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Opportunities for Maximizing Revenue and Access to Care for Immigrant Populations

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Introduction

Community health centers (CHCs) and local health departments (LHDs) have long been the primary, if not the only, source of medical care for millions low-income individuals, including many who have no health insurance and cannot afford to pay for care. Due to the Affordable Care Act of 2010 (ACA), CHCs and LHDs face increasing demand from those who are newly insured.[1]

Yet 36 million individuals remain uninsured under the ACA, of which the majority includes citizens and legal immigrants.[2] For example, 4 million citizens and legal immigrants who remain uninsured are eligible for Medicaid, but live in one of the 21 states that have not expanded Medicaid.[3] Moreover, due to complex eligibility rules and misinformation, immigrants are often eligible for affordable coverage, but not enrolled.[4] Whether insured or not, immigrants are more likely to continue to seek services at CHCs and LHDs because of trusted relationships, locations in the community, and enabling services such as language access that they rely on.

This paper seeks to:

- Increase understanding of the barriers immigrants face in accessing primary clinical care and public health services;
- Provide best practices that help encourage immigrants to seek care and coverage;
- Identify health programs and services that should be available to all individuals regardless of immigration status.

Section I. Providing safety-net clinical care at CHCs post ACA

As a result of the ACA, almost 23 million Americans have gained coverage. This includes 11.7 million individuals who have purchased health policies through the health insurance Marketplaces and almost 11 million newly eligible individuals covered by Medicaid and the Children's Health Insurance Program (CHIP).[5]

In the 29 states that have expanded Medicaid under the ACA, CHCs are already experiencing increased demand. [6] CHCs are included in the majority of Medicaid managed care plan networks and continue to accept new Medicaid patients more often than private practioners.[7] Moreover, individuals who are newly insured by Medicaid are more likely to remain with their existing provider.[8]

Model Legislation
To overcome difficulties in contracting with private health insurers, LHDs in Arizona successfully passed HB 2430 in 2013 that requires insurance plans to provide in network reimbursement to LHDs, regardless of contract status. For more info, go to Publications at www.naccho.org.

Individuals who are newly insured with private subsidized coverage from the health insurance marketplaces may also make up some of the new patient mix. Although CHCs and LHDs traditionally have not contracted with commercial plans, there will be increased opportunities due to ACA's requirement on plans in the marketplaces to include "Essential Community Providers," such as CHCs, in their networks.[9]

Section II. Identifying and Overcoming Immigrants' Barriers to Care

There is no federal, state, or local law that prevents immigrants, including those who are not lawfully present (or undocumented) from accessing health care services. Nor is there any law that prevents health care providers from treating individuals without lawful immigration status or prevents health insurance companies from selling health coverage to individuals without immigration status. However, many federally funded health programs, as discussed below, limit eligibility based on immigration status. Those restrictions are often incorrectly applied by providers, eligibility workers, as well as immigrants to all health services.

This section discusses common barriers that immigrants face in accessing clinical care, the publicly funded health care programs and services for which immigrants are eligible, and existing laws that may help promote or deter access to care.

A. Common Barriers for Immigrants Seeking Care

Barriers are faced by immigrants, whether they are citizens, legal immigrants, or are undocumented, when they attempt to access care or apply for health coverage. These barriers also deter other immigrants who may have only heard about the challenges accessing care, creating a chilling effect that keeps many more individuals in the family or community from getting the care they may need.

Cultural and Linguistic Barriers

The U.S. health care system may be very different from what many immigrants were accustomed to in their home country, and holistic health care practices may be more trusted than "modern" American medical care.[10] For instance, the concept of health insurance and the need for regular, preventive care (including lab work, x-rays, medications for chronic conditions) may be unfamiliar to immigrants.

Add to the challenge of these cultural barriers, the inability of immigrants who are Limited English Proficient (LEP) to communicate or understand their health care provider or written instructions or forms when language access is not provided.[11]

Additional resources:

HHS Office of Minority Health's "A Patient-Centered Guide To Implementing Language Access Services In Healthcare Organizations,"

National Health Law Program's "Language Services Resource Guide for Health Care Providers (Appendix F)

About 25 million people in the United States, 9% of the total population, speak a language other than English at home.[12] Title VI of the Civil Rights Act of 1965 requires health care entities that receive federal funding, either directly via Public Health Services Act Section 330 or by serving Medicare and Medicaid patients, to provide language interpretation and translation of materials to individuals who are LEP.[13] CHCs and LHDs are required by law to ensure access to linguistically and culturally competent care and must increasingly do so simply in response to the changing demographics of their patients throughout the U.S.[14]

Collecting and reporting of immigration status

There are approximately 12 million undocumented immigrants living in the U.S., which represents about 3.5% of the total U.S. population.[15] The immigrant population also includes naturalized citizens and legal immigrants, such as lawful permanent residents, refugees, or visa holders. Thus, an immigrant family often has individual members with different immigration statuses, referred to as a "mixed-status" family, such as a family with U.S. citizen children and parents who are undocumented. As a result, there may be individuals in a mixed status family who are eligible for federally funded health care programs such as Medicaid or federal subsidies in the health insurance marketplaces, but there may also be one or two family members who are undocumented and are ineligible for affordable coverage. Assuming all family members have the same immigration status, for example, has likely resulted in U.S. citizen children of immigrant parents being disproportionately uninsured than those with native-born parents.[16]

Undocumented immigrants may be reluctant to seek care because they believe health care providers will report them to immigration authorities. Citizens and legal immigrants in a family may also not seek health care or apply for coverage if doing so could potentially harm their legal status or would place undocumented family members at risk of deportation. For instance, the

request for immigration status and Social Security Number (SSN) of all family members on an application or intake form may lead immigrants to believe such information is required to get care and that it will be shared with immigration authorities; thus, the questions on an application or form alone may create a chilling effect, even for those in the family who are citizens or legal immigrants.

> The U.S. Immigration and Customs Enforcement (ICE) agency issued a memo in October 2013 in English and Spanish to reassure immigrants that it was safe to apply for health coverage under the ACA.

Under the ACA, only those members of the family who are applying for non-emergency Medicaid, CHIP, or premium tax credits in the marketplaces are required to provide an SSN and their citizenship or immigration status.[17] This information will be electronically verified against federal databases, but only for purposes of determining health care eligibility.[18] If an individual's immigration status cannot be electronically verified during the application process, this only indicates that his or her information could not be found in the database, not that the individual is undocumented. In this case, the marketplace or CHIP may simply deny the individual health care coverage, or he or she may be approved for Emergency Medicaid only.

Even if a patient states he or she is undocumented, health care providers are not mandated by law to report individuals who are undocumented to legal authorities. In fact, individuals seeking services that are available regardless of immigration status, such as Federally Qualified Health Centers (FQHCs), should not be asked or required to provide their immigration status so that a patient's immigration status should remain unknown.[19] Moreover, hospitals, CHCs, and LHDs should be considered exempt from immigration enforcement actions as "sensitive locations," but even when immigration authorities request patients' immigration status, a warrant must be required before providing that information.[20]

> For a list of programs that are not considered as public charge, see Public Charge Fact Sheet available at www.uscis.gov.

Being Considered a "Public Charge"

Immigrants may not seek or apply for health care coverage because they fear that they or their family members will be considered a "public charge" by immigration authorities, thereby preventing them from obtaining lawful permanent residency or citizenship. An immigrant is considered a "public charge" if he or she will likely need to rely on government assistance for basic necessities in the long-term, and prior use of government benefits may indicate reliance on assistance in the future. However, use of non-cash benefits, such as public health care or nutrition programs should not be considered in the public charge evaluation.[21] Moreover, the public charge test does not apply to immigrants who already have their green card, are naturalized citizens, or are seeking government benefits for

their U.S. citizen children; these individuals can apply and seek health care services without fear of public charge.

B. Health programs and services for which immigrants are eligible

Although affordable health coverage options may be limited for undocumented immigrants, many legal immigrants or citizens are eligible for affordable care options, but remain uninsured. Individuals who are "eligible, but not enrolled" are the result of complicated immigrant eligibility rules, lack of proper training of enrollment assisters and eligibility workers, and misinformation among the immigrant community.[22]

Below are some key public health coverage options for both undocumented and legal immigrants that may increase access to services for patients. They may also help provide additional revenue for CHCs whose patients are immigrants.

Programs available regardless of status

The Personal Responsibility Work Opportunity Reform Act of 1996 (PRWORA) severely restricted eligibility for "federal public benefits," including Medicaid, for both undocumented and lawfully present immigrants.[23] However, there are four exceptions to the restrictions, listed below, where programs can be provided to a broader group of immigrants. While there is no exhaustive list of programs that are available regardless of status, as long as a program or service meets one of the following four exceptions, they are available to individuals regardless of immigration status. Examples of current programs that are available regardless of immigration status that fall within each exception are listed below.

1) **Services or programs that were explicitly exempted from the PRWORA;**[24]
    - Emergency Medicaid
    - Public health assistance for immunizations and treatment of symptoms of communicable diseases "whether or not such symptoms are caused by a communicable disease"
    - "Short-term, non-cash, in-kind emergency disaster relief"
2) **Services or programs that are not designated as a "federal public benefit" subject to the 1996 restrictions**;[25]
    - Community health centers or hospitals
    - Family planning services
    - Early Breast Cancer Detection
    - Women Infants and Children (WIC)
    - School lunch and breakfast
    - Charity care or financial assistance
3) **State or locally funded services or programs;**
    - Healthy San Francisco
    - Illinois' All Kids program

- California's Children's Health Initiatives (CHIs) (a.k.a., Healthy Kids)(funded by tobacco tax)

4) **Services, programs, or assistance that are provided at the community level or are needed to "protect life and safety" as designated by the U.S. Attorney General;** [26]

- Community food banks, soup kitchens
- Short-term shelter or housing assistance for homeless persons or runaway, abused, or abandoned children
- Crisis counseling and intervention programs
- Treatment of mental illness and substance abuse
- Child protection, adult protective services, violence and abuse preventions
- Senior nutrition programs such as Meals on Wheels, and other nutritional services for persons requiring special assistance

Complaints of discrimination based on national origin, such as being restricted from programs that should be available to everyone, can be filed with HHS' Office of Civil Rights by any individual or entity.

Private Health Insurance

Immigrants who are "lawfully present" can buy health insurance and obtain premium tax credits through the ACA's marketplaces without any waiting periods, unlike in Medicaid.[27] In addition, an undocumented parent can apply for health insurance and premium tax credits through the marketplace on behalf of eligible family members if the family otherwise qualifies and the parent agrees to file taxes.[28]

Although the health insurance marketplaces created under the ACA require proof of citizenship or immigration status, there are no similar restrictions on the purchase of private health insurance that is sold outside the marketplace.[29]

Medicaid and Children's Health Insurance Program (CHIP)

Medicaid and CHIP are federal health coverage programs available to low to middle income individuals who meet certain eligibility criteria. To qualify for CHIP or non-emergency Medicaid, immigrants must also have an immigration status that is listed under the federal definition of "qualified" immigrant and must wait five years before they can apply.[30]

States can expand coverage, with federal funding, to a broader group of immigrants by electing the state options to provide prenatal care under CHIP to pregnant women regardless of status and non-emergency Medicaid and CHIP to "lawfully residing" immigrant children and pregnant women without a five year waiting period.[31] Currently, fifteen states provide prenatal care to pregnant women regardless of status and twenty eight states cover immigrant children and women without a waiting period.[32]

Emergency Medicaid

If they meet all other Medicaid eligibility criteria, undocumented immigrants as well as legal immigrants who are "qualified" and in their five year waiting period or who are "not qualified" for non-emergency Medicaid are eligible for emergency Medicaid.[33] Under Emergency Medicaid, providers must screen potentially eligible individuals and bill Medicaid for services rendered to treat an "emergency medical condition, defined as:

> *"a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:*
>
> *(A) placing the patient's health in serious jeopardy,*
> *(B) serious impairment to bodily functions, or*
> *(C) serious dysfunction of any bodily organ or part."*[34]

Because there must be a "sudden onset" of the original emergency condition for treatment to be reimbursable under Emergency Medicaid, preventative care or medications are not covered.[35] However, services need not be performed in a hospital emergency department to be covered. Any treatment needed to prevent "serious impairment" or damage to a "bodily organ or part," whether inpatient or outpatient care, should be covered under Emergency Medicaid. For example, in some states, dialysis treatment performed by an outpatient dialysis center is billed to and paid for by Emergency Medicaid.

Note that Emergency Medicaid may cover treatment beyond what may be required under the Emergency Medical Treatment & Labor Act (EMTALA).[36] EMTALA requires services to be provided to the point where the patient is stabilized, but Emergency Medicaid may cover additional procedures, such as surgery, if medically necessary to treat the underlying emergency medical condition so that the patient's health is no longer in jeopardy.

Section III. Best practices

Below are suggested best practices for CHCs and LHDs with patient populations that include immigrants and immigrant family members to help ensure linguistic and culturally competent care and identifying potential revenue sources for uninsured immigrants.

1. Educate and outreach to immigrant communities to allay fears and encourage the use of all available public health services.

- Develop culturally and linguistically appropriate outreach and education to patients to educate them about health services and programs for which immigrants are eligible or that are available regardless of status.[37]

- For example, use trusted messengers or trusted health educators in outreach and enrollment efforts. For example, the Promotoras de Salud model of health educators is an example of an effective approach in reaching Hispanic immigrants as the educators themselves are immigrants and live in the communities they educate.[38]

- Develop consumer friendly materials that directly address immigrants' fears about public charge, reporting of their information to immigration authorities and other myths that can be dispelled through education.
- Educate immigration attorneys in the community that they should not be deterring immigrants from seeking care, as health is not a public charge.

2. Assess and train clinic staff, enrollment assisters, and providers to address gaps in knowledge about immigrants.

- As a precursor to training, conduct an informal survey of staff and patients about their perceived beliefs and understanding of immigrants' eligibility for health services and barriers to seeking care. Develop training and materials that specifically address common concerns or misinformation.
- Work with a local consumer health or immigrant rights' advocacy group to develop a training curriculum about the different health programs and services for which immigrants may be eligible.
- Provide training regarding immigrants' eligibility for programs to enrollment assisters, all clinic staff (including at the front desk), as well as providers, who are often most trusted by immigrants.
- Connect patients to a health consumer ombudsman or advocacy group in the community. Immigrants may need additional help applying for coverage as they are often incorrectly denied coverage because eligibility workers often misunderstand or misapply immigrant eligibility rules or information is not translated.

3. Review current forms or applications to make sure only necessary information is requested to avoid deterring immigrant patients from applying or seeking care.

- Review what information is being collected from patients at what point in the process and determine if it is absolutely necessary. For example, requesting an SSN or immigration status is not relevant for treatment purposes and thus is not needed on an initial intake form, but may be requested at the time of collecting payment as an optional question.
- Do not request or require a SSN or immigration status for health programs that are available regardless of immigration status, such as services at FQHCs, public health treatments, Emergency Medicaid, or family planning services. If existing intake or admission forms request an SSN and immigration status, consider deleting the questions, or at a minimum, clearly indicate on the form that those questions are optional.
- Inform patients that information about other family members is not required on admission forms for treatment purposes, with the exception of a minor child needing a parent or guardian to provide consent.

U.S. Department of Health and Human Services' Office of Civil Rights provides Model Notices of Privacy Practices (in Spanish and English) to help inform patients of how their information will be used.

- When assisting families apply for health coverage, make clear that the immigration status and an SSN are needed only for those family members applying for coverage, not for everyone in the household. Ensure that on any state or federal application for health coverage that the request for SSN is marked optional and there is an explanation as to how the SSN will be used. [39]

4. Strengthen privacy policies regarding patient information as well as access to facilities.

- Review and ensure compliance with state privacy laws that may be stricter than what is required under The Health Insurance Privacy and Portability Act (HIPPA).[40]
    - For example, in California, medical information is protected from disclosure for marketing purposes by providers as well as insurance companies, and health care facilities are subject to fines for privacy violations.[41]
- Reassure patients that information they provide on an application will not be shared for immigration enforcement purposes.
    - For example, provide a copy of the October 2013 ICE memo (see earlier text box) that informs immigrants it is safe for them to apply.
- To protect against immigration enforcement action at CHCs or LHDs:
    - Partner with an immigration attorney in the community for referrals and legal advice.
    - Educate immigrant patients about their right to remain silent and avoid incriminating statements.
    - Train staff to not provide verbal or written information about patients without a warrant.
    - Do not consent to a search of the premises without a warrant. Only public areas are searchable by law enforcement without a warrant.
    - Designate areas of the CHC or LHD as private and public, including the waiting room.

5. Increase screening and use of Emergency Medicaid for outpatient services.

- Work with the state Medicaid agency on improving and simplifying billing of Emergency Medicaid services.
    - Request your state's Medicaid agency to allow pre-qualification of Emergency Medicaid.[42]
    - Ensure the state Medicaid agency permits outpatient providers, clinics, health centers and public health departments to bill for emergency services under Emergency Medicaid and that it does not limit billing to only inpatient providers.
- Train enrollment assisters and billing staff about the availability of Emergency Medicaid for both legal and undocumented immigrants.
- Make clear that the requirements for treatment under Emergency Medicaid are broader than what may be required by EMTALA.
- Develop a form that explains the definition of "emergency medical condition" and would allow practioners to easily document why a prescribed treatment falls within the definition. The form could be used as supporting document when filing an Emergency Medicaid claim.

6. Increase cultural competence and language access capacity.

- Hire bilingual and bicultural staff.
- Provide initial and ongoing training to volunteer interpreters.[43]

- Do not allow family members to act as interpreters. If an interpreter is not available, inform the patient of his/her right to an interpreter and require consent to allowing a family member or friend to serve as an interpreter.
- Do not allow minor children to serve as interpreter, even with the patient's consent.
- Educate administrative and legal staff about the benefits of language access for risk management and reducing potential tort liability.
- Create an on-line repository of sample forms, privacy practices, and translated materials for patients that can be shared among CHCs, LHDs, and hospitals.
- For other best practices on medical interpretation, read National Standards Of Practice For Interpreters In Health Care, National Council on Interpreting in Health Care, September 2005.

Conclusion

Individuals with diverse immigrant backgrounds make up a growing percent of patients seeking care at CHCs and LHDs across the nation. Many immigrants are eligible for Medicaid, CHIP or private insurance through the ACA's marketplaces but may be unaware or reluctant to apply for coverage, or may face barriers in the application process. There are also many federal or state programs that are available regardless of immigration status that can provide access to health and social services to legal and undocumented immigrants. CHCs and LHDs that adopt best practices for serving immigrant patients will not only improve quality of care and health outcomes for these patients, but can increase revenue by connecting eligible immigrants to affordable care options.

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[1] Peter Shin, Jessica Sharac, Zoe Barber, Sara Rosenbaum, and Julia Paradise, "Community Health Centers: A 2013 Profile and Prospects as ACA Implementation Proceeds," Kaiser Family Foundation, March 17, 2015, available at: http://kff.org/medicaid/issue-brief/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds/.

[2] Melissa Majerol, Vann Newkirk, and Rachel Garfield, "The Uninsured: A Primer - Key Facts About Health Insurance and the Uninsured in America," Kaiser Family Foundation, January 13, 2015, available at: http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer .

[3] Melissa Majerol, Vann Newkirk, and Rachel Garfield, "The Uninsured: A Primer - Key Facts About Health Insurance and the Uninsured in America," Kaiser Family Foundation, January 13, 2015 available at: http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer ; *see also* Terri Shaw, "The remaining uninsured: Closing ACA gaps," Government Health IT, January 5, 2015, available at: http://www.govhealthit.com/news/closing-acas-unintended-gaps-uninsured-americans.

[4] Jessica Stephens and Samantha Artiga, "Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act," Kaiser Family Foundation, March 2013, available at: http://kff.org/disparities-policy/fact-sheet/key-facts-on-health-coverage-for-low/.

[5] "Current Marketplace Enrollment," Kaiser Family Foundation's State Health Facts, February 2015, available at: http://kff.org/health-reform/state-indicator/current-marketplace-enrollment/; "Medicaid & CHIP: December 2014 Monthly Applications, Eligibility Determinations and Enrollment Report," Centers for Medicare and Medicaid Services, February 23, 2015, page 3, available at: http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2014-enrollment-report.pdf.

[6] Melinda K. Abrams, Michelle M. Doty, Jamie Ryan, Dominique Hall, and Pamela Riley, "Ready or Not? How Community Health Centers View Their Preparedness to Care for Newly Insured Patients," Commonwealth Fund, May 2014, available at: http://www.commonwealthfund.org/publications/issue-briefs/2014/may/ready-or-not-how-

chcs-view-their-preparedness ; *see also*, Brystana Kaufman, Pam Silberman, Mark Holmes, "Rural Provider Perceptions of the ACA: Case Studies in Four States," Findings Brief: NC Rural Health Research Program, February 2015 available at: http://www.shepscenter.unc.edu/wp-content/uploads/2015/02/ACAProviderPerceptionsFebruary2015.pdf.

[7] *See e.g.*, Brendan Saloner, Genevieve M. Kenney, Daniel Polsky, Karin Rhodes, Douglas Wissoker, and Stephen Zuckerman, "The Availability of New Patient Appointments for Primary Care at Federally Qualified Health Centers: Findings From an Audit Study," April 7, 2014, available at: http://www.urban.org/research/publication/availability-new-patient-appointments-primary-care-federally-qualified-health-centers-findings-audit-study.

[8] Melinda K. Abrams, Michelle M. Doty, Jamie Ryan, Dominique Hall, and Pamela Riley, "Ready or Not? How Community Health Centers View Their Preparedness to Care for Newly Insured Patients," Commonwealth Fund, May 2014, available at: http://www.commonwealthfund.org/publications/issue-briefs/2014/may/ready-or-not-how-chcs-view-their-preparedness.

[9] Title 45 Code of Federal Regulations (C.F.R.) Section 156.235; " Frequently Asked Questions on Essential Community Providers," Centers for Medicare and Medicaid Services, May 13, 2013, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf; *see also* "2015 Letter to Issuers in the Federally-facilitated Marketplaces," Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services Guidance, March 14, 2014, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf ; Cristina Jade Peña, Laurie Sobel, and Alina Salganicoff, "Federal and State Standards for 'Essential Community Providers' under the ACA and Implications for Women's Health," Kaiser Family Foundation, January 23, 2015, available at: http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/.

[10] *See e.g.*, Anne Fadiman, "The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures."

[11] Without cultural and linguistically appropriate health care provided, patients may be unable to access the care they need and unintended outcomes, such as lack of patient compliance or medical malpractice, may occur.

[12] Monica Whatley, Jeanne Batalova,"Limited English Proficient Population of the United States," Migration Policy Institute, July 25, 2013, available at: http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states/.

[13] *See e.g.*, "Health Centers: Improving Health Care Access For Limited English Proficient Patients," Association of Asian Pacific Community Health Organizations (AAPCHO), March 2004, available at: http://www.aapcho.org/resources_db/health-centers-improving-health-care-access-for-limited-english-proficient-patients/. The term "translation" is used when referring to providing language access in written materials and "interpretation" is used when providing language access orally (via an interpreter).

[14] *See e.g.*, Arshiya A. Baig, et al., "Community Health Center Provider and Staff's Spanish Language Ability and Cultural Awareness," Journal of Health Care Poor Underserved, May 2014, pp. 527-545. For data on migration patterns of immigrants today, see e.g., "Changing Patterns in U.S. Immigration and Population Immigrants Slow Population Decline in Many Counties," The Pew Charitable Trusts, December 18, 2014, available at: http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2014/12/changing-patterns-in-us-immigration-and-population.

[16] "Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act," Kaiser Family Foundation, March 4, 2013, available at: http://kff.org/disparities-policy/fact-sheet/key-facts-on-health-coverage-for-low/; Genevieve M. Kenney, Jennifer M. Haley, Nathaniel Anderson, Victoria Lynch , "Children Eligible for Medicaid or CHIP: Who Remains Uninsured, and Why?," Academic Pediatrics, Volume 15, Issue 3, S36 - S43, May - June 2015, available at: http://www.academicpedsjnl.net/article/S1876-2859(15)00010-8/abstract.

[17] *See e.g.*, 42 C.F.R. §435.907(e); 45 C.F.R. §155.310(a)(2). Family members who are "non-applicants" should still be listed on the application because they are considered part of the household to determine eligibility for the individuals who are actually applying.

[18] 42 C.F.R. §435.907(f) and § 435.945(b) (Medicaid); 45 C.F.R. §155.302(d)(3) and 45 C.F.R. §155.320(e) (Marketplace). *See also*, "Systematic Alien Verification for Entitlements (SAVE) Program," available at: http://www.uscis.gov/save/about-save-program.

[19] Section 330 of the Public Health Service Act (Title 42 of United States Code (U.S.C.) Section 254b) provides funding for FQHCs and as a condition for receipt of this funding, FQHCs must ensure that "services shall be

available to all residents…without regard to method of payment or health status" (42 C.F.R. § 51c.303 (v)(3)) and cannot disclose information without consent or as required by law (42 C.F.R. § 56.111).

[20] *See e.g.*, "Immigration Enforcement: Know Your Patients' and Your Rights," National Immigration Law Center, July 2004, available at: http://nilc.org/document.html?id=578; "Enforcement Actions at or Focused on Sensitive Locations," a Memorandum to all ICE field office directors, special agents in charge, and Chief Counsel from John Morton, Director, U.S. Immigration and Customs Enforcement, Oct. 24, 2011, (stating "the sensitive locations covered by this policy include, but are not limited to, schools, hospitals...that "particular care should be exercised with any organization assisting children, pregnant women, victims of crime or abuse, or individuals with significant mental or physical disabilities."), available at: https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf.

[21] "FAQ on Public Charge," United States Citizenship and Immigration Services (USCIS), September 3, 2009, available at: http://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge. Long-term care, however, is a non-cash benefit that may be considered in the public charge evaluation.

[22] "Barriers to Immigrants' Access to Health and Human Services Programs," ASPE Issue Brief, April 2012, available at: http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.pdf.

[23] For helpful summary of the immigrant eligibility restrictions under PRWORA that apply still today, see "Overview of Immigrant Eligibility for Federal Programs," National Immigration Law Center, available at: http://www.nilc.org/table_ovrw_fedprogs.html.

[24] 8 U.S.C. § 1611(b).

[25] 8 U.S.C. § 1611(c); "Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA): Federal Public Benefit Interpretation; Notice Eligibility for Public Benefits Verification," U.S. Department of Health and Human Services, 63 Fed. Reg. 41658 (August 4, 1998); *see also*, "Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of ``Federal Means-Tested Public Benefit," U.S. Department of Justice, 62 Fed. Reg. 45256 (Aug. 26, 1997).

[26] 8 U.S.C. § 1611(b)(1)(D); Specifically, programs, services, or assistance which "(A) deliver in-kind services at the community level, including through public or private nonprofit agencies; (B) do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and (C) are necessary for the protection of life or safety." *See also*, "Final Specification of Community Programs Necessary for Protection of Life or Safety Under Welfare Reform Legislation," 66 Fed. Reg. 3613, 3616 (January 16, 2001).

[27] *See* 45 C.F.R. §152.2 for list of lawfully present immigrants eligible under the ACA. However, individuals granted Deferred Action Status for Childhood Arrivals (DACA) are not permitted to buy private health insurance or qualify for premium tax credits in the new marketplaces although they are lawfully present under immigration laws. For more information, see "FAQ: Exclusion of Youth Granted 'Deferred Action for Childhood Arrivals' from Affordable Health Care," National Immigration Law Center, September 25, 2013, available at: http://nilc.org/acadacafaq.html.

[28] *See e.g.*, "Instructions for Form 8962, Premium Tax Credit," Internal Revenue Service (2014), page 3, available at: http://www.irs.gov/pub/irs-pdf/i8962.pdf .

[29] Although private insurance companies may claim that an individual must provide an SSN to apply for coverage, no law requires it. Instead, undocumented immigrants can indicate "N/A" to the request for SSN and insurance companies can generate "dummy ID's" to enroll these individuals.

[30] 8 U.S.C. §1641. PRWORA also required that "qualified" immigrants wait 5 years before becoming eligible for full-scope Medicaid and CHIP. 8 U.S.C. § 1613. For more details on "qualified" and "non-qualified" immigrants for Medicaid and CHIP eligibility, see "Overview of Immigrant Eligibility for Federal Programs," National Immigration Law Center, October 2011, available at: http://www.nilc.org/table_ovrw_fedprogs.html .

[31] "Medicaid and CHIP Coverage of 'Lawfully Residing' Children and Pregnant Women," Centers for Medicare and Medicaid Services State Health Officials Letter 10-006, July 1, 2010, available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO10006.pdf. *See also* "State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children," 67 Fed. Reg. 61956 (October 2, 2002).

[32] Tricia Brooks, Joe Touschner, Samantha Artiga, Jessica Stephens, and Alexandra Gates, "Modern Era Medicaid: Findings From A 50-State Survey Of Eligibility, Enrollment, Renewal, And Cost-Sharing Policies In Medicaid And CHIP as of January 2015," Kaiser Family Foundation, January 20, 2015, available at: http://kff.org/health-reform/report/modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015.

[33] 42 U.S.C. § 1396b(v); In Medicaid expansion states, parents and childless adults with incomes below 138% FPL who are not eligible for non-emergency Medicaid due to immigration status (including legal and undocumented immigrants) are eligible for Emergency Medicaid. *See* "Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing," Centers for Medicare and Medicaid Services, December 2013, available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/FAQ-12-27-13-FMAP-Foster-Care-CHIP.pdf .

[34] 42 U.S.C. § 1396b(v)(3)(A)–(C). Organ transplants are explicitly excluded under Emergency Medicaid. 42 U.S.C. § 1396b(v)(2)(C).

[35] 42 C.F.R. § 440.255. For more information regarding the "sudden onset" requirement under Emergency Medicaid, see Jane Perkins, "Medicaid Coverage of Emergency Medical Conditions," 38 Clearinghouse Review, pp. 384-392 (Sept.-Oct. 2004), available at: http://povertylawprod.emphanos.net/sites/default/files/webfiles/chr_article_pdf/chr_2004_september_october_perkins_2.pdf.

[36] *See e.g.*, "Frequently Asked Questions about the Emergency Medical Treatment and Active Labor Act (EMTALA)," available at: http://www.emtala.com/faq.htm.

[37] *See e.g.*, Julia Paradise, Sara Rosenbaum, Peter Shin, Jessica Sharac, Carmen Alvarez, Julia Zur, and Leighton Ku, "Providing Outreach and Enrollment Assistance: Lessons Learned from Community Health Centers in Massachusetts," Kaiser Commission on Medicaid and the Uninsured, September 24, 2013, available at: http://kff.org/health-reform/issue-brief/providing-outreach-and-enrollment-assistance-lessons-learned-from-community-health-centers-in-massachusetts/.

[38] *See e.g.*, Teresa Nino, "Promotoras de Salud,"Office of Public Engagement, Centers for Medicare & Medicaid Services, October 2011, available at: http://www.cdph.ca.gov/programs/cobbh/Documents/Promotores%20de%20Salud%20HHS%20%28CMS%20%29.pdf; *see also*, "The Effectiveness of a Promotora Health Education Model for Improving Latino Health Care Access in California's Central Valley," available at: https://www.fresnostate.edu/chhs/cvhpi/documents/cms-final-report.pdf.

[39] 5 U.S.C. § 552a (The Privacy Act of 1974). *See generally*, "Overview of the Privacy Act of 1974," U.S. Department of Justice's Office of Privacy and Civil Liberties, available at http://www.justice.gov/opcl/overview-privacy-act-1974-2012-editionPrivacy Act of 1974.

[40] *See generally*, "Health Information Privacy," U.S. Department of Health and Human Services, available at: http://www.hhs.gov/ocr/privacy/index.html.

[41] For a summary of health-related privacy laws in California, see "Privacy Laws," California Department of Justice, available at: https://oag.ca.gov/privacy/privacy-laws; For best practices, *see e.g.*, "Improving the Patient Experience: Best Practices for Safety-Net Clinic Redesign," The Center for Health Design, March 2009, available at: http://www.chcf.org/publications/2009/03/improving-the-patient-experience-best-practices-for-safetynet-clinic-redesign#ixzz3Yaz7JVCP.

[42] In California, Pennsylvania, and New York, individuals can be pre-screened as potentially eligible for Emergency Medicaid similar to those who are eligible for full-scope Medicaid and may even receive a Medicaid card that they can present at the hospital or clinic.

[43] Oswaldo Hasbun Avalos, Kaylin Pennington, and Lars Osterberg, "Revolutionizing Volunteer Interpreter Services: An Evaluation of an Innovative Medical Interpreter Education Program," Journal of General Internal Medicine, June 6, 2013, pp. 1589-95, available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3832724/.