principal investigator, **Error! Contact not defined.** 25 Upland Rd Somerville MA, 02144 Tel: 773 339 0623 Email: talya.peltzman@tufts.edu. In addition, you may contact Yvonne Wakeford at the Office of the Institutional Review Board at (617) 627-3417.

SIGNATURE: I confirm that I understand the purpose of the research and the study procedures. I understand that I may ask questions at any time and can withdraw my participation without prejudice. I have read this consent form and my signature below indicates my willingness to participate in this study.

Participant Name__-

_____

Participant

Signature_____

PI Signature:_____

Date_____

The participant agrees to be audio-taped YES ____ NO_____
Initial _____

APPENDIX C
INTERVIEW GUIDE

I'm going to begin by asking some general questions about your job and role as a _____ at the Dorchester House.

- How long have you been at Dorchester House?
- Could you tell me a little bit about your job?
- Could you tell me what sorts of things you do on a day to day basis?
- Can you tell me a little bit about how you got to your position?

- *In what ways do you interact with (other) health care providers at your clinic?*

As you know, I am interested in learning about how MassHealth Reform has affected life here at your clinic, especially in your interactions with immigrant populations (but before I ask you to discuss policies,) I'd like to hear some background information about your interactions with immigrant populations.

- What are your personal interactions with immigrants?
- In what settings have these interactions taken place?
- Have you interacted with undocumented or documented immigrants or both?
- Have these interactions differed according to status? How?
- What programs or services does your clinic provide specifically for immigrant populations?
- In your experience, what barriers, if any, do immigrants experience when accessing health care?
- What does your clinic do to address these barriers?

Study
Navigate
Trust/fear

Great. Now I'd like to ask some more pointed questions about Massachusetts Health care Reform and MassHealth Insurance Policies.

- First, I'd like you to tell me about how recent policy changes have affected the _____ clinic.
  - How has this changed practices in day-to-day life?
- How have these issues affected your job as a _____
  - Can you describe some of the challenges that you face or have faced in dealing with these changes?
  - In what ways do these issues affect your job?

This is really helpful context for me. Now I'd like to understand a little bit more about how the two issues we've already discussed- immigrants and Masshealth reform- I'd like to know how these two issues interact in your clinic.

- First of all, of the policy issues that we've discussed, which do you think are important to immigrant health
  - In what ways?

(OR IF NOT DISCUSSED) Massachusetts implemented Health Care Reform across the state in 2007. As a result, undocumented immigrants are required to receive care through the health safety net (which replaced the Free Care pool) not able to get access to comprehensive state-funded health care plans such as MassHealth or CommonWealth Care. Addition reforms were made in August 2008 removing health care from 30,000 legal MA immigrants.

- Overall, what effect do you think that these recent Massachusetts health care reform changes have had on your immigrant patients' access to health care?
- What effects have these reforms had on the ways you practice?
- Are there ways in which you think the roles of the health center has changed for immigrant patients (either because of health care policy or otherwise)?

FOR PROVIDERS

As a health care provider who works directly with immigrant populations, I was curious to know a little more about your personal interactions with immigrant patients

- What barriers do you, personally, face in delivering care to immigrants?
- Have you observed immigrant patients reporting anxiety or fear of deportation? About immigration status? About health insurance status?
- Have you ever observed immigrant patients relating anxiety or fear to medical treatment or follow-up?
  - Follow up questions: Can you describe in these circumstances? What circumstances? What advice and or resources were you able to offer these patients? Was it effective?

Great, I'd like to just ask you two final questions to get a sense of your general perspective:

- Since the beginning of MA health reform (2006) have you had an increased number of missed appointments without follow-up among your immigrant patients?
- In what ways do you try and mediate the legal/medical interface in your clinic? What challenges do you face with this?

Wrap up

- Is there anything that you think I've missed?
- Do you have any questions for me?

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