Report on Boston Children's Hospital's Response to the DPH on Impacts to Medicaid Population in the Matter of DoN Project 4-3C47

John A. Lynch
May 10, 2016

Prepared for the Anne Gamble Ten Taxpayer Group

This report concerns the Department of Public Health's request of Boston Children's Hospital (BCH and Applicant) to "describe the impact of this project (Project # 4-3C47) on your Medicaid patient population." The BCH Response of 4/11/16 notes that Factor 2.1 of the Determination of Need ("DoN") application requires it to address "[h]ow this project will affect accessibility of services for the prospective patients who are poor, medically indigent and/or Medicaid recipients".

EXECUTIVE SUMMARY

Boston Children's Hospital's DoN Application should be denied because the project will reduce the availability and accessibility of heath care services to poor, medically indigent and Medicaid children in Massachusetts. BCH's meager explanation of how its proposed project will affect the Medicaid population in Massachusetts is unresponsive and misleading.

BCH fails to discuss the reclassification of many Medicaid children as private pay managed care patients in its statistics, and how the hospital is free to increase rates for these Medicaid children in Managed Care Plans. With its refusals to negotiate affordable rates with Medicaid Managed Care Plans, the Hospital is effectively depriving Massachusetts Medicaid children of access to its pediatric care.

Approval of this Application would exacerbate this adverse effect by increasing BCH's already exorbitant charges even further beyond what Medicaid Managed Care Plans can afford to pay.

THE APPLICANT'S RESPONSE IS UNRESPONSIVE AND MISLEADING

In the single sentence of the Applicant's response of 4/11/16 ("Response") that's actually responsive to this question from the Department, the Applicant states "Boston Children's hospital (sic) does not anticipate any decline in its MassHealth or out-of-state Medicaid payor volume as a result of this Project."

The Applicant's strategic decision to project no change in its Medicaid volume or revenues from 2014 to 2024—the only payor category so "frozen in time"—appears to be a disingenuous tactical attempt to justify its unsubstantiated contention that its enormous proposed project ("DoN Project #4-3C47", or "Project") would have no impact on access to BCH services for this underserved patient population.

Why is it that the Applicant is able to make assumptions to support future volume and revenue projections for every payor category *except* Medicaid? Is it really any harder to project utilization by Medicaid recipients in one's own state than assuming what will happen with demand for your services in Saudi Arabia or Qatar?

This untenable position is an ill-disguised attempt to nullify this central and legitimate concern of the DoN review process. Simply dismissing it with the false assurance that the proposed Project will have absolutely no impact on BCH's future patient volumes and revenues for this underserved patient population is too clever a ruse by half. **BCH's statement on Medicaid projections should be dismissed out-of-hand given its inherent improbability.** The Department should not accept this non-response at face value but demand a more plausible response from the Applicant.

WHAT'S REALLY GOING ON WITH THE APPLICANT'S MEDICAID ACCESS: BCH IS CUTTING OFF CARE TO MEDICAID CHILDREN IN MANAGED CARE PLANS

More tellingly, the Applicant's Response fails to address the reality of Medicaid coverage in Massachusetts that is quickly moving away from traditional fee-for-service coverage (reflected as Medicaid patients in BCH's financials) to Medicaid managed care plans (called Managed

Care Organizations and included with BCH's Private Pay patients). Half of the children covered by Medicaid in Massachusetts are now in these managed care organizations ("MCOs"), with the rest scheduled to be moved into them soon.

As the Department knows, MassHealth is transitioning from traditional payments directly to hospitals like BCH to instead contract with MCOs responsible for their own hospital payment arrangements. This explicitly means that "Hospitals are not entitled to, and may not claim for, any fee-for-service payment from EOHHS for any services that are MCO-covered services or are otherwise payable by the MCO".[1]

While these children are no longer considered traditional Medicaid patients in the Applicant's financial statements, they are nonetheless *de facto* Medicaid patients that the Applicant has a history of denying access to its services by refusing to offer Medicaid MCOs affordable hospital rates.

If the consequence of MassHealth's intention to move all its recipients into MCOs is for Medicaid children in MCOs to lose access to the Applicant's services, then this should be factored into the Department's analysis and decision about the impact of approving this Project on the state's Medicaid children—both the small minority who might remain in traditional Medicaid and the growing ranks of *de facto* Medicaid children in MCOs.

The impact of this proposed project on the Medicaid population is likely to be highly adverse. The largest of these MCOs have been forced to terminate and/or substantially curtail access to BCH's services due to its already exorbitant charges.[2,3]

The Applicant states in its Response that converting its remaining double-bed rooms to single-bed (private) rooms will have no effect on its Medicaid volume because MassHealth pays a fixed amount regardless of room type. As more MassHealth patients are forced into MCOs, however,

[1] State Plan Under Article XIX of the Social Security Act, Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

[2] December 5, 2014 *Boston Business Journal,* Thousands lose access to Boston Children's Hospital over insurance rate dispute

[3] April 6, 2016 *The Boston Globe,* New policy for Children's affects poorest patients

this payment restriction will no longer apply to them.[4] Given the Applicant's history of hard-ball negotiations with these MCOs, it's unlikely to offer private rooms for the *de facto* Medicaid children in MCOs at rates comparable to what traditional Medicaid allows.

Increased rates for MCO's will further dampen *de facto* Medicaid access to the Applicant's proposed expanded services and may—given BCH's demonstrated willingness to sacrifice access to its services for Medicaid MCO children—represent a "tipping point' in the Applicant's commitment to this state's poor, medically indigent and Medicaid children.

This might explain why the Applicant makes no mention in its Application or Response of its non-compliance with the DoN regulatory requirement that it consult with Massachusetts' Division of Medical Assistance, which oversees MassHealth and would presumably be very concerned about this unintended consequence of transitioning the remaining 50% of traditional Medicaid recipients not yet in MCOs into them.

Perhaps this is why the Applicant bypassed this planning consultation as required by 105 CMR 100.533(B)(1). Given the seriousness of this issue—now and in the future—this regulatory failure alone warrants denial of the Application.

This attempt to bypass both DoN regulatory requirements and BCH's historical commitment to serving Massachusetts' poor and medically indigent children flies in the face of the Applicant's assurance in its Response that its values include that "all Massachusetts children should have access to our care regardless of whether they have commercial or public coverage".

BCH also notes that it "must treat very few uninsured or self-pay patients from Massachusetts", but sees no hypocrisy in failing to contract with Massachusetts' MCOs serving these very same children now having coverage as a result of Massachusetts' highest-in-the-nation rate of insured patients.

---

[4] June 16, 2015 Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by Managed Care Organizations

THE APPLICANT'S FISCAL SLEIGHT OF HAND IS UNWORTHY OF ITS HISTORY: BCH'S SERVICE TO THE POOR AND MEDICALLY INDIGENT IS DECREASING

While Medicaid can effectively dictate what it will pay its providers, Medicaid MCOs cannot. This dramatic transformation, expected to accelerate with Massachusetts' state budget for FY17[5], has given BCH leverage to negotiate pricing with MCOs that it doesn't have with traditional Medicaid.

Instead of agreeing to subsidize Medicaid MCO children as it has traditional Medicaid children in the past, this new fiscal paradigm empowers BCH to end these traditional public subsidies and attempt to negotiate higher Medicaid MCO rates instead. **If these Medicaid MCOs can't afford BCH's pricing demands, Medicaid children in these plans are denied access to the Applicant's services.**

Let's connect the dots in this fiscal shell game…

- Like all hospitals, the Applicant has a history of subsidizing the state's Medicaid population by accepting Medicaid payments that cover less than its full costs of care;
- Massachusetts Medicaid (MassHealth) patients are being completely moved into Medicaid MCOs;
- The pace of this transition will accelerate will the state's FY17 budget effective 7/1/16;
- The state's two largest Medicaid MCOs - Neighborhood Health Plan & HealthNet – have effectively terminated their contracts with BCH because they can't afford its rates (these non-profit MCOs both lose money, BCH is one of the state's wealthiest hospitals); and
- The Applicant will end up serving fewer Medicaid children directly (because they'll no longer be traditional Medicaid patients) and fewer such children indirectly (because it refuses to sufficiently discount its prices with Medicaid MCOs for the very same medically-indigent children who were previously traditional Medicaid patients).

---

[5] January 25, 2016 Masslive.com, Shira Schoenberg Gov. Charlie Baker's budget finds ways to trim MassHealth spending

In this real world context, the almost certain net effect of approving this Project will be that the BCH of the future will have very little Medicaid volume (it's already much lower than its peers nationally) and much higher private pay volume (including the few children previously covered by Medicaid but forced into MCOs that reclassify them as private pay, in the unlikely event any such MCOs can actually afford rates driven even higher with approval of this proposed Project).

Given this actual and projected decline in Massachusetts Medicaid patient volume, the Department should require the Applicant to document how much of its projected FY24 Medicaid payor mix is from out-of-state Medicaid programs.

Given BCH's recent history of denying access to Massachusetts' children in Medicaid MCOs—combined with the Applicant's acquisition of a large for-profit out-of-state physician group practice—it would appear that BCH is on a deliberate path to serving more out-of-state Medicaid patients than Massachusetts Medicaid children.

The Applicant's demonstrated pattern of seeking to reduce its number of Massachusetts Medicaid MCO children while continuing to serve out-of-state Medicaid patients should be taken into account in the Department's review of its Application as a serious defect warranting Project denial.

The Applicant will also have higher volumes of international clientele demanding VIP treatment and amenities. BCH has made no secret of the driving force behind its Application for its unprecedented hospital expansion Project. It isn't to serve more Medicaid patients or offer more uncompensated care. According to a report in the highly respected *Becker's Hospital Review*...

> "Due to the hospital's increased outreach and marketing overseas, the number of patients from the Middle East, Asia and Latin America seeking care at Boston Children's in fiscal 2014 was up 47%...."[6]

[6] January 2, 2015 *Becker's Hospital Review,* Boston Children's Hospital gets financial boost from international patients

> "Boston Children's CFO Doug Vanderslice told the *Boston Globe*, 'The population in the Boston and New England area is fairly static. Finding growth in international patients is very much a positive sign'."[7]

The question is, positive for whom? It's not likely to be Massachusetts' "poor, medically indigent and/or Medicaid recipients", nor the growing ranks of Medicaid children about to be reclassified as private pay patients in Medicaid MCOs. **Virtually all children insured through Medicaid MCO's will be denied access to BCH due to hospital rates that will only be increased with approval of this lavish Project.**

Proposing such an extravagant Project that's blatantly targeting wealthy international clients with many treatment choices available to them while at the same time turning away medically indigent Massachusetts children (who happen to be enrolled in Medicaid MCOs) with far fewer treatment choices lays bare the true ulterior motives of this proposed Project.

According to an article in *Middle East Health*…

> *Most patients who come for expensive procedures pay the full price for their care. Boston's Children's Hospital saw profits jump last year by 28%, thanks, in part, to a surge in medical tourism patients from the Middle East...*
>
> *"Not surprisingly, marketing efforts have been extended to reach this lucrative clientele from the oil-rich Kuwait, Saudi Arabia, the United Arab Emirates and Qatar at a time when revenue growth from the US patients has stagnated.*[8]

THE APPLICANT IS REVERSING ITS MISSION:

A NON-PROFIT HOSPITAL IS SEEKING TO MAXIMIZE PROFITS WITH THIS PROJECT

This recent dynamic in which BCH has replaced its historic willingness to subsidize Massachusetts Medicaid patient care with a refusal to continue such subsidies via Medicaid MCOs that most Medicaid children are now enrolled in is ample evidence of the dramatic shift in how BCH's mission is being compromised by its global corporate ambitions.

---

[7] January 2, 2015 *Becker's Hospital Review,* Boston Children's Hospital gets financial boost from international patients

[8] May-June 2015 *Middle East Health.* US hospitals forge close ties with Middle East

BCH's current rate of access for Massachusetts' poor, medically indigent and Medicaid recipients is already far less than that of its peer children's hospitals nationally (see table below). BCH's Medicaid census at 33.2% of admissions may be high compared to general acute care hospitals (who also have Medicare patients to care for, which leaves them with double BCH's rate of public pay patients and much lower rates of private payors). **However, BCH's Medicaid census is over 36% lower than the national average for children's hospitals[9] of 52%.[10]**

In fact, both Medicaid and free care rates at BCH are much lower than peer hospitals nationally:

	Boston Children's Hospital (BCH)	Peer Hospitals Nationally	BCH Differential	Peer Differential
Medicaid %	33.2%	52%[11]	-36%	+56.6%
Free Care	1%[12]	2%[13] All US hospitals -3.3%[14]	-50%	+100%

Combined with the current transition of most Medicaid patients to Medicaid MCOs with little clout to negotiate pricing discounts, the Applicant's own Medicaid Accountable Care Organization (ACO) efforts to reduce reliance on expensive inpatient resources is also likely to reduce the Applicant's inpatient Medicaid payor mix and further reduce its subsidies for this population. A similar pediatric ACO reports reducing hospitalizations by as much as 40%.[15]

Despite all this, the Applicant is proposing to substantially *expand* its current bed capacity and has inexplicably decided to freeze its projected FY24 Medicaid payor mix at FY14 levels—while

[9] September 25, 2011, *Kaiser Health News*, Growing Size And Wealth Of Children's Hospitals Fueling Questions About Spending

[10] January 1, 2014, Children's Hospital Association, childrenshospital.org, Medicaid DSH Payments Are Critical To Children's Hospitals

[11] January 1, 2014, Children's Hospital Association, childrenshospital.org, Medicaid DSH Payments Are Critical To Children's Hospitals

[12] September 25, 2011 *Kaiser Health News,* Nonprofit Children's Hospitals Get Valuable Tax Exemptions But Many Provide Little Free Care

[13] September 25, 2011, *Kaiser Health News*, Growing Size And Wealth Of Children's Hospitals Fueling Questions About Spending

[14] Spring 2014 Alliance or 340B Integrity and Reform, Unfulfilled Expectations: An Analysis of charity care provided by 340B hospitals

[15] December 31, 2015 *Fierce Health Finance,* Pediatric ACO cuts hospital costs for chronically ill kids

adjusting all other payor data to reflect expected changes—in order to arbitrarily support its contention that this Project, if approved, will have no impact on access to its services by Massachusetts' poor, medically indigent and Medicaid patients.

In short, assuming no change in the Applicant's Medicaid payor mix—at least its *Massachusetts* Medicaid payor mix—is extremely unrealistic in light of these adverse institutional and systemic trends that approval of the Applicant's proposed Project will only exacerbate.

PROJECT'S IMPACT ON RATES WILL FURTHER REDUCE MEDICAID & INDIGENT ACCESS

BCH's rates are already sufficiently high that Massachusetts' two largest Medicaid MCOs—Neighborhood Health Plan and HealthNet—have terminated their previous contracts with BCH because they simply can't afford their rates. According to a report at *Becker's Hospital Review*...

> *An insurance plan designed to provide coverage to low-income families has changed its contract, which will result in restricted access to specialists at Boston Children's Hospital...Neighborhood Health Plan...has altered its contract, leading its members on Medicaid to either find new specialists outside of Children's or join a new health plan, according to the report.* ***Neighborhood officials said the change was made because they can't afford the rates at Children's.***[16]

Approval of BCH's Application will exacerbate this trend of indirectly (i.e., via Medicaid MCOs) discouraging Medicaid access to BCH's services because BCH enjoys unique status as the state's only dedicated children's hospital. As such, they enjoy "a kind of market power that many adult systems didn't have, a unique ability to raise their rates and raise money".[17]

BCH's exorbitant pricing has produced wealth that is much greater than its peers nationally. According to a report at *Kaiser Health News*[18], **Children's Net Assets were almost three times that of their children's hospital peers, while their charitable (free) care was less than half**

---

[16] April 2, 2016 *Becker's Hospital Review* Changes to Partners' health plan limits access to care for poor at Boston Children's

[17] September 25, 2011 *Kaiser Health News*, Talking Building Ambitions: The Big Money World Of Kids' Care,

[18] September 25, 2011 *Kaiser Health News,* The Wealth Of Children's Hospitals

that of their peers at less than 1% of revenues[19]—a level low enough to revoke hospitals' tax-exempt status in other states.[20]

This occurs despite higher levels of insurance coverage and lower levels of uncompensated care than found in general acute care hospitals.[21]

PROJECT SHOULD BE DENIED DUE TO ADVERSE IMPACT ON MEDICAID & INDIGENT ACCESS

BCH is fond of "transformation" terminology. The transformation represented by this Application is at least as nefarious as noble in that it would hasten the demise of the Applicant's tradition of service to needy Massachusetts children in favor of wealthy international clientele.

This is more than disappointing, especially given that the Applicant is the beneficiary of a number of financial advantages over other Massachusetts hospitals and peer pediatric hospitals nationally. These include:

1. A much higher private payor mix than non-pediatric acute care hospitals which must serve both Medicaid and Medicare patients;
2. A much higher private payor mix than peer pediatric hospitals nationally that serve over 50% more Medicaid children in their payor mix;
3. A higher rate of insurance coverage in Massachusetts than any state in America;
4. Less pressure to reduce utilization than general acute care hospitals;
5. A state Medicaid program that is transitioning from fee-for-service payments that forced it to subsidize Medicaid children to Medicaid MCOs without the same leverage to dictate what they will pay for BCH's services;
6. A growing share of wealthy international patients able and willing to pay full charges or close to it; and
7. Corporate wealth well in excess of its peer hospitals nationally.

---

[19] September 25, 2011 *Kaiser Health News*, Nonprofit Children's Hospitals Get Valuable Tax Exemptions But Many Provide Little Free Care
[20] August 17, 2011 *Fierce Healthcare*, Regulators continue crackdown on hospitals' tax-exempt status
[21] September 25, 2011 *Kaiser Health News*, Talking Building Ambitions: The Big Money World Of Kids' Care

Despite all these inherent advantages, the Applicant—a non-profit corporation—has chosen not to share its wealth by subsidizing more free care than its current rate of half the national average of its peer hospitals. Nor has BCH been willing to reduce its charges as needed to contract with Medicaid MCOs that can't afford rates that have forced the state's two largest Medicaid MCOs to terminate their prior contracts with BCH.

With its vast resources and multi-billion dollar investment portfolio, if the Applicant were truly concerned with protecting Medicaid children's access to its services - instead of finessing its mission by dumping these children on other pediatric facilities willing to serve them via their Medicaid MCOs at more reasonable rates - it would create its own Medicaid MCO like Partners, Boston Medical Center and others more committed to serving this population have done.

Instead, it has made the calculated decision to extricate itself from its long-standing tradition of subsidizing care for Massachusetts' poor and medically indigent children by refusing to negotiate substantial discounts with the state's largest Medicaid MCOs that would very likely still generate more revenue than they receive for traditional Medicaid patients. **This tacit abandonment of these medically indigent children flies in the face of BCH's proud history, mission, and fiduciary duties as a public non-profit organization.**

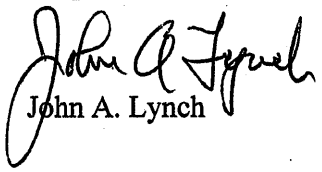
This clever fiscal strategy has the obvious and intended effect of reducing utilization by these unprofitable patient populations to make room for more lucrative clientele. Approval of this Project would further relegate Massachusetts' poor, medically indigent and Medicaid patents to second-class status at BCH.

From the strict perspective of this proposed Project's impact on Massachusetts' poor, medically indigent and Medicaid populations, this pricing strategy alone warrants denial of the Application as there's clearly no need for more capacity to serve these populations. The Applicant's chosen pricing strategy is instead creating the systemic opportunity to serve this underserved in-state population with much *less* hospital capacity rather than the significant expansion being proposed to serve non-Massachusetts residents.

The harm to the availability and accessibility of BCH's services for Massachusetts residents produced by this conscious corporate choice to expand access to BCH for wealthy international clients—for which the Department has neither authority nor capacity to evaluate need—at the expense of poor, medically indigent and Massachusetts Medicaid patients will be greatly increased with an approval of this Application.

The Project's approval as submitted would further distance BCH from its roots in service to the poor in favor of global riches and ambitions that not only defy its history, but render it increasingly inaccessible by the very indigent patient populations for which it was founded and which are the focus of the Determination of Need review process.

Respectfully submitted,



John A. Lynch

John A. Lynch

Planning, Regulatory & Management Experience

Consultant **2015-present**

Consult with small and midsize businesses and other clients on healthcare analysis, marketing and financial management improvements, and business strategy.

Chairman, President & CEO **1984-1995**

Medical Diagnostics, Inc., Burlington, MA

Founded mobile MRI company—Medical Diagnostics, Inc. (MDI)—as a more cost-effective shared service approach to disseminating this new technology compared to conventional hospital-owned and operated units that encouraged overutilization of an expensive technology. Took company public as the only profitable company of its type. Innovative business model reversed traditional approach of leasing expensive diagnostic equipment to hospitals and instead leased space from hospitals to run independent licensed clinics. This gave the company's 200+ employees full operational control leading to productivity twice the industry average. *BusinessWeek* ranked MDI one of top ten "Best Small Companies" in America.

Responsibilities included:

- Writing and securing DoN/CoN regulatory approvals for clinic licenses In MA, NH and ME
- MA model innovated mobile clinics based at hospitals with new clinic licensure rules
- Received first DoN approval for mobile MRI in western Massachusetts (simultaneous with region's largest medical center) by demonstrating shared service's economic benefit to region
- Recruiting management team and board membership
- Strategic planning, secured equipment and working capital financing
- Early adoption of teleradiology for M.D. training & Q.A.
- Presentations for public offering – U.S. & Europe
- Public company reporting and shareholder presentations

President **1981-1984**

Lynch Associates, Inc, Lynnfield, MA

Consulting practice for doctors and hospitals with a focus on strategic planning, program development, regulatory approvals, and new technology adoption.

- Managed introduction of first free-standing MRI center in New England (Wellesley's West Suburban MRI Center). Conceived and guided team of radiologists from 9 participating hospitals in developing an innovative DRG-weighted methodology to assist DPH review of the need for this still-emerging technology before FDA Approval or Medicare coverage. Received unprecedented DoN approval simultaneously with region's major medical centers by documenting the favorable financial impact of this regional shared service model;
- Developed strategic plan to convert Barnstable County Hospital to private multi-level facility. Prepared DoN for original licensure to transition from solely chronic disease care to multi-service facility to better serve the region's unmet needs. Secured state

approvals for half-dozen MRI units in MA, NH and CT. Clients included UMass Medical Center, Shields MRI, St. Vincent's Hospital

- Developed early need methodology for emerging MRI technology, recognized by American Hospital Association
- Wrote DoN and secured state approval for former Youville Hospital's chronic disease hospital renovation by demonstrating via financial analysis that reducing the hospital's bed count, as DPH staff recommended, would result in increased utilization of more expensive acute hospitals at millions in increased costs to the system. Project was approved with no bed reduction.
- Managed multi-disciplinary teams of lawyers, architects, accountants to ensure DoN applications met every regulatory requirement in a stringent regulatory climate.

Vice President, Planning & Marketing **1981-1983**
Leonard Morse Hospital, Natick, MA

Duties included strategic planning, program development, physician recruitment, project management, multi-hospital affiliations and hospital-medical staff joint ventures; developed hospital's inpatient alcoholism program, child psychiatry unit and medical office building. Wrote DoN and secured DoN approval for hospital renovation project for new lab space, new child psychiatric unit, and other needed improvements.

Deputy Director/Planning Director/Regulatory Review Director **1978-1981**
Health Planning Council for Greater Boston (HSA 4), Boston, MA

Oversaw all planning and regulatory activities for New England's largest regional health planning agency, including development of agency's Health Systems Plan and regional planning agency (HSA) reviews of DoN Applications; managed agency's Public Health Council presentations & made select presentations for larger or innovative projects with no review Guidelines. Formed multi-disciplinary team of architect, financial analyst, nursing, and others to assure thorough vetting of region's DoN applications that often resulted in leaner and more cost-efficient facilities receiving DoN approvals.

Director, Ambulatory & Community Health Services **1974-1978**
St. Elizabeth's Hospital, Brighton, MA

Administered emergency room, 33 outpatient clinics, three affiliated health centers, and several special projects. Developed Watertown Health Center and hospital programs in alcoholism treatment, podiatry and sports medicine. Board member for Greater Boston's first EMS regional response system. Secured DoN approval for Watertown Health Center by demonstrating its favorable financial impact on local and regional healthcare costs..

Executive Director **1971-1974**
Project Turnabout, Inc., Brighton, MA

Managed Massachusetts' largest self-help drug rehabilitation and prevention program with seven facilities in Greater Boston and Cape Cod. Co-wrote and edited training manual on drug prevention with State Department of Education for high school teachers statewide.

Manager **1968-1971**
Little City Halls - City of Boston, Mayor's Office of Public Service

Appointed youngest Little City Hall Manager out of college - Introduced "Little City Halls" to four Boston neighborhoods and managed two others; represented City on policy matters relating to transportation and urban universities. Helped reverse City's position on federal government's proposal to extend I-95 federal highway through Boston, which led to ultimate reversals at state and federal levels in favor of more cost-effective public transit (Orange Line) services.

Education

Boston College, B.S. History, Political Science - Magna Cum Laude **1964-1968**

Volunteer Activities (past and present)

Health Care For All - Board Member
Youville Hospital - Board Member, Chaired Strategic Planning Committee
Massachusetts Hospital Association - Trustee Advisory Committee
Greater Boston Council on Mental Health & Retardation – Chairman
Mass Mental Health Center Area Board - Chaired Geriatric Committee
Greater Boston Emergency Medical Services Committee
Joseph M. Smith Community Health Center - Board Member
Jamaica Plain Transportation Committee - Co-Chairman
Jamaica Plain Community Council – President