Immigrant Access to Health Benefits

A Resource Manual

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The Access Project is a national initiative of The Robert Wood Johnson Foundation, in partnership with Brandeis University's Heller Graduate School and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve health care and promote universal coverage, with a focus on people who are without insurance.

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The National Health Law Program is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, community-based organizations, the private bar, providers and individuals that work to preserve a healthcare safety net for the millions of uninsured or underinsured low-income people.

NHeLP seeks to provide a seat at the table for representatives of low-income people, to protect consumers in the emerging managed care systems, and to find creative financing solutions that also preserve government's responsibility as provider of last resort.

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Chapter 1 Medicaid and State Children's Health Insurance Program (SCHIP) for Immigrants

I. MEDICAID BASICS

A. What is Medicaid?

The Medicaid program was established by the federal government in 1965 as part of the Social Security Act to provide health care and services to certain groups of low-income people. Medicaid is the largest and most important public health insurance program in the country. In 1997, the Medicaid program covered 40.6 million people. Over half of all Medicaid enrollees are children under age 21.[1]

Although children are the largest group of beneficiaries, the Medicaid program is a critical source of health insurance for people who are elderly and who have disabilities. Medicaid pays for over half of all nursing home care. Medicaid dollars account for nearly 50 percent of all public funding for mental health and substance abuse treatment and 68 percent of dollars spent by state developmental disability service systems. Medicaid is also the primary payer of medical care for more than half of all adults living with HIV/AIDS and for 90 percent of all children with HIV/AIDS.[2]

The Medicaid program is operated jointly by the federal government and state governments. The federal government shares the cost of the program with the states and sets the basic rules concerning eligibility, scope of coverage, quality, and administration. However, within this framework, states have a great deal of flexibility to individualize their Medicaid programs and, under certain circumstances, can obtain waivers from some of the federal requirements.[3] Thus, state Medicaid programs vary greatly in terms of who can get Medicaid, what services are provided, and how the services are paid.[4]

The federal share of cost is called federal financial participation (FFP). FFP ranges from 50 to 83 percent, depending on poverty levels within the state. States pay providers for medical services and then submit claims to the federal government to obtain reimbursement of the federal share of costs.
At the federal level, the agency responsible for administration of the Medicaid program is the Health Care Financing Administration (HCFA).

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[1] For more information about the Medicaid program generally, see *Medicaid: A Primer*, Kaiser Commission on Medicaid and the Uninsured, August 1999, posted at *http://www.kff.org*.
[2] *Medicaid's Role for People with Aids, Fact Sheet*, The Henry J. Kaiser Family Foundation, December 1996.
[3] Medicaid's federal requirements are found at 42 U.S.C. §1396a et seq. Federal regulations implementing the Medicaid program are found at 42 C.F.R. §430 et seq.
[4] Every state must file a state plan with the federal government that describes the state's Medicaid program. Information about a state's Medicaid program should be available from the agency within the state responsible for its administration.

HCFA is headquartered in Baltimore and there are ten regional offices throughout the United States.

At the state level, the Medicaid program must be administered by a single state agency, usually the state human services agency or health department. Often, the welfare agency will also play an important role in making eligibility determinations.

B. Who can get Medicaid?

1. *Anyone has the right to apply for Medicaid, but not everyone can get it.* There are two major requirements:

    a. **The person must be poor or low-income.** As a general rule, a successful applicant for Medicaid must demonstrate that his/her income and resources fall below levels set by the state. The amount of income and resources that an applicant can have will depend on the specific limits set by the state, and the limits may vary between the different eligibility groups offered by the state.

    b. **The person must fit into a group that is covered by Medicaid.** It is not enough to be poor; you must also fit into the profile of one of the groups that Medicaid covers. Millions of poor men and women are ineligible for Medicaid because they do not fit the profile of any of the covered groups.[5]

2. *States must cover certain specified groups.* These groups are referred to as "mandatory categorically needy." They include:

    a. **Families with dependent children under Section 1931 of the Social Security Act.** These are primarily single parent families with incomes and resources that do not exceed eligibility standards established under the state's old Aid to Families with Dependant Children (AFDC) program that was in effect on July 16, 1996. Families with dependent children who meet the income and resource guidelines do not have to be on welfare to get Medicaid.

    b. **Families with dependent children moving from welfare to work.** If a family with at least one dependent child loses welfare or their Medicaid coverage under the Section 1931 standards because they obtained employment and had increased earned income, and if the family had been receiving 1931 Medicaid coverage in at least three of the six months

[5] Childless, nondisabled adults under age 65 generally are not eligible for Medicaid.

immediately before they became ineligible, the state must provide six months of *transitional* Medicaid. Transitional Medicaid is sometimes called Transitional Medical Assistance or TMA. The state must provide an additional six months of transitional Medicaid provided the family complies with certain income reporting requirements and the family's income does not exceed 185 percent of the federal poverty level.[6]

c. **Families with dependent children with increased child support.** If a family loses welfare or Medicaid coverage under Section 1931 because of increased child support or spousal support, the state must provide Medicaid for an additional four months.

d. **Children who receive federal adoption assistance or foster care maintenance payments.**

e. **Pregnant women.** Pregnant women are eligible for Medicaid if their income is less than 133 percent of the federal poverty level (FPL). Women who applied for and received Medicaid while they were pregnant remain eligible for Medicaid for all pregnancy and post partum services during the 60-day period beginning on the last day of the pregnancy.[7]

f. **Children.** Children age five or younger are eligible if family income is less than 133 percent of the federal poverty level. Children born after September 30, 1983 (who are less than 19 years old) are eligible if their family income is less than 100 percent of the federal poverty level. By September 30, 2003, states must cover children who are age six through 19 with family income up to 100 percent of the federal poverty level. (States have the option to cover these children immediately.)

g. **Infants.** Infants born to women who are eligible for and receiving Medicaid on the date of the child's birth are automatically eligible for Medicaid for one year from birth as long as the mother remains eligible.

h. **People who are aged, blind, and disabled.** In most states, all aged, blind, and disabled poor who get Supplemental Security Income (SSI) get Medicaid.[8] In a few states, such persons are

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[6] Federal poverty levels for 1999 are reproduced in a chart at Appendix A.

[7] It is clear that Medicaid has taken particular steps to ensure that needy pregnant women and children are covered through the program. As a result, a first-time pregnant woman can now qualify for Medicaid even if she has no other dependent children in the house, and a child may qualify for Medicaid although her/his parent does not.

[8] As of January 1998, the states where SSI recipients do not automatically get Medicaid are:

not automatically eligible. They must meet a "spend down" requirement. (See explanation of *medically needy* on the following page.)

i. **People receiving mandatory state supplements**. Medicaid must cover persons receiving mandatory state supplements.

j. **People with disabilities**. Under limited circumstances, states must provide Medicaid to people with disabilities who work, certain disabled adult children, and disabled widows or widowers.[9]

k. **"Pickle" people**. States must provide Medicaid to people who lose SSI because they have received a cost-of-living increase in their Social Security checks.

l. **Low-income Medicare beneficiaries.** States must provide Medicaid coverage to pay for Medicare Part A and Part B premiums, deductibles, and coinsurance for Medicare beneficiaries who have incomes at or below 100 percent of the federal poverty level and have resources that do not exceed twice the SSI resource eligibility standard.

3. *States have the option to provide Medicaid to other groups.* These are called the "optional categorically needy."[10] For example, states can decide to cover:

a. **People who are eligible for SSI but have not applied for it.**

b. **Children under state adoption assistance programs.** Most states cover this category of children.

c. **Optional targeted low-income children.** These are children who are eligible for Medicaid under the State Children's

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Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

[9] There are two programs for the working disabled: 1) "qualified severely impaired individuals" who work and a) were eligible and received SSI benefits on the basis of blindness or disability in the previous month, and were eligible for Medicaid, b) continue to be blind or have the disabling condition, c) except for their earnings, they would be eligible for SSI, d) not receiving Medicaid benefits would seriously inhibit their ability to continue or obtain employment, and e) their earnings are insufficient to make up for the loss of SSI, Medicaid, and attendant care services;
and 2) "qualified disabled and working individuals" who have exhausted their extended Medicare coverage and would otherwise be entitled to purchase extended Medicare Part A benefits, and a) have incomes at or below 200% of the FPL, b) have resources at or below twice the SSI standard, and c) are not otherwise eligible for Medicaid.

[10] For the most part, if the state elects to provide Medicaid coverage, it must follow the eligibility criteria of the most closely related cash-assistance program; i.e., for families and children, it would be Section 1931, and for the aged, blind, and disabled, it would be SSI.

Health Insurance Program (SCHIP). (See discussion at Section III.)

d. **Pregnant women and infants with incomes up to 185 percent of the federal poverty level.** The state gets to decide the exact percentage of poverty that it will cover.

e. **Persons who are age 65 or older or disabled with incomes up to the federal poverty level.** Again, the state gets to determine the exact percentage of poverty it will cover. Only a few states have chosen to cover this group of the aged and disabled.

4. *States have the option to provide Medicaid to people who are "medically needy".* The medically needy are people who would qualify for Medicaid except that their incomes are too high. The medically needy are able to meet the costs of daily living—food, shelter, and clothing—but if a medical crisis occurs or if they have ongoing chronic medical problems, they cannot afford the care they need. To qualify for Medicaid, these individuals must spend their excess income on medical expenses during a specified period before they qualify for Medicaid. This is usually called "spend down" or "share of cost." States choosing to cover the medically needy must at least cover pregnant and postpartum women and children under age 18.[11]

C. What does Medicaid cover?

States must cover a basic package of health care services including hospital care, nursing home care, physician services, laboratory and x-ray services, family planning services, health center and rural health center services, nurse midwife, and nurse practitioner services. Medicaid also provides a comprehensive children's health benefit package known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT covers a wide range of screening, diagnostic, and treatment services for children under age 21.

States have the option to provide additional services under Medicaid, including prescription drugs, institutional care for people with mental retardation, home and community-based care for the elderly, case management services, personal care and other services for individuals with disabilities, and adult dental and vision care.

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[11] The following states cover the medically needy: California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, West Virginia and Wisconsin, as well as the District of Columbia.

D. Applying for Medicaid benefits

1. *Place of application.* Applicants for Medicaid ordinarily apply through the state or local welfare agency. States must also accept and process Medicaid applications for pregnant women and children at locations other than welfare offices. These locations must include public hospitals, community and migrant health clinics, and other facilities serving large numbers of poor pregnant women and children.

2. *Form of application.* States have considerable flexibility to design their Medicaid applications. Many states are moving to simplify and shorten their forms and are reducing the amount of information that applicants must provide during the application process. Many states have also developed joint application forms for their SCHIP and Medicaid programs and are using mail-in applications.

3. *State of residence.* States must provide Medicaid to eligible residents of the state, including residents who are absent from the state. State residency requirements are:

    a. **As a general rule, the state of residence is where the individual is living with the intention to remain there permanently or for an indefinite period of time.**[12]

    b. **States are prohibited from denying Medicaid to an otherwise qualified resident of the state because:**

        - The individual's residence is not maintained permanently or at a fixed address.
        - Of a durational residence requirement.
        - Of a temporary absence from the state.

    c. **There are special rules for migrant and other transient workers.** An individual involved in work of a transient nature or who goes to another state seeking employment has two choices:

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[12] Residency can be proven by showing a driver's license, pay stubs, rent receipts, bills, or proof that the applicant's children are enrolled in school. It may be difficult for people with border crossing cards and for non-immigrants such as tourists, students, and temporary workers to prove state residency because their status as non-immigrants implies that they do not intend to stay in the United States; however, it is not impossible. In California, a recent case held that the Department of Health Services could not automatically conclude that people who possess border crossing cards or temporary visas are not California residents. They could use other forms of identification, such as those listed above, and residency determinations should be made only after all the evidence is considered. Latino Coalition for a Healthy California, San Francisco Superior Court Case No. 987374 (injunction issued August 11, 1998). It is advisable to see an immigration counselor for additional information.

- The individual can establish residence in the state in which he/she is employed or is seeking employment.

- The individual may wish to claim one particular state as his/her domicile or state of residence.

4. *Use of Social Security numbers.* All applicants for and recipients of Medicaid benefits must supply the state agency with a Social Security number (SSN.) However, non-applicant household members (such as a parent applying for benefits on behalf of a minor child) are not required to supply Social Security numbers. States have no legal basis for denying an application based upon the failure of a nonapplicant to supply his or her SSN.

5. *Declaration of citizenship or satisfactory immigration status.* Applicants for Medicaid must sign a declaration under penalty of perjury and provide documentation that the applicant is a citizen or national of the United States or has satisfactory immigration status (is a qualified immigrant).

   For children only, current federal policy permits states to accept self-declaration of citizenship status without further verification. States, however, may require further documentation and verification as a condition of eligibility.

   Note: It is unclear whether states will still be allowed to accept a child applicant's self-declaration of citizenship status after new regulations implementing the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) go into effect. These new rules give states the option to accept third-party declaration, but do not authorize states to accept self-declaration.

   Applicants must be given a reasonable amount of time to provide the required documentation.

   States must verify immigration status through the Systematic Alien Verification for Entitlements (SAVE). However, states must provide Medicaid eligibility pending verification of immigration status, if the applicant meets all nonimmigration Medicaid eligibility requirements. For more information about verification requirements, see Chapter 5.

6. *Income verification.* Federal rules only require that states verify income after the initial eligibility determination has been made. States must have an income and eligibility verification system for this purpose. To the extent possible, states verify income by using an applicant's Social Security number to request information from other federal and state agencies. The applicant must be told in writing, at

the time of application, that the agency will be requesting this information.

7. *Presumptive eligibility.* Certain categories of applicants may be able to receive Medicaid on a temporary basis without waiting for the state to make an eligibility determination. This is called presumptive eligibility. They include:

    a. **Pregnant women.** At state option, pregnant women may be determined presumptively eligible for Medicaid if their gross family income does not exceed the highest income standard under which they may be eligible. Only "qualified" providers can make determinations of presumptive eligibility and the period of eligibility lasts only a short time. If a pregnant woman fails to apply for Medicaid before the last day of the month following the month in which she was determined presumptively eligible for Medicaid, her Medicaid benefits will end. Entities that are qualified to make presumptive eligibility determinations for pregnant women include community health centers, hospital clinics, and other specified Medicaid providers determined by the state to be capable of making the necessary income determinations.

    b. **Children.** In 1997, Congress amended the Medicaid statute to give states the option to provide presumptive eligibility for children under age 19. A period of presumptive eligibility begins on the date when a "qualified entity" determines that a child's family income is not greater than allowed and would end on the date the child's Medicaid eligibility was finally determined or, if no Medicaid application was filed, the last day of the next month, whichever came first. Entities that are qualified to make presumptive eligibility determinations for children include Medicaid providers and entities which are authorized to determine a child's eligibility for services under the Head Start Act, the Child Care and Development Block Grant, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and those which have been determined by the state to be capable of making the necessary income determinations.

E. Recipients' rights (see Appendix B)

Federal laws and regulations provide protections for those applying for and receiving Medicaid benefits. These include:

1. *The right to apply for Medicaid on the day that assistance is sought.*

2. *The right to bring someone with you to help you with the application.*

3. *The right to translation services and translated written materials.*

4. *The right to have a decision made about your application within 45 days, or if the application is based on disability, within 90 days of applying.*

5. *The right (in most states) to receive coverage beginning with the third month prior to the date of application.* This is called *retroactive* Medicaid.

6. *The right to receive medically necessary treatment and services.* While a state has some authority to limit the amount, duration and scope of coverage, the state may not restrict the amount, duration or scope of coverage based solely on the individual's diagnosis, type of illness, or condition.

7. *The right to receive treatment and services without discrimination based on national origin, race, color, sex or disability.*

8. *The right to free choice of providers, unless the state has obtained a waiver that requires beneficiaries to obtain their services through a managed care organization.*

9. *The right to continue to receive Medicaid until ineligible to receive Medicaid.*

10. *The right to prior notice and to a fair hearing to contest any decision by the Medicaid agency to deny, terminate or reduce benefits.*

II. IMMIGRANT ELIGIBILITY FOR MEDICAID

Prior to enactment of PRWORA, states were required to provide Medicaid to all legally present immigrants who met Medicaid eligibility requirements. PRWORA fundamentally changed immigrants' access and eligibility in several significant ways:

- States can choose to provide Medicaid coverage (or not) to all qualified immigrants who were legally present in the United States on or before August 22, 1996, the date the welfare law was enacted.[13]

- Certain groups of legally present immigrants who previously were eligible for Medicaid, such as Persons Residing Under the Color of Law (PRUCOL), are no longer eligible for Medicaid.

[13] Note: All states but Wyoming have opted to provide Medicaid to pre-enactment immigrants.

- Many new immigrants are barred from receiving Medicaid and other federal means-tested public benefits for their first five years in the United States.

- States can establish eligibility rules for post-August 22, 1996 entrants who are no longer subject to the five-year bar.[14]

- New sponsor-deeming of income rules and enforceable affidavits of support create additional barriers to access. (See Chapter 4.)

A. Basic rules: pre-enactment immigrants

To be eligible for Medicaid, a noncitizen who established residency in the United States prior to August 22, 1996 (the date the welfare law was enacted) must:

1. *Meet the eligibility requirements of the Medicaid program.*

2. *Meet the PRWORA definition of a "qualified" immigrant.*

B. Qualified immigrant defined

To be "qualified," an immigrant must have one of the following immigration statuses:

1. *Legal Permanent Resident (LPR).* A person who has been granted legal permanent residence status (a green card holder) and thus is entitled to remain in the United States indefinitely.

2. *Refugee.* A person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and who obtains the status while abroad.

3. *Asylee.* A person who has been determined to meet the same requirements as a refugee, but who was already present in the United States at the time he/she obtained asylum.

4. *Immigrant who has had deportation withheld.*[15] A person who establishes that he/she would be likely to face persecution if returned to his/her home country.

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[14] Virginia, Oregon, Ohio, Idaho, Mississippi, and Wyoming report they will not provide Medicaid to post-enactment immigrants following the five-year bar. These decisions, however, are subject to change because the provision is not effective until August 2001.

[15] Withholding of removal was formerly known as withholding of deportation.

5. *Immigrant granted parole for at least one year.* The Department of Justice has discretionary authority to permit certain persons or groups to enter the United States in an emergency or because it serves an overriding public interest. Parole may be granted for humanitarian, legal, or medical reasons.

6. *Immigrant granted conditional entry.* A person who immigrated based upon a marriage that occurred within two years of obtaining permanent residence.

7. *Battered immigrant and her child/children.* This status requires a pending or approved visa petition filed by a U.S. citizen or LPR spouse/parent, a self-petition pursuant to the Violence Against Women Act (VAWA), or an application for cancellation of a removal/suspension of deportation under VAWA, and whose need for benefits have a substantial connection to the battery or cruelty. It also applies to the parent of a battered child and the child of a battered spouse.

8. *Immigrants born in Canada who possess at least 50 percent blood of the American Indian race, or who are members of certain Indian tribes.*

C. "Not qualified" immigrants

Not qualified immigrants are not eligible for Medicaid, except in emergencies, and include all other noncitizens, such as:

1. *Persons Residing Under Color of Law (PRUCOL)*[16] *including:*
    a. **Immigrants granted indefinite voluntary departure.**
    b. **Immigrants residing in the United States under orders of supervision.**
    c. **Immigrants who have lived in the United States continuously since January 1, 1972.**
    d. **Immigrants granted stays or suspension of deportation.**
    e. **Applicants for asylum and family unity.**
    f. **Applicants for adjustment of status.**

[16] This category generally means that INS is aware of the person's presence but has no intent to deport him/her. However, PRUCOL is defined differently in different jurisdictions and for different programs.

g. **Other immigrants whose departure the INS does not contemplate enforcing.**

2. *Undocumented immigrants.*

3. *Nonimmigrants such as students and foreign visitors.*

D. Special rules for SSI-linked Medicaid recipients

1. *Any individual who is receiving SSI is automatically eligible for Medicaid.* However, under PRWORA, an immigrant can only receive SSI (and therefore Medicaid) if he or she was receiving SSI on August 22, 1996.

2. *An immigrant who was not receiving SSI on August 22, 1996, can establish eligibility for SSI (and therefore Medicaid) if he or she:*

   a. **Is a qualified immigrant.**

   b. **Was legally residing on August 22, 1996.**

   c. **Meets the SSI disability standard at the time of application.**

3. *Elderly immigrants (age 65 or over) who are qualified immigrants and meet the SSI income and resource standards but who are not disabled are not eligible for SSI.* However, depending on income and resources, an elderly qualified immigrant may qualify for Medicaid under an optional Medicaid eligibility category.

E. New entrants—special rules for immigrants who arrive in the United States after the PRWORA

1. *Qualified immigrants who arrive in the United States on or after August 22, 1996, are barred from receiving Medicaid and other federal means-tested public benefits for the first five years after they enter the country with a "qualified" status.*

2. *After five years, although qualified immigrants are no longer barred from receiving Medicaid and other federal means-tested public benefits, many likely will remain ineligible because of the new rules on sponsor-to-immigrant deeming of income.* (See Chapter 4.)

F. Mandatory coverage of certain qualified immigrants

States must provide Medicaid for certain groups of qualified immigrants regardless of their date of entry. Except as noted below, these immigrants are

not subject to the five-year bar that applies to immigrants who arrive on or after August 22, 1996. Specifically:

1. *Refugees are eligible for their first seven years in the United States.*

2. *Asylees are eligible for the first seven years after asylum is granted.*

3. *Immigrants whose deportation has been withheld are eligible for the first seven years from the date withholding is granted.*

4. *Cuban and Haitian entrants are eligible for the first seven years in the United States.*

5. *Amerasian immigrants are eligible for the first five years in the United States.*

6. *Honorably discharged U.S. military, active duty military personnel and their spouses and unmarried dependent children (regardless of date of entry) are eligible.*

7. *Legal Permanent Residents whose residency was established prior to August 22, 1996, must be covered if they have 40 credited quarters of Social Security coverage.*

8. *Legal Permanent Residents who enter the country after August 22, 1996, are subject to the five-year bar.* However, once they have been in the country for five years and have 40 credited quarters of coverage under the Social Security Act, they too must be covered, provided they received no federal means-tested public benefits in any such qualifying quarter for any period beginning after December 31, 1996. Generally, these are people who have a ten- year work history.

III. THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

A. Basic program features

The State Children's Health Insurance Program was established by Congress in 1997 as part of the Balanced Budget Act. The program provides nearly $40 billion over a ten-year period to enable states to provide health insurance to uninsured, "targeted low-income children." Targeted low-income children are children under the age of 19 whose family incomes meet state-specified guidelines and who are not eligible for Medicaid or any other health insurance.

States have the option to structure their SCHIP program as a separate state health insurance program or to expand their Medicaid programs. States

choosing to establish a separate state child health insurance program have considerable flexibility to decide how to structure their programs. States can decide who is eligible, what the benefit package will be, and how much families must pay in premiums, copayments, and deductibles. If the state chooses to implement SCHIP by expanding its Medicaid program, then all Medicaid rules apply.

States must have screening procedures to ensure that only targeted low-income children are provided coverage using the new funds. In addition, if a Medicaid-eligible child is identified through the screening, they are to be enrolled in the Medicaid program and not in the separate state child health insurance program if the state has established one.

All 50 states, the District of Columbia, and all U.S. territories have developed SCHIP programs that have been approved by the federal government. Each program is unique and many have unusual or catchy names such as Badgercare, Healthy Families, ChildcarePlus, and HuskyCare.

On November 8, 1999, HCFA proposed new regulations to implement SCHIP that include many important consumer protections for separate SCHIP programs. As of the date that this manual was published, the rules have not been finalized.

B. SCHIP and immigrants

1. *Eligible children include:*

    a. **Children born in the United States.** U.S. born children are U.S. citizens, even if their parents are not legally present. These children are eligible for SCHIP subject to the same eligibility requirements that apply to any other U.S. citizen child.

    b. **All qualified legal immigrant children who were in the United States before August 22, 1996.**

    c. **Refugees, asylees, and certain Cuban, Haitian, and Amerasian immigrants to the same extent that they are eligible for Medicaid.**

    d. **Unmarried, dependent children of honorably discharged veterans and active duty service members of the Armed Forces, regardless of the date of entry.**

    e. **Battered children or children of battered spouses.**[17]

[17] Similar to the requirement for a qualified immigrant under Medicaid, this also requires a pending or

2. *Ineligible children include:*

    a. **Like Medicaid, the SCHIP program is a "federal means-tested public benefit."** Therefore, the welfare law's restrictions on immigrant eligibility also apply to SCHIP. As a general rule, children not qualified are ineligible for SCHIP. Qualified immigrant children who enter the country on or after August 22, 1996, also are *not* eligible for SCHIP for the first five years after entry unless they are exempted from the five-year bar.

C. Applying for benefits

1. *The SCHIP statute does not require applicants to provide Social Security numbers when applying for benefits.* Thus, if a state has opted for a separate, non-Medicaid SCHIP program, applicants should not be required to provide SSNs. Note: **Proposed** federal rules implementing the SCHIP program would prohibit states from requiring an applicant to provide a social security number.

2. *States must verify citizenship and immigration status in accordance with procedures discussed in Chapter 5.*

D. SCHIP funding for services to immigrant communities

Under the SCHIP program, states can receive federal matching funds to pay for specialized types of expenditures, but only to the extent that the expenditures do not exceed 10 percent of the state's total expenditures on SCHIP benefits. The types of specialized expenditures subject to the 10 percent cap include:

1. *Outreach.* In order to facilitate the enrollment of eligible children, many states are using these federal matching funds for outreach to low-income communities. Outreach strategies can be targeted to immigrant communities to identify and enroll children living in immigrant families who are uninsured and eligible for federal public benefits.

2. *Other child health assistance.* Other child health assistance refers to health benefits coverage that is in addition to the basic benefit package that the state is providing.

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approved visa petition filed by a U.S. citizen or LPR spouse/parent, a self-petition pursuant to the Violence Against Women Act, or an application for cancellation of a removal/suspension of deportation under VAWA, and a child or children whose need for benefits is substantially connected to the battery or cruelty. This also includes the parent of a battered child and the child of a battered spouse, 8 U.S.C. §1641 (c.)

3. *Administrative costs.*

4. *Health services initiatives.* Health services initiatives are activities that protect the public health, protect the health of individuals, or improve or promote a state's capacity to deliver public health services and/or strengthen resources needed to meet public health goals.

   Note: All immigrant children, regardless of their status or date of entry, can participate in, and benefit from, health services initiatives. Health services initiatives such as health education activities, school health programs, and direct services such as newborn screening and lead testing can be targeted to low-income, immigrant communities including temporary communities of migrant or seasonal farm workers.

E. Obtaining a variance of the 10 percent cap

Under certain circumstances, states can obtain a variance from the 10 percent cap. Getting a variance allows a state to spend more money on health services initiatives and other specialized SCHIP expenses. A state that obtains a variance is no longer subject to the 10 percent cap limitation. While a state can receive additional amounts of federal matching funds for specialized SCHIP expenditures, the amount will be limited because of the need to preserve cost-effectiveness.

To obtain a variance, a state must:

1. *Provide coverage to some portion of SCHIP enrollees through a community-based delivery system.* A community-based delivery system is a network of providers that must have a contract with the state to provide care under the SCHIP program.

2. *Provide cost-effective coverage.* This means that the amount paid to the community-based delivery system on a federal fiscal year, per child basis, must not be greater than the amount that would otherwise have been paid for that child to receive coverage under Title XXI.

IV. MAXIMIZING MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS

The complexities of Medicaid and SCHIP eligibility rules are daunting. Even highly trained attorneys have difficulty wading through the impenetrable text. Yet, buried within this oftentimes baffling array of rules and regulations, are many opportunities to maximize the potential of the Medicaid and SCHIP programs to cover more low-income families including immigrants. Here are some suggestions:

1. *Eligibility rules*. States have many choices and considerable flexibility to liberalize eligibility rules to provide expanded Medicaid access. The first step is finding out who your state covers and whether the state has exercised any of the various options to expand coverage. Has the state opted to provide Medicaid coverage to all pre-enactment and post-enactment qualified immigrants? Has the state opted to use more generous financial methodologies and standards under Section 1931 to reach single and two-parent families with more income than Medicaid traditionally covers? Has the state opted to implement presumptive eligibility for pregnant women and for children? Does the state cover any of the optional categories of beneficiaries? Has the state considered a health services initiative under SCHIP?

2. *Application forms.* Review application forms to determine whether they contain information or request information that might deter immigrants or members of their families from seeking benefits. Is the form simple and easy to understand? HCFA's Model SCHIP/Medicaid Joint Application Form for Children is available at *http://www.hcfa.org.*

3. *Process*. Applying for benefits can be difficult. Families may be compelled to spend long hours waiting to submit paperwork or talk to caseworkers, who may be unfriendly, and even hostile. Offices and office hours may not be convenient for those who work or who rely on public transportation. Applicants may be asked to return to the welfare office multiple times and to produce multiple copies or forms of verification. Much of this is unnecessary and only serves to deter people from following through and filing their applications. Applicants who do not speak or read English well or appear to be foreign born often face additional barriers and receive little help or encouragement. Find out and document what an applicant seeking Medicaid or SCHIP benefits confronts, then work to improve the process.

4. *Language and cultural access*. For immigrants, lack of translation services and translated, understandable written materials create additional barriers to access. The extent to which the Medicaid and SCHIP eligibility process comply with Title VI of the Civil Rights Act of 1964 (see Chapter 7, Section I(a)), must be thoroughly assessed. Complaints may be forward to the U.S. Department of Health and Human Services (HHS), Office of Civil Rights. (See Chapter 7.)

5. *Outreach to families with children.* States are engaged in a variety of outreach strategies primarily directed at enrolling more children in Medicaid and SCHIP. These activities should be assessed to ensure that outreach strategies are targeted to immigrant communities.

6. *Outreach to the elderly.* Immigrants who are 65 or older and have lived in the United States since before August 22, 1996, can establish eligibility for SSI if they are found to be disabled. However, the Social Security Administration has found that many older adults applying for SSI fail to allege common health problems associated with aging that may establish their eligibility. Outreach and education about the eligibility process and standards can help older immigrants obtain needed benefits.

7. *Recipient education.* There is no substitute for educating the community about the Medicaid and SCHIP programs and providing them with the information they need to navigate the system on their own. A number of states and communities have employed effective strategies for consumer involvement. The National Health Law Program has several publications addressing how to involve and empower consumers in the Medicaid program.

Chapter 2 Health Benefit Programs Available to All Noncitizens Regardless of Status

Since enactment of PRWORA, the perception in many communities is that noncitizens are no longer entitled to any federal or state public health benefits. In reality, noncitizens remain eligible to receive a wide range of publicly funded health benefits. Moreover, as discussed below, some of these benefits are available to all noncitizens, regardless of their immigration status or when they entered the country.

The following health benefit programs and services are available to all noncitizens, regardless of their immigration status or when they entered the country.

I. EMERGENCY MEDICAID

A. General rule

As a general rule, states are prohibited from providing Medicaid to immigrants, unless they are legal permanent residents or have a special immigration status that "qualifies" them to receive benefits.[18] An exception to this general rule is ***Emergency Medicaid***--a form of Medicaid that only pays for treatment of an "emergency medical condition".

B. What is an emergency medical condition?

An emergency medical condition is defined as:

The sudden onset of a medical condition (including 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:

1. *Placing the patient's health in serious jeopardy.*
2. *Serious impairment to bodily functions.*
3. *Serious dysfunction of any bodily organ or part*[19]

C. Qualifying for Emergency Medicaid

To qualify for Emergency Medicaid, the immigrant must:

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[18] 42 U.S.C. §1396b(v)(1).
[19] 42 U.S.C. §1396(v)(3); 42 C.F.R. §440.255.

1. *Otherwise qualify for Medicaid.* This means that the immigrant must satisfy all Medicaid financial and categorical eligibility requirements. (See Chapter I, Section II, "Immigrant Eligibility for Medicaid")

2. *Meet state residency requirements.* (See State Residence, Chapter 1.)

D. Applying for Emergency Medicaid

Hospitals generally can assist an immigrant to complete an application for Emergency Medicaid. Because immigration status is not relevant to the eligibility decision, the immigrant should not be required to:

1. *Sign a written declaration (under penalty of perjury) that he or she is a citizen, national, or qualified alien.*

2. *Provide documentation of citizenship or alien status.*

3. *Provide a Social Security Number.*

Examples:

Jane was pregnant when she came to visit her family in the United States on a tourist visa. She decided to stay in the United States. Her visa expired and a week later, she went into early labor. Is she eligible to receive Emergency Medicaid to deliver her child? Yes, if she intends to live and stay in the state and she meets financial and categorical eligibility requirements of the Medicaid program.

Isabelle is a single mother and has two children, ages two and four. She has high blood pressure and difficulty breathing. Her children are U.S. citizens, but she has no papers. She arrives in the emergency room complaining that she has felt dizzy and short of breath for the past two weeks. She is not in acute distress. Is she eligible to receive Emergency Medicaid? If Isabelle meets the financial eligibility criteria for Medicaid and is a state resident, she could be eligible for Emergency Medicaid. However, based on the facts, it is not clear that her condition meets the definition of an emergency medical condition.

Marco is 28 years old and has been working as a migrant laborer. Recently, however, he has had no work and no income. He has been sleeping in a homeless shelter. One night, another shelter resident beat him up. He suffered a swollen lip, lost a couple of teeth, and cracked two ribs. He went to the emergency room for treatment. Is Marco eligible for Emergency Medicaid? Probably not. Although Marco meets the financial eligibility requirements, as a single person with no dependents he does not fit into a category that Medicaid covers.

II. ACCESS TO EMERGENCY CARE UNDER EMTALA[20]

A. General rules

EMTALA of 1986--the Emergency Medical Treatment and Active Labor Act is a federal law designed to prevent hospital emergency rooms from refusing to treat people who need emergency medical assistance but have no health insurance or other means to pay the bill. It is sometimes called the federal antidumping statute.

Under EMTALA, any hospital that participates in Medicare and has an emergency room must:

1. *Examine every patient who comes to the emergency room to determine whether they have an "emergency medical condition," or are in "active labor."* If they do, the hospital must provide stabilizing treatment within the capacity of the facility.

2. *Not transfer a patient prior to stabilization unless the physician on duty (or another qualified medical person with the doctor's permission) certifies in writing that the medical benefits of transfer outweigh the increased risks to the individual or unborn child, because proper medical treatment is unavailable there.*

B. When is a transfer to another hospital or health care facility appropriate?

A transfer is appropriate only when:

1. *It is made to a facility that has space and qualified personnel to treat the patient and has agreed to accept the transfer and to provide appropriate treatment.*

2. *The transferring hospital provides all medical records relating to the emergency medical condition available at the time of the transfer.*

3. *The transfer is effected through qualified personnel and by suitable transportation equipment.*

4. *Reasonable steps have been taken to obtain a written consent from individuals who refuse treatment or transfer.*

C. Other important provisions of EMTALA

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[20] 42 U.S.C. §1395dd. For further discussion of EMTALA, see *Access to Emergency Medical Care: Patients' Rights and Remedies*, National Health Law Program, October 1991.

1. *Nondiscrimination.* Hospitals with specialized capabilities or facilities, such as burn units or neonatal intensive care, cannot refuse to accept an appropriate transfer of a patient who requires the specialized care if the hospital has the capability of treating the patient.

2. *No delay in examination of treatment.* Hospitals may not delay the screening or treatment of a patient to inquire about the individual's health insurance status or proposed method of payment.

3. *No retaliation.* Hospitals may not take adverse action against or penalize a physician or other qualified medical person who refuses to authorize the transfer of an individual with an unstabilized emergency medical condition, or any hospital employee because the employee reports a violation of the statute.

4. *Compliance.* Hospitals must have and enforce policies to ensure compliance with the law.

5. *Notice.* Hospitals must post signs in emergency rooms alerting individuals including women in labor of their right to examination and stabilizing treatment. They must also post information indicating whether the hospital participates in Medicaid.

   Note: If the hospital serves patients who do not speak English, the hospital is required to translate notices and to provide translation services. See Chapter 7 for further discussion of language access requirements.

6. *Penalties.* Hospitals and physicians that fail to comply with EMTALA can be fined up to $50,000 by the U.S. Department of Health and Human Services for each violation. Hospitals can also lose the right to participate in Medicare and can be sued by individuals for damages for personal injury or to obtain a court order to require the hospital to comply with the law.

III. HILL-BURTON OBLIGATIONS

The Hill-Burton Act[21] is a federal law that provided hospitals and nursing homes with construction and renovation grant funds. In return, the facilities accepted two distinct obligations: the uncompensated care obligation and the community service obligation.

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[21] 42 U.S.C. §291c.

A. The uncompensated care obligation

Facilities receiving Hill-Burton funds agree to provide a "reasonable volume of services to persons unable to pay." The annual amount of free care provided must be worth 10 percent of all grants received or 3 percent of their annual operating costs. The obligation lasts only for 20 years after the date of the grant, so many facilities are no longer bound by it, but many are. To obtain a current list of facilities with an uncompensated care obligation go to *http://158.72.83.3/osp/dfcr/obtain/hbstates.htm.* Facilities with uncompensated care obligations are supposed to post notices about their program in the facility. These notices must be easy to read and printed in languages other than English if a significant part of the community has limited English proficiency.

B. The community service obligation

Unlike the uncompensated care obligation, the community service obligation never ends. It prohibits Hill-Burton facilities from discriminating on any ground unrelated to an individual's need for services or the availability of the needed services in the facility. Hill-Burton facilities are obligated to accept all persons able to pay for their care, either directly or through insurance coverage including Medicaid, Medicare, and state or local government programs. The facility also has a duty to take reasonable steps to ensure that the facility and its services are available to public assistance beneficiaries and to notify patients of any governmental programs for which they may be eligible. Notably, Hill-Burton hospitals must maintain an open emergency room for everyone in the service area, even those unable to pay.

C. Enforcing Hill-Burton

The U.S. Department of Health and Human Services Office for Civil Rights is responsible for investigating complaints of hospitals that refuse to honor their community service or uncompensated care obligations. Hill-Burton obligations also may be enforced by filing an action in court.

IV. FEDERALLY QUALIFIED HEALTH CENTERS

A. General rules

Federally Qualified Health Centers (FQHCs)[22] receive grants from the federal government to provide health services to underserved populations without regard to a person's ability to pay.

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[22] 42 U.S.C. §254b et seq.

B. Populations served

Underserved populations include migratory and seasonal agricultural workers, the homeless, public housing residents, and people who face barriers in accessing health services because they have difficulty paying for services, because they have language or cultural differences, or because there is an insufficient number of health professionals/resources available in their community.

C. Services that must be provided

All FQHCs must provide:

1. *Basic health services.* Basic health services include primary care; diagnostic, laboratory and radiology services, cancer and other disease screening; well child services; immunizations against vaccine-preventable diseases; screening for elevated blood lead levels, communicable disease and cholesterol; eye, ear, and dental screenings for children; family planning services and preventive dental services; emergency medical and dental services; and pharmaceutical services as appropriate to a particular health center.

2. *Services that help ensure access to basic health and social services.* Such services include case management; referrals to other medical and health-related providers; outreach, transportation, and interpretive services; health education; and help applying for benefits, including Medicaid.

V. MIGRANT HEALTH CLINICS

The U.S. Department of Health and Human Services also makes grants to public and private nonprofit health clinics that agree to provide services to migratory agricultural workers, seasonal agricultural workers, and their families.[23] The required services and obligations are almost identical to those of community health clinics except that migrant health clinic funds can only be used to serve migrants. Funding for this program is inadequate; the program serves only about 15 percent of the estimated farm worker population in need.

VI. RURAL HEALTH CLINICS[24]

The Health Care Financing Administration designates certain clinics in rural areas to receive grant assistance. Services at these clinics include physician,

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[23] 42 U.S.C. §254b.
[24] 42 U.S.C. §1395x(aa).

nurse practitioner, and physician assistance services. Many of the services and payment rules that apply to community health clinics also apply to rural clinics.

VII. SHORT-TERM, NON-CASH, IN-KIND EMERGENCY DISASTER RELIEF

Immigrants, regardless of immigration status or date of entry, are eligible to receive short-term, non-cash, emergency disaster relief[25] such as emergency shelter, food, and clothing.

VIII. NON-MEDICAID FUNDED PUBLIC HEALTH SERVICES

Immigrants, regardless of immigration status or date of entry, are eligible to receive non-Medicaid funded public health assistance[26] including:

- Immunizations for children and adolescents.
- HIV/AIDS-related care and treatment including services funded under the Ryan White Care Act.
- Tuberculosis screening, diagnosis, and treatment.
- Sexually transmitted disease screening, diagnosis, and treatment.
- Testing and treatment of symptoms of other communicable diseases even if the communicable origin is ruled out.

IX. COMMUNITY-BASED PROGRAMS NECESSARY TO PROTECT LIFE AND SAFETY

A. General Rule

The PRWORA authorized the U.S. Attorney General, in her sole and unreviewable discretion, to designate other community programs, services and assistance for which all immigrants, regardless of immigration status, will continue to be eligible.[27]

B. Requirements for designation

To be eligible for designation, the program, services, or assistance must meet three criteria:

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[25] 8 U.S.C. §1611(b)(1)(B).
[26] 8 U.S.C. §1611(b)(1)(C).
[27] 8 U.S.C. §1611(b)(1)(D).

1. *Be delivered in-kind at the community level, including through public or private nonprofit agencies.*

2. *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.*

3. *Be necessary for the protection of life and safety.*

C. Designated programs

Programs, services, and assistance designated by the attorney general include:

1. *Police, fire, ambulance, transportation, sanitation, and other regular, widely available services.*

2. *Crisis counseling and intervention programs, such as services and assistance relating to child protection, adult protective services, violence and abuse prevention, including victims of domestic violence or other criminal activity, or treatment of mental illness or substance abuse.*

3. *Short-term shelter or housing assistance for the homeless, for victims of domestic violence, or for runaway, abused, or abandoned children.*

4. *Programs, services, or assistance to help individuals during periods of adverse weather conditions.*

5. *Soup kitchens, community food banks, senior nutrition programs such as meals on wheels, and other such community nutritional services for persons requiring special assistance.*

6. *Medical and public health services (including treatment and prevention of diseases and injuries) and mental health, disability, or substance abuse assistance necessary to protect life and safety.*

7. *Activities designed to protect life and safety of workers, children, and youths or community residents.*

8. *Any other programs, services, or assistance necessary for the protection of life and safety.*

X. HEALTH SERVICES INITIATIVES UNDER SCHIP

Immigrant children, regardless of status or date of entry, may be eligible for services under a Health Services Initiative. Health Services Initiatives are special programs funded with money from the States' Children's Health Insurance Program.[28]

XI. ADDITIONAL STATE AND COUNTY PROGRAMS

Be sure to check your local state statutes to see if nonqualified immigrants have access to other programs beyond those mandated by federal law. Different states and counties vary in their provision of additional health programs for immigrants and their children regardless of their immigration status.[29] Also, most counties provide health care services to low-income persons at county facilities and clinics, regardless of immigration status.

XII. MAXIMIZING ACCESS TO SERVICES AVAILABLE TO ALL IMMIGRANTS REGARDLESS OF STATUS AND DATE OF ENTRY—RECOMMENDATIONS

Despite immigrant eligibility for Emergency Medicaid and other non-Medicaid funded services, obtaining care and coverage can be problematic.

- There may be little public awareness of the availability of these programs for non-qualified immigrants.
- Some states control access to Emergency Medicaid through restrictive—and arguably illegal—policies.
- Even if eligible for benefits, immigrants may be turned away or treated differently than other individuals in need of emergency and public health treatment because of discrimination.[30]
- Many immigrants have been discouraged from applying for any public benefits based on their fear of being identified as a "public charge" or being deported by Immigration and Naturalization Service for applying and/or receiving any such public benefits.

Here are some ideas to improve immigrant access to Emergency Medicaid:

- Review state policies and application forms to determine whether the policies and forms hinder or facilitate access to Emergency Medicaid. Do the forms require applicants to provide a Social Security number?

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[28] 42 U.S.C. §1397aa et seq. See Chapter 1 for additional information about Health Services Initiatives.
[29] See Chapter 3 for further discussion of state and local programs.
[30] Such discrimination may be actionable pursuant to Title VI, EMTALA, and the Hill-Burton Act.

Do they ask questions about immigration status, which are not relevant to the eligibility determination? Do they ask questions about the immigration status of family members? Do they require unnecessary documentation?

- Survey public and private hospitals to determine whether they are: complying with EMTALA, making Emergency Medicaid available, and providing appropriate translation and interpreter services. Collect stories from immigrants about their experiences in hospital emergency rooms.

- Advocate for precertification of eligibility for Emergency Medicaid. At least two states, California and Massachusetts, have procedures in places that allow nonqualified immigrants to pre-qualify for Emergency Medicaid. Immigrants found eligible for Emergency Medicaid are issued a Medicaid card that entitles them to emergency care only. Notably, utilization of emergency care by immigrants in California far surpasses utilization in all other states. According to the Urban Institute, for example, undocumented immigrants in California are ten times more likely to receive Emergency Medicaid than undocumented immigrants in the other 49 states. Although more research is needed to account for the wide discrepancy in utilization rates, pre-certification appears to have a positive impact on public and provider awareness of Emergency Medicaid coverage. Pre-certification of Medicaid eligibility for emergency care also gives providers assurance that they will get paid for services they provide and therefore probably helps to increase provider participation.

- Educate the immigrant community about their eligibility for Emergency Medicaid, EMTALA protections, public health services, and community-based services necessary to protect life and safety. Reassure immigrants that they cannot be denied a green card or be deported solely for seeking and receiving Medicaid or any other healthcare services for which they qualify.

- Identify gaps in coverage (e.g., post-stabilization treatment, preventive care for nonqualified immigrants, and immigrants who arrived after August 22, 1996), identify allies, and work together to develop and fund programs to fill the gaps.

Chapter 3 State and Local Programs[31]

Before welfare reform, state and local governments funded programs to provide health care to low-income immigrants who did not qualify for federally funded programs such as Medicaid. Now, if states want to provide state and local benefits to undocumented immigrants, the welfare law requires states to affirmatively pass legislation to provide for such eligibility. The welfare law also allows states to impose new restrictions on qualified immigrants' access to state and local public benefits.

Fortunately, many states that had programs in place prior to the welfare law continued to fund them, and some have committed new funds to cover additional initiatives. Still, immigrant health access remains a patchwork. Although an exhaustive discussion of state and local programs is beyond the scope of this manual, this chapter summarizes characteristics of state-funded programs that address immigrant health needs.

I. LIMITED COVERAGE

Most state-funded initiatives provide limited coverage. Coverage may be limited to particular populations such as children or immigrants who are living in nursing homes. Some states limit coverage by types of service such as prenatal care. Many limit coverage to those who were receiving benefits when the welfare reform law was enacted or some other date—in effect "grandfathering" coverage and avoiding having to cut people off who otherwise would have lost their benefits.

II. RESTRICTING ACCESS

States have applied sponsor-deeming rules, residency requirements, and other restrictions that limit immigrants' eligibility for coverage.

III. EXAMPLES OF STATE PROGRAMS

There is tremendous variation in state-funded programs and the extent to which immigrants are covered. States with the most extensive coverage include California, Washington, Hawaii, Connecticut, Massachusetts, Rhode Island, Minnesota, New Jersey, New York, Pennsylvania, and Wisconsin.[32] However, no state has come close to replacing the health benefits lost when the welfare law was enacted or filled in all the gaps that predate the law. For example:

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[31] For an excellent discussion of how states have responded to immigrants' assistance needs after welfare reform, see W. Zimmerman and K. Tumlin, *Patchwork Policies: State Assistance for Immigrants Under Welfare Reform*, The Urban Institute, May 1999. See also Appendix C.

[32] Zimmerman and Tumlin, Table 18.

A. Covering Persons Residing Under Color of Law

Eight states are continuing to provide the equivalent of Medicaid coverage to PRUCOL immigrants. These states are: California, Michigan, Pennsylvania, Connecticut, Missouri, Rhode Island, Delaware, and Maine. Another 11 states are providing coverage to PRUCOL immigrants, but coverage is limited to particular populations or types of care. In Washington, post-enactment PRUCOL immigrants are subject to a one-year residency requirement.

B. Prenatal care

Twenty-one states provide coverage for prenatal care to legally present immigrants. Ohio limits coverage only to immigrants who were legally present prior to August 22, 1996. Seventeen states provide coverage for prenatal care for undocumented immigrants.

C. Long-term care and other special populations

Twenty-three states provide some long-term care coverage for legally present immigrants. Most states only cover people who were already receiving benefits.

- In New York, only immigrants who were receiving Medicaid and living in a licensed health care facility as of August 4, 1997 are covered. New York also provides coverage to immigrants who were receiving Medicaid and were diagnosed with AIDS as of August 4, 1997.

- In Texas, only PRUCOL immigrants who were receiving benefits as of August 22, 1996 remain eligible.

- Ohio and Alaska only cover PRUCOL immigrants who were present prior to the welfare law.

- California and Minnesota provide long-term care to undocumented immigrants.

D. Health insurance for the elderly and people with disabilities

Nineteen states have state-funded health insurance programs that provide some coverage to immigrants. In most states, however, coverage is less than that provided under Medicaid. For example,

- New Jersey has two state-funded health insurance programs for uninsured people who are elderly or disabled. The Charity Care

program covers all uninsured individuals with incomes up to 200 percent of the Federal Poverty Level. There is a sliding-fee scale for individuals with incomes between 200 percent and 300 percent of FPL. There is no verification requirement for Charity Care and both post and pre-enactment qualified immigrants are eligible. The GA-Medical program covers elderly and disabled residents who qualify for the state's General Assistance program. However, only pre-enactment qualified immigrants are eligible. The program is also time-limited. Non-citizens who are eligible to naturalize are limited to six months of assistance.

- Washington has three programs that provide health care to uninsured elderly and disabled residents: GA-Unemployable, the Medically Indigent program, and the Basic Health Plan. All three programs are open to qualified immigrants, regardless of when they entered the country; however, sponsor-deeming applies (although it has not yet been implemented).

- Connecticut has a state-funded General Assistance Medical program. Noncitizens must live in the state for 6 months to qualify for these services.

- Wyoming has a state-funded prescription program that covers three prescriptions per month as well as oxygen. Qualified immigrants are eligible.

E. Health insurance coverage for families with children

Twenty states have some form of health insurance coverage for families with children. All provide coverage to pre-enactment qualified immigrants; three restrict the access of post-enactment qualified immigrants. For example:

- In California, counties are mandated to provide General Relief, including medical assistance to needy persons who do not qualify for federally funded assistance. The program eligibility rules and services vary by county. Some counties impose time limits.

- Several states such as Massachusetts and Colorado have programs that provide coverage for children, but not their parents.

F. Coverage for new entrants

Only four states have opted to provide state-funded Medicaid coverage for immigrants arriving on or after August 22, 1996, the date the welfare law was enacted. These states—Illinois, Maryland, Virginia, and Rhode Island—all

limit coverage to immigrant children and pregnant women.[33]

IV. MAXIMIZING STATE AND LOCAL BENEFIT PROGRAMS

Advocacy is key to securing and maintaining funding at the state and local levels for programs that provide health care to immigrants. States with the strongest safety nets are also the states with organized coalitions that work to influence political leadership. Clearly, much can be done at the state and local level to direct resources to fill the gaps and serve the health needs of immigrant communities. Here are some suggestions:

- Identify the programs currently funded by state and local dollars. Find out about how they operate and who they cover. Are there eligibility rules or restrictions that make immigrant access difficult or unlikely? If so, work to eliminate those barriers.

- Explore how well these programs are utilized by immigrants. If utilization is low, find out why. Create an outreach campaign to let communities know about the programs that exist.

- Identify the community's needs. There are many gaps to fill so you will need to prioritize. Find out what other states and communities have done. Create an action plan and then work collaboratively with others to build support to expand coverage.

- Institutional health care providers such as hospitals can be powerful allies in these efforts.

[33] Congress is currently considering several proposals to give states the option to restore Medicaid benefits to some new entrants.

Chapter 4 New Responsibilities for Sponsors: Affidavits of Support/Sponsor Deeming of Income

As part of the immigration process, many, but not all, immigrants will need to have a sponsor. A sponsor is someone who is willing to sign an agreement to provide financial support to the immigrant. The agreement is called "an affidavit of support."

Prior to the enactment of PRWORA and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) in 1996, INS and consular officials could require that a sponsor sign an affidavit of support to provide assurances that the immigrant would not become a "public charge." Once signed, the income of the person signing the affidavit could be deemed available to the immigrant for three years.

The PRWORA and IIRIRA substantially changed the rules regarding affidavits of support and sponsor deeming of income. As explained in this chapter, the new changes impose greater legal liability on sponsors and make it more difficult for new immigrants to qualify for public benefits even after they have lived in the United States for five years.

I. AFFIDAVITS OF SUPPORT[34]

A. Definition

An affidavit of support under PRWORA and IIRIRA is a *legally enforceable* agreement between the sponsor and the government whereby the sponsor agrees to provide sufficient support to maintain an immigrant at 125 percent of the FPL. The new affidavit of support is Form I-864.

B. Effective date

The new Form I-864 became effective on December 19, 1997. Almost all family-based immigrants who have consular interviews or who are filing adjustment of status applications on or after December 19, 1997, must file the new Form I-864.

C. Duration

New affidavits of support are legally binding upon the sponsor until:

1. *The sponsor dies.*

[34] 62 Fed. Reg. 54,346-56, Oct, 20, 1997 adding 8 C.F.R. Part 213a.

2. *The immigrant:*

    a. **Becomes a U.S. citizen.**

    b. **Obtains 40 quarters of creditable Social Security coverage.**

    c. **Leaves the United States and gives up Legal Permanent Resident (LPR) status.**

    d. **Dies.**

D. Extent of sponsor liability

1. If a sponsored immigrant subject to a new affidavit of support receives a federal means-tested public benefit[35] that has not been specifically exempted from this requirement, the sponsor is responsible for repayment of the benefit within 45 days of a *request* for repayment by a benefit-granting agency.

2. Any federal, state, or local government entity can take legal action against the sponsor to enforce the affidavit of support.

3. The government has up to ten years from the date on which the immigrant last received the public benefit to bring an action for repayment against the sponsor.

4. The sponsor must keep INS informed of her/his current address. Failure to do so can result in fines ranging from $2,000 to $5,000.

E. Means-tested public benefits

Only receipt of nonemergency Medicaid, SCHIP, Temporary Assistance for Needy Families (TANF), SSI, and food stamps triggers sponsor liability for repayment.

F. State option to use deeming rules

States have the option to use the sponsor deeming rules when determining immigrants' eligibility for state and local benefit programs. States cannot use sponsor deeming rules to determine eligibility for:

- Emergency Medicaid.

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[35] The following have been defined as federal means-tested public benefits: Supplemental Security Income, food stamps, TANF, and Medicaid/SCHIP.

- Short-term emergency relief.
- Child nutrition programs.
- Public health assistance for immunizations.
- Testing and treatment of communicable diseases.
- Foster care and adoption assistance.
- Services delivered in-kind, at the community level, that are necessary to protect life or safety.

G. Immigrants who must submit "new" affidavits (Form I-864)[36]

Almost all family-based immigrants, including employment-based immigrants when the petitions are also family-based (such as when a relative is the employer/petitioner/sponsor or a relative owns 5 percent or more of the employing company), are required to submit Form I-864. Exceptions are made only for:

1. Widows/widowers (who must have been married for two years to a citizen, not to an LPR).
2. Battered spouses (pursuant to the Violence Against Women Act).

H. Who can be a sponsor?

Under the new affidavit of support rules, a petitioner must be a sponsor. A sponsor can be anyone who is:

1. *A U.S. citizen, national or legal permanent resident.*
2. *At least 18 years of age.*
3. *Domiciled in the United States or any U.S. territory or possession.*
4. *Able to meet income/assets requirements.*

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[36] The old I-134 form may still be used for categories of immigrants who are not required to use the I-864 form, such as students, parolees, or diversity immigrants. U.S. INS News Release, *Questions and Answers—Public Charge*, June 2, 1999.

II. SPONSOR DEEMING

Since the early 1980s, several federally funded programs such as AFDC, SSI, and food stamps have automatically deemed income and resources to immigrants from their sponsors (those persons who sponsor their entry into the United States) to determine the immigrants' eligibility for, and amount of benefits available under, each of those programs. Under PRWORA, all federal means-tested public benefits, including Medicaid and SCHIP, are subject to new sponsor-to-immigrant-income-deeming rules.

A. Deeming defined

Deeming means that in determining financial eligibility, the benefits' granting agency counts the income and resources of the sponsor and the sponsor's spouse as though they were available to the sponsored immigrant.

B. Duration of the attribution period

Immigrants subject to new affidavits of support are subject to sponsor-to-immigrant deeming of income until they naturalize or have 40 qualifying quarters of coverage.

C. Exceptions to deeming rules:

1. *Benefit granting agencies may not apply sponsor deeming rules to*:

    a. **Refugees.**

    b. **Asylees.**

    c. **Battered spouses and their children for one year (where the need for benefits has a substantial connection to the battery or cruelty and may be extended if the abuse has been recognized by a court, Administrative Law Judge or the INS).**

    d. **Indigent immigrants who have been abandoned by their sponsor and would otherwise go without food of shelter (limited to one year).**

2. *Some types of benefits are exempt from the deeming rules*. These include:

    a. **Emergency Medicaid.**

    b. **Short-term, noncash, in-kind emergency disaster relief.**

c. **Assistance or benefits comparable to benefits provided under the National School Lunch Act and the Child Nutrition Act of 1966.**

d. **NonMedicaid-funded, public health assistance for immunizations and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease.**

e. **Foster-care and adoption assistance.**

f. **In-kind services such as soup kitchens, crisis counseling, and shelters.**

3. *State options to apply sponsor-deeming rules to state benefits.*

a. **In determining the eligibility and the amount of benefits of an immigrant for state public benefits, states have the option to count the income and resources of the immigrant's sponsor and his/her spouse.**

b. **States may not apply sponsor immigrant deeming rules to exempt programs such as Emergency Medicaid, short term, noncash, in-kind disaster relief, public health assistance, programs designated by the attorney general, child nutrition and school lunch programs, among others.**

II. CURRENT SPONSOR LIABILITY ISSUES— RECOMMENDATIONS

The stricter Affidavit of Support and sponsor deeming rules were implemented to ensure that no recent immigrant would become a "public charge" in the future. Since both the INS and the State Department have broad discretion in deciding the likelihood of an applicant's becoming a public charge, this area is gray and constantly changing. This makes advocates' role in advising immigrant sponsors very difficult. However, there are advocacy efforts that can maximize the chances that eligible immigrants will receive public benefits, ensure that sponsors will not be discouraged from completing an affidavit of support to sponsor immigrants, and prevent an immigrant from being disqualified for public benefits due to the new sponsor deeming rules:

- Review your local and state benefit agencies' policies to determine if any agency requires the sponsor to repay any benefit payments. The decision to demand payment is discretionary, therefore public benefit

granting agencies, particularly those providing health benefits, may be persuaded that becoming a collection agency is antithetical to its mission and is not cost-effective.

- Monitor your local agencies' interpretation of the federal statute and regulations governing affidavits of support and sponsor deeming rules. Because the agencies have so much discretion to interpret and implement the federal statute and regulations, they can exercise their authority to interpret ambiguous provisions of the statute in ways that are more favorable to the immigrant.

Chapter 5 Verification of Status, Confidentiality, and Reporting

One of the major barriers to health care access for immigrants is their fear that their use of benefits and accessing of health services may be reported to the INS and that the mere use of benefits will have an adverse impact on their immigration status. Recent changes in the welfare and immigration laws have heightened immigrants' concerns. This chapter reviews the rules governing verification, reporting, and confidentiality and provides some suggestions to help minimize immigrants' concerns about being reported to the INS.

I. VERIFICATION OF IMMIGRATION STATUS, GENERALLY

Under PRWORA and IIRIRA, the U.S. Attorney General was required to issue new regulations establishing a system to verify the status of immigrants applying for federal public benefits and to establish a fair and nondiscriminatory procedure for a person to establish proof of citizenship. Within 24 months of the date of the regulations, state agencies that administer federal public benefits must have a verification system in place that complies with the regulations.

The U.S. Attorney General issued interim guidance on verification of citizenship and immigration status on November 17, 1997.[37] The U.S. Attorney General's proposed regulations were published on August 4, 1998.[38] They have not yet been finalized.

Most of PRWORA's verification requirements are not new. Since 1986, various benefit-granting agencies, including state Medicaid agencies, have been required to verify immigration status using a system operated by the INS called the Systematic Alien Verification for Entitlements system (SAVE). The INS has refined and operated SAVE for over ten years. The Attorney General's interim guidance and proposed rules are based on the SAVE system. However, there are some new requirements.

II. VERIFICATION OF IMMIGRATION STATUS AND THE MEDICAID AND SCHIP PROGRAMS

A. Signed declaration of proper immigration status

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[37] See *Interim Guidance on Verification of Citizenship, Qualified Alien Status, and Eligibility Under Title IV*, of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 62 Fed. Reg. 61344, November 17, 1997.

[38] See *Verification of Eligibility for Public Benefits*, 63 Fed. Reg. 41662, August 4, 1998 (proposed rule).

An applicant for Medicaid or SCHIP must provide a signed declaration under penalty of perjury that he or she is a citizen or national of the United States, or a qualified immigrant.

If the applicant is a child or is not competent, another individual must complete the same written declaration under the same terms and penalties. However, if an immigrant is applying for benefits on behalf of another person, federal law only allows the agency to verify the status of the person who will actually be receiving the benefits.

An applicant who is not a citizen or national of the United States, and who is not a qualified immigrant, is not required to provide a declaration of satisfactory immigration status.

B. Documentation

In addition to the signed declaration, adult citizens, nationals, and qualified immigrants who are applying for Medicaid must provide the state with documentation of citizenship or immigration status and the date upon which that status was granted.

Under current federal policy, children who are citizens and who are applying for either Medicaid or a separate state SCHIP program may establish their citizenship on the basis of self-declaration. States are permitted to require further verification as a condition of eligibility.[39] Self-declaration may not be permitted once the Attorney General's regulations are finalized.

Children who are qualified immigrants must present documentation of their immigration status. States must verify this status using SAVE.

C. Methods of documentation

1. *Acceptable documentation for U.S. citizens and nationals include:*

    a. **Birth certificate.**

    b. **Religious record showing the date of birth or individual's age at the time the record was made.**

    c. **United States passport.**

    d. **Report of Birth Abroad of a Citizen of the United States (Form FS-240).**

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[39] *State Medicaid Director's Letter*, Health Care Financing Administration, September 10, 1998.

e. **Certification of Birth (INS Form FS-545).**

f. **U.S. Citizen I.D. Card (INS Form I-197).**

g. **Naturalization Certificate (INS Forms N-550 or N-570).**

h. **Certificate of Citizenship (INS Forms N-560 or N-561).**

i. **Northern Mariana Identification Card (issued by the INS).**

j. **American Indian Card with a classification code "KIC".**

k. **Contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1988), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands.**

l. **Evidence in lieu of documentation: Under the Attorney General's proposed rule, states have the option to accept a written declaration made under penalty of law from one or more third parties indicating a reasonable basis for personal knowledge that an applicant who cannot produce evidence of U. S. nationality is a U. S. national.**

2. *Acceptable documentation of qualified immigrant status consists of the following:*

a. **Legal Permanent Resident.** INS Form 1-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

b. **Refugee**. INS Form I-94 annotated with stamp showing entry as refugee and date of entry to the United States; INS Forms I-688B annotated "274a.12(a)(3)", I-766 annotated "A3", or I-571.

c. **Asylee.** INS Forms O-94 annotated with stamp showing grant of asylum; a grant letter from the INS Asylum Office; Forms I-688B annotated "274a.12(a)(5)" or I-766 annotated "A5."

d. **Alien whose deportation has been withheld.** Order of an Immigration Judge showing deportations withheld and the date of the grant, or INS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10."

e. **Alien granted parole for at least one year by the INS.** INS Form I-94 annotated with stamp showing grant of parole and a date showing granting of parole for at least one year.

f. **An alien granted conditional entry under immigration law in effect before April 1, 1980.** INS Form I-94 with stamp showing admission under §203(a)(7) of the INA, refugee, conditional entry; or INS Forms I-688B annotated "274a 12(a)(3)" or I-766 annotated "A3."

E. Expired and missing documents

An applicant who presents expired INS documents or is unable to present any documentation of his or her immigration status should provide the Medicaid agency with his alien registration number. If the immigrant is unable to provide his/her alien registration number, the Medicaid agency will refer the immigrant to the local INS district office to obtain evidence of his/her status.

Medicaid agencies are required to provide applicants with a reasonable amount of time to provide documentation and must provide Medicaid eligibility pending verification of immigration status if the applicant meets all other nonimmigration Medicaid eligibility requirements.

F. Duty to verify immigration status

1. *Federal benefit-granting agencies.* All federal benefit-granting agencies, including state agencies administering federal programs and provider organizations must verify immigration status using procedures established by the Attorney General.

2. *State and local benefit-granting agencies.* Under PRWORA, state and local benefit-granting agencies are not required to verify immigration status. However, under immigration laws, states are authorized to require applicants to provide proof of satisfactory immigration status and they have considerable flexibility to use the SAVE system or establish their own verification procedures.

3. *Nonprofit charitable organizations.* Under PRWORA, nonprofit charitable organizations that provide federal, state, and local public benefits are not required to determine, verify, or otherwise require proof of an applicant's eligibility for such benefits based on the applicant's status as a U.S. citizen, a U.S. noncitizen, national, or qualified alien. To be eligible for this exemption, an organization must be both "nonprofit" and "charitable" (see glossary).

   A nonprofit charitable organization cannot be penalized for providing federal public benefits to an individual who is not a U.S. citizen, U.S.

noncitizen national, or qualified alien, except when it does so either in violation of independent program verification requirements or in the face of a verification determination made by a nonexempt entity.

G. Nondiscrimination

Various federal civil rights laws and regulations prohibit discrimination by governmental and private entities on the basis of race, color, national origin, gender, religion, age, and disability.[40] Therefore, verification procedures must be administered in a nondiscriminatory way. Providers and benefit granting agencies are prohibited from singling out individuals who look foreign or requiring certain groups or individuals to provide additional documentation. All similarly situated individuals should be treated in the same manner.

In recognizing the "particular potential for discrimination on the basis of national origin," the Attorney General's interim guidance warns against "obvious or subtle" forms of discrimination, ranging from:

1. *Denials or delays of determinations of eligibility for benefits because of race, color, or national origin.*

2. *Denials because the applicants "have ethnic surnames or origins outside the U.S."* or because they "look or sound foreign" or actions based on assumptions of such characteristics.

3. *Imposition of additional eligibility requirements on ethnic or racial minorities because of their ethnicity or race.*[41] "It may be discriminatory to demand a specific applicant present three documents to establish her identity merely because she speaks Spanish or looks Asian, while allowing English-speaking persons and non-Asians to present only one identity document. It may also be a violation of Title VI to assume, based on an applicant's national origin, that his or her documents are fraudulent."

H. Exempt programs

Some benefits are not federal public benefits or are exempt from the law. If the federal program does not provide a "federal public benefit" or is otherwise exempt, the benefit provider is not required to, *and should not attempt to*, verify an applicant's status, unless otherwise required or

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[40] They include *Title VI of the Civil Rights Act of 1964*, 42 U.S.C. §2000d *et seq.*; §504 of the *Rehabilitation Act of 1973*, 29 U.S.C. §794, the *Americans with Disabilities Act of 1990*, 42 U.S.C. §12101 *et seq.*, the *Age Discrimination Act of 1975*, 42 U.S.C. §6101 *et seq.*, and the *Fair Housing Act*, 42 U.S.C. §3601 *et seq.*

[41] The guidance explains that there is no single immigration document that will establish every immigrant's qualifications to receive benefits under PRWORA.

authorized to do so by law, because all immigrants, regardless of their immigration status, are eligible for such benefits.

I. Determine whether the applicant is eligible for benefits under the general program requirements

In most circumstances, a provider should determine whether an applicant otherwise meets the specific program requirements for benefit eligibility before initiating the verification process.

III. PRIVACY AND CONFIDENTIALITY

The Medicaid program operates under strict privacy protections. By law, federal and state Medicaid authorities must:

- Safeguard information regarding applicants for and recipients of Medicaid benefits.[42]

- Not disclose information to an outside entity unless it relates directly to the administration of the state plan.[43]

When implementing verification requirements:

- Benefit-granting agencies should be sensitive to privacy interests. Citizenship and immigration status information should be used only for purposes of verifying the applicants' eligibility for benefits.

- Governmental entities may use the information to the extent provided under PRWORA (see reporting requirements below).[44]

The Privacy Act[45] and state and local privacy protections and program requirements may also provide protection for immigrants.[46]

IV. REPORTING

There is much confusion and ambiguity concerning PRWORA's new reporting requirements.

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[42] §1902(a)(7) of the *Social Security Act.*

[43] Id. State Medicaid agencies, for example, are prohibited from providing information about the receipt of benefits or the dollar amount of those benefits to the INS, the State Department, or immigration judges. The only exception would be if the disclosures were necessary to assist the state to collect outstanding debts incurred for the receipt of benefits paid. See *Letter from Sally Richardson to State Medicaid Directors*, December 17, 1997.

[44] Interim Guidance on Verification of Citizenship, 62 Fed. Reg. 61346, November 17, 1997.

[45] 5 U.S.C. 552a

[46] For example, *California Welfare & Institutions Code*, §10500 states that persons administering public assistance shall secure aid "without attempting to elicit any information not necessary to carry out" the program.

A. Mandatory reporting under Section 404

1. *PRWORA Section 404 requires agencies that administer SSI, housing assistance programs under Section 6 and 8 of the U.S. Housing Act of 1937, or block grants under TANF programs to make a quarterly report to the INS of the name and other identifying information of persons the agency knows are not legally present in the United States.*

   This provision does *not* apply to the Medicaid or other health programs. However, in many states, the same agency that is responsible for TANF eligibility determinations is also responsible for making Medicaid eligibility determinations. Forty-eight states actually use a single or combined application form for TANF and Medicaid.

B. Preemption of "sanctuary ordinances"

1. *PRWORA, Section 434, and IIRIRA, Section 642, both contain provisions that are intended to preempt sanctuary ordinances.* These are ordinances that have been adopted by over 20 jurisdictions to protect immigrants who report crimes or seek assistance from public authorities.

2. *Both provisions prohibit restrictions on communication of information with the INS regarding the citizenship or immigration status of any individual.* Although these provisions do not negate existing privacy protections, they create enormous potential for breaches in confidentiality.

V. RECOMMENDATIONS TO MINIMIZE CONCERNS ABOUT REPORTING AND CONFIDENTIALITY

PRWORA's reporting and verification requirements are having a major negative impact on immigrant access to health services. Immigrants are discouraged from applying for Medicaid for fear of being reported to the INS despite their eligibility. The following recommendations provide suggestions to protect their rights and privacy:

- To the greatest extent possible, urge your state to permit self-attestation and third-party declarations as alternatives to requiring an applicant to produce documentary evidence that the applicant is a U.S. national.

- Monitor your state verification and reporting procedures, as well as your state privacy laws. Some state policy directives concerning verification and reporting have been confusing, and sometimes contrary to federal guidelines. For example, in New York, Social Securities Law Section 123(3) provides that "every local district is

required to report identifying information to the 'department' regarding any alien known to be unlawfully in the United States." Advocates in New York are seeking clarification to minimize the risk that undocumented immigrants who seek emergency care and other health services will be reported to INS in violation of federal law and policy.

- Applicants who are very old or are mentally incapacitated may have difficulty producing the types of documentation required under existing policies. Civil rights laws including Title VI and the American Disabilities Act may help win accommodations that make it easier for some applicants to prove their status.

- Advocate for separate applications for those programs requiring verification and reporting and for those that do not. In most states, the agency responsible for processing TANF applications is also responsible for processing Medicaid applications, and most states are using a single application for both programs.

- If they don't ask, they can't tell. Make sure that your state application procedures only ask for information that is absolutely necessary to make the eligibility determination. Eligibility workers never need to ask whether an applicant is undocumented or not lawfully present. If the information is not being collected, it cannot be reported.

- Publicize the confidentiality protections of the Medicaid statute. Include them on the application forms.

- Minimize the potential for workers and others to make unauthorized disclosures by making sure your state agency has clear policies and rules about the process for appropriate communications with INS. This is especially important considering an agency's obligation to comply with civil rights laws.

- Train eligibility workers so they clearly understand the verification and reporting requirements for the different federal and state benefit programs. Eligibility workers and their supervisors are likely to be confused about their reporting obligations, and sorting them out may be easier said than done. For example, in the District of Columbia, the Office of Income Maintenance (which is responsible for processing TANF, food stamp, and Medicaid applications) distributed a notice informing recipients that the agency is required by law to inquire as to immigration status and report the information to INS in almost all situations where a recipient would be applying for benefits, including Medicaid benefits. This notice was subsequently withdrawn. There have also been reports that eligibility workers insist that all parents produce Social Security Numbers and verification, even when only

the child is applying for benefits. These actions are clearly wrong and are sending an incorrect message to immigrants.

- Ask your state and local agencies to make it clear to applicants that only those applicants who are receiving covered federal benefits are required to provide verification of immigration status. Applications for medical assistance often routinely ask for Social Security Numbers and other identifying information contributing to immigrants' fear of being reported to INS. Although HCFA State Medicaid Manual Section 3211.9 makes clear that "not qualified" immigrants who are undocumented do not have to provide a Social Security Number in order to receive Emergency Medicaid, the failure or refusal to fill in the blanks on a preprinted form may itself raise anxiety.

- Encourage your governor, cabinet secretary, department head, or other appropriate state official to issue executive orders to clarify and coordinate reporting requirements to assure confidentiality and protection of antidiscrimination laws.

- If any public or private agency operating any program or activity receiving federal funds or other federal financial assistance appears to be making determinations based on race, color, or national origin in violation of civil rights laws, consider pursuing a complaint with the Office of Civil Rights. (See Appendix D.)

Chapter 6 Public Charge Determinations

Under U.S. immigration law, a person who is likely to become a "public charge" can be excluded from entering or reentering the United States as an immigrant, denied permanent resident status, or, under very limited circumstances, deported. Immigrants' fear of being found a public charge, especially in the wake of PRWORA, has deterred many immigrants from seeking and accepting public benefits, including health care benefits, even when they are lawfully entitled to receive them.

On May 26, 1999, the Immigration and Naturalization Service issued clarifying guidance and a proposed rule on public charge determinations.[47] The guidance and rule provide comprehensive information about how and under what circumstances public charge determinations are made. Among other things, the guidance and rule provide: 1. a clear definition of the term "public charge" and 2. a description and list of the kinds of benefits that will and will not result in a public charge finding. This chapter describes the new guidance and its potential to improve immigrants' access to health care.

I. THE MEANING OF PUBLIC CHARGE

Public charge is a term used by the INS to identify an immigrant who has or is likely to become primarily dependent on the government for subsistence as demonstrated either by:

- Receipt of public cash assistance for income maintenance.
- Institutionalization for long-term care at government expense.

Note: Keep in mind that public charge determinations have nothing to do with whether or not an immigrant is eligible to receive a public benefit. Benefit-granting agencies such as the Medicaid agency or the welfare department do not make public charge determinations.

A. Receipt of public cash assistance

The types of public benefits considered to be public cash assistance for income maintenance and therefore relevant to the public charge determination include:

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[47] *Inadmissibility and Deportability on Public Charge Grounds: Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, Proposed Rule and Notice, 64 Fed. Reg. 28676, May 26, 1999.

1. *Supplemental Security Income.*

2. *Temporary Assistance to Needy Families.*

3. *State and local cash assistance programs for income maintenance (such as General Assistance).*

B. Cash benefits not considered public cash assistance

Some types of cash benefits are *not* considered to be public cash assistance for income maintenance. These include:

1. *Supplemental "cash" benefits that are paid to TANF recipients that are excluded from the term "assistance" under TANF program rules.*[48]

2. *Cash benefits that are not intended for income maintenance such as: the Low-Income Home Energy Assistance Program (LIHEAP),*[49] *which pays benefits to help low-income families purchase heating oil and fuel; food stamp benefits paid in cash;*[50] *payments made to help families pay for child care;* [51] *educational assistance; non-recurring, and short-term crisis benefits.*

3. *Cash benefits that have been earned, such as government pension benefits, veterans' benefits, and Social Security benefits under Title II.*[52]

C. Institutionalization for long-term care at government expense

The guidance and proposed rule do not clearly define what is meant by institutionalization for long-term care at government expense. The guidance and rule do make clear that short-term institutionalization for periods of rehabilitation do not demonstrate primary dependence on the government.

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[48] TANF regulations list the following exclusions: 1) nonrecurrent, short-term benefits that: i) are designed to deal with a specific crisis situation or episode of need, ii) are not intended to meet recurrent or ongoing needs; and, iii) will not extend beyond four months; 2) work subsidies i.e., payment to employers or third parties to help cover the costs of employees' wages, benefits, supervision, and training; 3) supportive services such as child care and transportation provided to families who are employed; 4) refundable earned income tax credits; 5) contributions to, and distributions from, Individual Development Accounts; 6) services such as counseling, case management, peer support, child care information and referral, transitional services, job retention, job advancement, and other employment-related services that do no provide basic income support; and, 7) transportation benefits provided under a Job Access or Reverse Commute project, pursuant to section 404(k) of the Act, to an individual who is not otherwise receiving assistance. 45 CFR 260.31.

[49] See 42 U.S.C. §8621 et seq.

[50] See e.g., 7 U.S.C. §2026 (b).

[51] See the Child Care and Development Block Grant Program (CCDBGP), 42 U.S.C. §9858 et seq.

[52] See 42 U.S.C. §401 et seq.

Arguably, the public charge question should only be relevant if the institutionalization is permanent and the government support substantial.[53]

II. NONCASH PUBLIC BENEFITS THAT ARE NOT, BY THEMSELVES, RELEVANT TO A PUBLIC CHARGE DETERMINATION

Noncash, supplemental public benefits are not relevant to the public charge determination. These include, among others:

- Food stamps.[54]
- Medicaid benefits (other than Medicaid payments for long term care).[55]
- Benefits under a State Children's Health Insurance Program.[56]
- Other types of health insurance and health services benefits such as emergency medical assistance, immunizations, testing for and treatment of communicable diseases, and use of health clinics.
- Nutrition programs including the Special Supplemental Nutrition Program for Woman, Infants and Children,[57] the Child Nutrition Act,[58] and the Emergency Food Assistance Act.[59]
- Emergency disaster relief.
- Housing benefits.
- Child care services.
- Energy benefits.[60]
- Foster care and adoption benefits.
- Transportation vouchers, or other noncash transportation services.

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[53] See *letter from Kevin Thurm, Deputy Secretary of Health and Human Services, to Doris Meissner, Commissioner*, INS, March 25, 1999, printed at 64 Fed. Reg. 28686, May 26, 1999.
[54] See 7 U.S.C. §2011 et seq.
[55] See 42 U.S.C. §1396 et seq.
[56] See 42 U.S.C. §1397aa et seq.
[57] See 42 U.S.C. §1786.
[58] See 42 U.S.C. §1771 et seq.
[59] See 7 U.S.C. §7501 et seq.
[60] See, e.g., 42 U.S.C. §8621 et seq.

- Educational benefits including Head Start and aid for elementary, secondary, or higher education.

- Noncash benefits funded under TANF.[61]

- State and local supplemental, noncash benefits that serve purposes similar to the federal programs listed in this paragraph.

- Other federal, state, or local public benefit programs under which benefits are provided in-kind, through vouchers, or any other medium of exchange other than payment of cash assistance for income maintenance.

III. FACTORS CONSIDERED IN MAKING PUBLIC CHARGE DECISIONS

A. The totality of the circumstances test

By law, public charge decisions are made by immigration or consular officers based on the totality of the circumstances.[62] At minimum, an immigration or consular officer will consider the immigrant's age, health, family status, assets, resources, financial status, education, and skills, as well as any Affidavit of Support filed by the immigrant's sponsor. No single factor, except for the lack of a sufficient Affidavit of Support, is supposed to control the public charge decision.

B. Treatment of exempt benefits

While the receipt of noncash supplemental benefits such as Medicaid, by itself, is not relevant to the public charge decision, a person receiving Medicaid may still be found a public charge if, under the totality of the circumstances test, the immigration or consular officer determines that the person is or is likely to become dependent on public benefits for subsistence.

C. Past receipt of public benefits

Past receipt of cash benefits and prior institutionalization for long-term care will not necessarily mean that an immigrant will be found inadmissible as a public charge or ineligible to adjust status. The decision must be made in light of the totality of the circumstances, including the length of time during which the immigrant previously received benefits or was institutionalized, and how long ago the benefits were received. The negative implication of past receipt of cash benefits for income maintenance or institutionalization

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[61] See Note 2.

[62] Proposed 8 C.F.R. Part 237, Subpart G, §212.104. Every public charge decision will be made on a case-by-case basis, Id.

for long-term care may be overcome by positive factors demonstrating that the immigrant is unlikely to become dependent on the government in the future.

D. Bonds and cash deposits

Although entirely discretionary, the INS may accept a suitable, legally binding public charge bond or cash deposit as insurance against becoming a public charge.

IV. USE OF BENEFITS BY FAMILY MEMBERS

Public cash benefits for income maintenance received by a relative will not be attributed to the immigrant seeking admission or adjustment of status unless the benefits represent the immigrant's sole support. If the benefits are attributed to the immigrant because they are his/her sole support, they must be considered along with all of the other factors as described in Section III(A).

V. IMMIGRANTS EXEMPT FROM PUBLIC CHARGE DETERMINATIONS

By law, the following immigrants are exempt from public charge determinations:

- Refugees and asylees at the time of admission and adjustment of status to legal permanent residency.
- Amerasian immigrants at the time of admission.
- Cuban and Haitian entrants at adjustment.
- Nicaraguans and other Central Americans who are adjusting their status under the Nicaraguan Adjustment Central American Relief Act (NACARA).
- Haitians who are adjusting their status under the Haitian Refugee Immigration Fairness Act of 1998.
- Immigrants who enter the United States prior to January 1, 1972, and who are otherwise "registry" eligible.
- Other immigrants who are exempted by future legislation.

VI. DEPORTATION AND PUBLIC CHARGE

Deportation on public charge grounds is extremely rare. An immigrant can only be deported on public charge grounds if the immigrant became a public charge within five years after entry into the United States.[63] Before deporting an immigrant on public charge grounds, the INS must demonstrate that:

- The government entity that provided or is providing the public cash assistance for income maintenance or is paying the costs of long-term institutionalization has a legal right to seek repayment of those benefits against the immigrant or another obligated party such as a family member;

- The public entity providing the benefit demanded repayment of the benefit within five years of the immigrants' entry into the United States.

- The immigrant or the obligated party failed to repay the benefits.

- There is a final administrative or court judgment obligating the immigrant or another party to repay the benefit.

- The benefit-granting agency has taken all actions necessary to enforce the judgment, including collection action.

  Note: The service need not make a demand for repayment if the INS proves that there was no one against whom repayment could have been enforced.

  Even then, an immigrant cannot be deported on public charge grounds if the immigrant can prove that the causes that led to becoming a public charge arose after entry to the United States.

VII. LEGAL PERMANENT RESIDENTS (GREEN CARD HOLDERS)

A legal permanent resident is not subject to a public charge determination, unless he/she has traveled outside of the United States for more than 180 days.

VIII. CITIZENSHIP AND PUBLIC CHARGE

Legal permanent residents who apply for citizenship are not subject to public charge determinations. There is no public charge test for naturalization

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[63] The five-year period begins each time the immigrant enters the United States, unless the immigrant is a Legal Permanent Resident.

purposes and no one can lose their citizenship because they have received public benefits.

IX. REPAYMENT OF BENEFITS RECEIVED

Immigration officers and immigration judges do not have authority to make immigrants repay public benefit-granting agencies for assistance received. Requests for repayment can only be made by the benefit-granting agency and any request by INS and State Department officers is improper.

X. RECOMMENDATIONS FOR HELPING IMMIGRANTS OVERCOME THEIR CONCERNS ABOUT PUBLIC CHARGE

Despite the issuance of the guidance and proposed rule, many immigrants remain fearful that use of public benefits, including health care, will result in a public charge determination and adversely impact their immigration status. Misinformation and rumors continue to spread. Public education is key to helping immigrants make informed choices about the types of benefits that can be used with little or no effect on their immigration status.

- Health care providers and benefit-granting agencies should work through community-based organizations, churches, and other entities that have language-appropriate and culturally sensitive staff and are trusted within immigrant communities to help educate immigrants about public charge rules.

- Work with state and local officials to help train caseworkers, enrollment brokers, outreach workers, and others about the new guidance so that they can help explain the rules to immigrants who are seeking benefits for themselves or their families.

- Meet with INS officials locally to find out what INS is doing to inform your community about the new public charge guidance. Suggest and pursue collaborations to disseminate information, including public service announcements and written information.

- Meet with and help educate the immigration bar and immigration judges. Immigration attorneys may not understand the relationship between the receipt of public benefits and their client's immigration status. Some have discouraged their clients from seeking or maintaining noncash public benefits such as Medicaid. It is therefore very important to work with the immigration bar to insure that immigration attorneys are aware of the new guidance and proposed rule.

- Monitor implementation and follow up on problems with local INS offices and state and local officials. Although the guidance and proposed rule are clear, immigrants may still experience misapplication of the rules. It is important to document these problems and report them to the INS through the regional offices and to the Commissioner in Washington, D.C.

See Appendix E: A Quick Guide to "Public Charge" issued by the INS in both English and Spanish.

Chapter 7 Linguistic and Cultural Access in Health Care Settings[64]

Overcoming language and cultural barriers to health care is critical to the well being of the nearly 32 million people in the U.S. who speak a language other than English at home. Immigrants with limited English proficiency (LEP) often face substantial communication problems at every level in the health care delivery system, from applying for benefits and scheduling appointments to understanding how and when to take medications. When health care providers are unable to communicate with their patients, they risk missing or misinterpreting symptoms and can end up providing inappropriate, even dangerous, medical care.

While both federal and state laws require access to linguistically appropriate health care, these laws are little known and rarely enforced. The result has been an unhealthy reliance on untrained interpreters and family members. Efforts are underway to address the problem, however. This chapter provides an overview of the laws governing language access and provides recommendations for improving language access services in health care settings.

I. LANGUAGE ACCESS RESPONSIBILITIES UNDER FEDERAL LAW

A. Title VI of the Civil Rights Act of 1964.[65]

1. *Title VI of the Civil Rights Act of 1964 states:* No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

2. *Actions prohibited under Title VI are:* Title VI prohibits intentional discrimination as well as practices and policies that have the effect of subjecting individuals to discrimination. Federal fund recipients may not, directly or through their contracts with others, on the grounds of race, color or national original, take actions that have the effect of:

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[64] For a comprehensive discussion of language access in health care settings including a review of federal and state laws requiring language access, see *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, the National Health Law Program for the Henry J. Kaiser Family Foundation, January 1998, available by calling 1-800-565-4533.

[65] 42 U.S.C. §2000d. See *also* 45 C.F.R. §80, app A (1994) (listing examples of federal financial assistance, including Medicare, Medicaid, and Maternal and Child Health grants).

a. **Denying an individual any service or the opportunity to participate in the program.**

b. **Providing services or benefits to an individual that are different, or provided in a different manner, from those provided to others.**

c. **Subjecting an individual to segregation.**

d. **Restricting an individual's enjoyment of any privilege enjoyed by others.**

e. **Treating an individual differently from others in determining whether he or she satisfies any admission, enrollment, eligibility or other requirement for a service.**

f. **Denying an individual the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.**[66]

3. *Title VI and health care providers.* Because federal funding of health care is pervasive, nearly every health care provider is bound by Title VI. The U.S. Department of Health and Human Services has long recognized that Title VI requires linguistic accessibility to health care. In addition, the Office for Civil Rights (OCR) within HHS has consistently interpreted Title VI to require the provision of qualified interpreter services and translated materials at no cost to patients.

4. *HHS Office of Civil Rights and language access.* HHS Office of Civil Rights plays a crucial role in defining a health care provider's obligations under the law. OCR regional offices are responsible for investigating formal complaints regarding discrimination against national origin minorities due to linguistic barriers.[67] Numerous OCR administrative decisions have relied upon Title VI to require health care providers, health plans, and social service agencies to undertake a range of activities to provide linguistically accessible services. These decisions commonly require federal fund recipients to:

a. **Provide translation services at no cost to LEP individuals.**

b. **Have written policies regarding language access services and staff who are aware of the policies.**

c. **Ascertain the language needs of prospective patients at the earliest possible opportunity.**

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[66] 42 C.F.R. §80.3(b).

[67] See Appendix D for information about how to file a complaint with the Office of Civil Rights.

d. **Systematically track LEP clients and client needs.**

e. **Identify a single individual or department charged with ensuring the provision of language access services.**

f. **Publicize the availability of no-cost programs and services in non-English community newspapers and on non-English radio and television stations.**

g. **Provide written notices to clients in their primary language informing them of their right to receive interpretive services.**

h. **Use family and friends as translators only as a last resort and only with informed consent.**

i. **Never use minors to translate.**

j. **Ensure the availability of a sufficient number of qualified interpreters on a 24-hour basis so that services are not denied or delayed.**

k. **Use only qualified and trained interpreters with demonstrated proficiency in both English and the other language; knowledge of specialized terms and concepts in both languages; and the ethics of interpreting.** Interpreter performance and proficiency must be evaluated on an ongoing basis.

l. **Limit the use of telephone translation.**

m. **Make translated, written materials available.**

n. **Conduct community outreach to immigrant communities and give notice to community agencies and referral sources about the facility's new policies.**

o. **Provide cultural sensitivity training for staff.**

B. The Hill-Burton Act

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a "community service obligation" that exists in perpetuity. OCR has consistently taken the position that this obligation requires Hill-Burton fund recipients to address the needs of LEP patients.

C. Medicaid

Current Medicaid regulations explicitly require state programs to operate consistent with Title VI of the Civil Rights Act. The Health Care Financing Administration, the agency in charge of Medicaid at the federal level, requires states to communicate with beneficiaries both orally and in writing in a language understood by the beneficiary and to provide interpreters at Medicaid hearings.[68] Current Medicaid regulations also provide heightened protections for people who reside in long-term care facilities and to children and adolescents who are part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Arguably, the costs of translation services are routine administrative expenditures of the Medicaid program; therefore, the state is eligible to receive federal financial participation (FFP), a substantial cost savings.

Proposed federal regulations implementing the Medicaid managed care provisions of the Balanced Budget Act of 1997, published in the Federal Register on September 29, 1998, would require that: state agencies establish a methodology for determining the "prevalent languages" spoken by populations in a given geographic area and to make information available in those languages; state agencies ensure that Managed Care Organizations (MCOs) ensure that services are provided in a culturally competent manner to all enrollees, including translation services; and MCOs provide toll-free numbers to enable enrollees to register complaints and grievances and that these toll-free numbers have adequate TTY and interpreter capability.

D. Medicare

Medicare is the federal health insurance program that covers people aged 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medicare provides reimbursement to Medicare-participating hospitals for bilingual services to inpatients and has initiated pilot programs employing the use of bilingual forms and educational materials.

E. Federal Categorical Grant Programs

Community health centers and health centers that serve migrant workers receive federal funding must agree to provide services in the language and cultural context most appropriate to their patients.

F. Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act of 1986 requires hospitals that participate in the Medicare program and have an emergency

[68] HCFA, State Medicaid Manual §§2900.4 and 2902.9, March 1990.

department to treat patients in an emergency (including women in labor) without regard to their ability to pay. EMTALA sets forth diagnosis and treatment responsibilities that may be difficult or impossible to meet for hospitals that fail to overcome language barriers with their patients.

II. LANGUAGE ACCESS RESPONSIBILITIES UNDER STATE LAW

In recent years, state legislatures and administrative agencies have begun to recognize the growing need for linguistically appropriate health care and to adopt measures that require or encourage health care providers to take steps to overcome language barriers.

A. Language access laws

A few states have passed comprehensive language access laws that set forth a general responsibility for health care facilities to ensure communication with LEP patients. Some of these laws, such as those passed in California, Massachusetts, and New York, detail specific guidance to providers on what they must do. In other states, such as Illinois, the legislation notes the importance of translation services, but leaves it largely to the health care provider to decide on the services it will offer. Many more states have tied language access laws to specific categories of health services. Not surprisingly, states have reserved some of the most stringent requirements for mental health and long-term care facilities. Many states also have enacted provisions that encourage or require both state agencies and social service agencies with whom they contract to provide language appropriate services to LEP patients. Model legislation in California, called the Dymally-Alatorre Bilingual Services Act, imposes direct obligations on state and local agencies to provide appropriate translation services. The Act requires, for example, that agencies translate materials explaining their services into languages spoken by five percent or more of the populations that they serve and employ sufficient numbers of bilingual persons to ensure access for non-English speaking persons.[69]

B. State civil rights laws

State civil rights laws provide another source of authority for the imposition of language access requirements on health care providers. For example, California's civil rights statute prohibits recipients of state funds from discriminating on the basis of ethnic identification, religion, age, sex, color, or physical or mental disability.

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[69] A list of state laws requiring language access is included at Appendix F.

C. Malpractice laws

State statutes and common law rules governing professional malpractice are yet another important source of language access obligations. Inadequate communication with patients may result in liability under tort principles in three ways. First, providers may discover that they are liable for damages resulting from treatment in the absence of informed consent. Second, providers face potential claims that their failure to bridge communication gaps breaches professional standards of care. Third, a provider's violation of language access laws may raise a presumption of negligence in some states.

D. English-only laws

At least eighteen states have enacted laws that make English the official state language. While many of these laws are purely symbolic, some require public officials to speak English—and no other language—when conducting state business. Even the most strict of these laws, however, includes exceptions for law enforcement and public health activities. The effect on language access of a public health exception contained in such laws is hard to measure. Some state agencies may interpret the exception broadly, while other agencies may choose to invoke the exception only in very specific public health activities involving, for example, infectious diseases.

III. LANGUAGE ACCESS RESPONSIBILITIES IN THE PRIVATE SECTOR

The provision of publicly financed health care services is rapidly being delegated to the private sector, with significant effect on the provision of language services. Two developments are particularly noteworthy—the increased reliance on for-profit managed care plans and the growing influence of private accreditation organizations.

A. Managed care

Some innovative HMOs are employing novel programs to provide linguistically appropriate services to LEP patients. Harvard Pilgrim Health Care in New England, for example, has adopted interpreting policies that encourage prescheduling of appointments and use of on-staff interpreters. State governments also can play an important role by adopting baseline standards that managed care companies doing business in the state must meet. While there has been little legislative activity to date in this area, about half of the 80 or so Medicaid managed care contracts reviewed for this manual addressed the need for culturally sensitive services. California, for example, has not only passed legislation that encourages assessment of the linguistic accessibility of managed care plans, but also has inserted noteworthy linguistic accessibility provisions in its Medicaid managed care contracts, including provisions that require health plans to assess the language

capability of their service areas and to develop plans explaining how they will serve LEP populations within those service areas.

B. Accrediting agencies

State and federal agencies are increasingly relying on private accreditation entities to set standards and monitor compliance with those standards. Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions (e.g., psychiatric facilities, home health agencies), and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health MCOs, have adopted standards that require language access in health care.

JCAHO standards require hospitals to employ policies that provide effective communication means for each patient served. For example, on admission, patients must be informed of their rights. If these rights are listed on written notices and postings that the patient cannot understand, then the patient should be informed of his or her rights in a manner that he or she can understand. The NCQA accreditation process calls for MCOs to be able to provide materials in languages understood by LEP enrollees if they serve major non-English speaking populations (at least 10 percent of membership). NCQA's Health Plan Employer Data and Information Set (HEDIS) 3.0 presents a set of performance measures for commercial, Medicare, and Medicaid managed care plans. It includes questions regarding bilingual doctors and staff, availability of trained interpreters, and whether materials are printed in languages other than English.

IV. NATIONAL STANDARDS

The Office of Minority Health is expected to publish for public comment recommendations for national cultural and linguistic competence standards in 1999.[70] National standards will help promote appropriate language access services for all language minority populations.

V. RECOMMENDATIONS

Much work must be done to assure that health providers comply with their legal obligations to provide culturally and linguistically accessible services. Here are a number of suggestions:

- Help educate health care providers and purchasers (such as Medicaid agencies) about the importance of providing culturally and linguistically accessible services to LEP populations as well as their legal obligations under state law. (See Appendix F.)

[70] An advance draft of these standards is posted on NHeLP's web site at www.healthlaw.org.

- Assess state and local laws that promote and require language accessibility. Work with others to enact stronger legislation.

- Use and adapt NHeLP's Language Access Assessment tool[71] to determine the availability of translation services in the local health care market. Highlight best practices.

- Contact the OCR regional office in your area and get to know the staff. Refer appropriate cases for investigation.

- Assess whether the state Medicaid agency promotes and provides appropriate language access services at eligibility centers and other points of contact. Work with your state Medicaid agency to incorporate language access requirements in all managed care contracts.

- State agencies and health plans must ensure that affected LEP consumers' views are understood and incorporated. Insist that LEP consumers are represented on the state's Medical Care Advisory Committee and other state and local advisory panels and task forces.

- Increase efforts to collect data on LEP health status and utilization.

71 Copy attached at Appendix G.

APPENDIX A

2000 POVERTY GUIDELINES

Size of Family Unit	*Gross Yearly Income*
1	$8,350
2	$11,250
3	$14,150
4	$17,050
5	$19,950
6	$22,850
7	$25,750
8	$28,650

For families with more than 8 members, add $2,900 for each additional member.

New poverty guidelines, 2/15/00 fed register

APPENDIX B

KNOW YOUR MEDICAID RIGHTS

If you are applying for or are receiving Medicaid, federal law protects you. Here's how:

- You have the right to apply for Medicaid on the first day that you seek it;
- You have the right to bring someone with you to help you with the application;
- You have the right to have a translator who speaks your language. Written material must be translated or explained in a language you understand
- You have the right to have a decision made about your application within 45 days, or if the application is based on disability, within 90 days of applying;
- You have the right (in most states) to receive coverage beginning with the third month prior to the date of application. This is called *retroactive* Medicaid;
- You have the right to receive treatment and services that are necessary to treat your medical condition. You cannot be denied services based on the type of illness you have or your diagnosis.
- You have the right to receive treatment and services without discrimination based on national origin, race, color, sex or disability;
- You have the right to go to any doctor or health care clinic that will accept your Medicaid card, unless you are getting your health care through a health maintenance organization (managed care plan).
- You have the right to continue to receive Medicaid. The Medicaid agency must find that you are not eligible before you can be cut off.
- You have the right to receive notice before your Medicaid is cut off and to have a hearing if you disagree with a decision to stop your benefits or give you less than what you were getting.

APPENDIX D

HOW TO FILE A COMPLAINT WITH THE U.S. OFFICE FOR CIVIL RIGHTS

If you believe you have been discriminated against because of your race, color or national origin, you may file a complaint with the U.S. Office for Civil Rights (OCR).

You have to file your complaint within 180 days (6 months) of when the discrimination happened.

You can write your own letter or use OCR's Discrimination Complaint Form.

You can send your complaint to the OCR Regional Office for your state or to the Washington, D.C. headquarters:

U.S. Department of Health and Human Services
Office of Civil Rights
Washington, D.C. 20201
202-619-0403

Your complaint must state:

- Your name, address and telephone number.
- You must sign your name.
  If you file a complaint for someone else, include your name, address and telephone number and state your relationship to that person.
- Name and address of the institution or agency you believe discriminated against you.
- How, why and when you believe you were discriminated against.
- Any other relevant information.

Once the complaint is filed, OCR staff will review it and decide whether they have grounds to begin an investigation. If discrimination is found, OCR will negotiate with the institution or agency to voluntarily correct the problems. If negotiations do not work, OCR may bring an action to take away the institution's or agency's federal funding.

If you file a complaint or provide information to OCR about discrimination, the law protects you against retaliation. Notify OCR immediately if anyone takes any action against you because you have complained.

APPENDIX E

Department of Justice
Immigration and Naturalization Service

SUMMARY

October 18, 1999

A Quick Guide to 'Public Charge'
And Receipt of Public Benefits

This guide provides a summary of how receiving public benefits in the United States may or may not affect an alien under the "public charge" provisions of the immigration laws.

- **Aliens applying to become Lawful Permanent Residents (LPRs) (who do not yet have a "green card") –**

  • An alien will **not** be considered a "public charge" for using:

  – **HEALTH CARE BENEFITS,** including programs such as Medicaid, the Children's Health Insurance Program (CHIP), prenatal care, or other free or low-cost medical care at clinics, health centers, or other settings (other than long-term care in a nursing home or similar institution)

  – **FOOD PROGRAMS,** such as Food Stamps, WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children), school meals, or other food assistance

  – **OTHER PROGRAMS THAT DO NOT GIVE CASH** such as public housing, child care, energy assistance, disaster relief, Head Start, or job training or counseling

  • INS **may consider** an alien's use of the following in deciding whether to issue a "green card:"

  - **CASH WELFARE,** such as Supplemental Security Income (SSI), cash · Temporary Assistance for Needy Families (TANF), and state General Assistance

  - **INSTITUTIONALIZATION** for long-term care, such as residing in a nursing home or mental health facility at government expense

Note: INS will **not** consider **CASH WELFARE** or **NON-CASH PROGRAMS** received by an alien's children or other family members for public charge purposes, **unless the cash welfare is the family's only means of support.**

- **Aliens who are LPRs (who already have a "green card") –**

  • LPRs **cannot** lose their status (have their "green card" revoked) if they, their children, or other family members use:

  – **HEALTH CARE, FOOD PROGRAMS** or other **NON-CASH PROGRAMS**

  – **CASH WELFARE** (* see note below for exception)

  – **LONG-TERM CARE** (* see note below for exception)

Notes:

- LPRs who **leave the country for more than 6 months** a time can be questioned about whether they are "public charges" when they return, and the use of cash welfare or long-term care may be considered.

- In very rare circumstances, LPRs who use cash welfare or long-term care within their **first 5 years** in the United States for reasons (such as an illness or disability) that existed **before** their entry to the United States could be considered deportable as a public charge.

• **REFUGEES AND PEOPLE GRANTED ASYLUM** can use any public benefits, including cash welfare, health care, food programs, and other non-cash programs without hurting their chances of getting a "green card."

• **SPONSORING RELATIVES** Using benefits, including cash welfare, health care, food programs, and other non-cash benefits, **does not prevent citizens and LPRs** from sponsoring relatives. However, sponsors must submit an Affidavit of Support showing that they have enough money (alone or with a co-sponsor) to support their relatives at 125 percent of the poverty level.

• **BECOMING A NATURALIZED U.S. CITIZEN** LPRs (who already have a "green card") **cannot be turned down** for U.S. citizenship for lawfully receiving any public benefits for which they are eligible.

Need More Information? For more information about "public charge" –

• Please see the INS Web site at www.ins.usdoj.gov for a fact sheet and questions and answers. Information is available in several languages under Public Affairs.

For more information about how to enroll in benefit programs –

• Please contact the appropriate federal, state or local service agency. Helpful contacts include:

For CHIP: 1-877-543-7669 (calls are free)

For Food Stamps: 1-800-221-5689 (calls are free)

For Medicaid or TANF: www.hhs.gov

For WIC: www.fns.usda.gov

Department of Justice
Immigration and Naturalization Service

SUMMARY

October 18, 1999

Guía Breve Relativa a la Noción de Carga Pública y al Recibo de Beneficios Públicos

La presente guía explica resumidamente cómo el recibo de beneficios públicos en los Estados Unidos puede o no afectar a los extranjeros según las disposiciones de "carga pública" que figuran en las leyes de inmigración.

• Extranjeros que solicitan la Residencia Permanente Lícita; es decir que todavía no tienen un *Green Card* (tarjeta verde)

• Un extranjero **no** será considerado como "carga pública" por recibir:

– **LOS BENEFICIOS DE ATENCION DE SALUD**, incluido el programa de *Medicaid*, el CHIP (Programa de Seguro de Salud para los Niños), la atención prenatal u otro tipo de atención médica gratuita o barata, en consultorios, centros de salud u otras instituciones (que no sea la atención a largo plazo en un hogar de ancianos u otra institución de esa índole).

– **LOS PROGRAMAS DE ALIMENTOS**, por ejemplo *Food Stamps* (sellos para la compra de alimentos), el WIC (Programa Especial de Nutrición Suplementaria para Mujeres, Recién Nacidos y Niños), comidas escolares u otro tipo de asistencia alimenticia.

– **OTROS PROGRAMAS NO MONETARIOS**, por ejemplo vivienda pública, servicios de guardería, ayuda en materia de energía, socorro en caso de desastre, el programa preescolar educativo y cultural *Head Start*, ni asesoramiento o capacitación en el trabajo.

• El INS, al expedir la tarjeta verde **podrá considerar** si el extranjero recibe los siguientes beneficios:

– **ASISTENCIA SOCIAL MONETARIA** por ejemplo el *Supplemental Security Income* (Ingreso de Seguridad Suplementario), el TANF (Asistencia Temporal Monetaria para las Familias Necesitadas) y la asistencia general del Estado.

– **INSTITUCIONALIZACIÓN** para la atención a largo plazo, por ejemplo la residencia en un hogar de

ancianos o institución de salud mental por cuenta del gobierno.

Nota: El INS **no** considerará los programas de **ASISTENCIA SOCIAL MONETARIA** ni los **PROGRAMAS NO MONETARIOS** recibidos por los hijos u otros familiares del extranjero para fines de carga pública, **a menos que la asistencia social monetaria sea la única forma de subsistencia familiar**

• Los extranjeros que sean residentes permanentes lícitos (que ya tengan una tarjeta verde)

• Los residentes permanentes lícitos no podrán perder su condición como tales (revocación de la tarjeta verde) si ellos, sus hijos u otros familiares se benefician de:

– ATENCION DE SALUD, PROGRAMAS DE ALIMENTOS u otros **PROGRAMAS NO MONETARIOS**

– ATENCION SOCIAL MONETARIA (*Véase a continuación la nota de la excepción.)

– ATENCION A LARGO PLAZO (*Véase a continuación la nota de la excepción.)

Notas:

• A los residentes permanentes lícitos que **abandonen el país por más de 6 meses seguidos** se les podrá preguntar si reciben beneficios públicos cuando regresen a los EE.UU. y se podrán tener en cuenta los beneficios de la asistencia social monetaria o de atención a largo plazo.

• En muy raras circunstancias, los residentes permanentes lícitos que se beneficien de la asistencia social monetaria o la atención a largo plazo en sus **primeros cinco años** en los EE.UU por ciertas razones (por ejemplo, enfermedad o discapacidad) que existían antes de su entrada en los Estados Unidos se podrían considerar deportables como carga pública.

• LOS REFUGIADOS Y LOS ASILADOS podrán recibir cualquier beneficio público, incluidos la atención social monetaria, la asistencia de salud, los programas de alimentos y otros programas no monetarios, sin perjuicio de sus posibilidades de obtener la tarjeta verde.

•FAMILIARES PATROCINADORES El recibo de beneficios, incluidos la asistencia social monetaria, la atención de salud, los programas de alimentos y otros beneficios no monetarios, **no impide que los ciudadanos y los residentes permanentes legales** patrocinen a familiares. Sin embargo, los patrocinadores deben presentar una Declaración Jurada de Sustento en la que indiquen que tienen suficiente dinero (sólos o con un copatrocinador) para sostener a sus familiares a un 125 por ciento del nivel de pobreza.

• CIUDADANIA ESTADOUNIDENSE POR NATURALIZACION. los residentes permanentes legales (que ya tienen una tarjeta verde) **no se les puede negar** la ciudadanía estadounidense por el hecho de recibir lícitamente cualesquiera beneficios públicos a los que tengan derecho.

¿Necesita Más Información?

Si necesita más información sobre "carga pública"

• Visite el sitio del INS en la Web www.ins.usdoj.gov para consultar la hoja de datos y la sección de preguntas y respuestas. La información está disponible en varios idiomas bajo *Public Affairs* (Asuntos Públicos).

Si desea más información sobre cómo inscribirse en los programas de beneficios

• Póngase en contacto con el organismo de servicios pertinente a nivel federal, estatal o local. La siguiente información le será de utilidad:

Para CHIP: 1-877-543-7669 (las llamadas son gratuitas)

Para Food Stamps: 1-800-221-5689 (las llamadas son gratuitas)

Para Medicaid o TANF: www.hhs.gov

Para WIC: www.fns.usda.gov

Glossary of Terms Used in This Manual

Affidavits of Support (New) – a legally enforceable agreement between the federal government and an immigrant's sponsor to provide sufficient support to maintain an immigrant at 125 percent of the federal poverty level. Nearly all family-based and some employment-based immigrant visa applicants have to submit the new affidavit of support, Form I-864, which became effective December 19,1997. For anyone not required to use the new form, the traditional affidavit of support, Form I-143, and the rules governing its use remain in effect.

Affidavit of Support (Old) – (Form I-143) a non-binding statement by an immigrant's sponsor to provide financial support to the immigrant.

Amerasian – a child fathered by a U.S. citizen in certain Southeast Asian countries during the years of U.S. conflict in that region. Amerasians are "qualified" immigrants because they were given Legal Permanent Resident (LPR) status under special provisions of the immigration law.

American Indian born in Canada, and certain other tribal members born outside the U.S. – People who possess at least 50 percent of the blood of the American Indian race who were born in Canada or outside the United States (8 U.S.C. Section 1359 & 25 U.S.C. Section 450b(e)).

Asylee – an immigrant who flees his or her country in fear of persecution or with a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and who is already present in the United States at the time he/she obtained asylum.

Battered immigrant spouse or child – a qualified immigrant who: 1) is a victim of domestic violence, 2) has a pending or approved visa petition filed by a U.S. citizen or LPR spouse/parent, a self-petition pursuant to VAWA, or an application for cancellation of a removal/suspension of deportation under VAWA, and 3) whose need for benefits have a substantial connection to the battery or cruelty. Also includes the parent of a battered child and the child of a battered spouse.

BBA – Balanced Budget Act of 1997.

Border crossing identification card – a document of identity bearing the designation issued to an immigrant who is lawfully admitted for permanent residence, or to an immigrant who is a resident in foreign contiguous territory, by a counselor or officer or immigration officer for the purpose of crossing over the borders between the United States and foreign contiguous

territory (8 U.S.C. Section 1101(6)).

Categorically needy – individuals who either qualify automatically for Medicaid because they are eligible for another form of assistance (i.e., Supplemental Security Income), or they fit into specified groups of low-income families and children, or low-income aged, blind, or disabled individuals.

Cuban and Haitian Entrant – a person paroled into the United States as a Cuban or Haitian entrant or any other national from Cuba or Haiti who is the subject of exclusion or removal proceedings or who has an application for asylum pending. Cuban and Haitian entrants are "qualified" immigrants (Refugee Education Assistance Act of 1980, Section 501(e)).

Deeming – the act of adding the income and resources of another person to the income and resources of an applicant to determine eligibility for federal or state public benefits.

Diversity immigrant – an immigrant who has obtained a visa through the diversity visa process. That is a program that makes available 55,000 visas yearly to applicants who: 1) are natives of countries that provided fewer than 50,000 immigrants to the United States over the preceding five years; and 2) have at least a high school education or its equivalent, or have worked for at least two years in an occupation that requires two years of training or experience.

Emergency Medicaid – a form of Medicaid that pays only for the treatment of an emergency medical condition for any immigrant, regardless of immigration status.

Emergency medical condition – the sudden onset of a medical condition (including 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 placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) – the federal anti-dumping statute that requires all hospitals receiving Medicare to examine and provide stabilizing treatment to all patients seeking care for emergency conditions, regardless of their ability to pay and regardless of their eligibility to Medicare (42 U.S.C. Section 1395dd).

Federal means-tested public benefits – defined as: Supplemental Security Income (SSI), Medicaid, Temporary Assistance to Needy Families (TANF), food stamps and the Children's Health Insurance Program (CHIP). Unless

specifically exempted by law, qualified immigrants who enter the United States after August 22, 1996, are ineligible for any federal means-tested public benefit for their first five years in the country.

Federal poverty level (FPL) – the amount of income established by the federal government below which a person is considered to lack adequate support for subsistence. FPL is used to establish eligibility for various federal and state benefit programs. It is also known as the **Federal Income Guideline.**

Federal public benefit – described in the welfare law as: retirement, welfare, health, disability, assisted housing, post-secondary education, food assistance, unemployment benefits, or "any other similar benefit" for which payments/assistance are provided to an individual/household b a U.S. agency or with U.S. funds. Federal public benefits also include any government grant, contract, loan, or professional or commercial license.

Five-year bar - the period of time during which most qualified immigrants who enter the United States on or after August 22, 1996, are barred from receipt of Medicaid and other federal means-tested public benefits.

Forty credited quarters – the term that refers to Social Security credits earned. A person earns Social Security credits by working at a job or as a self-employed individual. For 1978 and later, the number of credits that can be earned is based solely on the person's total yearly earnings. A maximum of four credits can be earned each year. The amount of earnings needed to earn a credit increases and is different for each year. Generally, a person with forty credited quarters would have to have a 10-year work history. To meet the 40 quarters threshold, immigrants may receive credit for work performed: 1) by their parents when the immigrant is under 18, and 2) by a spouse during the marriage (unless the marriage ended in divorce or annulment); however, no credit is given for a quarter worked after December 31, 1996, if a federal means-tested benefit is received in that quarter

Health Care Financing Administration (HCFA) – the federal agency in charge of Medicaid and Medicare.

Hill-Burton Act – a federal law that provided grants to states to build hospitals and other health-care facilities. Hospitals and health care facilities built with Hill-Burton funds assume obligations to provide community services and, to a more limited degree, free care.

Immigrant – a person who is not a U.S. citizen or national who enters the United States with the intent to remain for an indefinite period of time.

Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) – federal statute that imposes restrictions on immigrants' access to

benefits.

Immigration and Naturalization Service of the U.S. (INS) – an agency within the Department of Justice which oversees the implementation of the federal immigration and naturalization laws, including the immigration, exclusion, deportation, expulsion, or removal of immigrants (* U.S.C. §1101(17) & (34)).

Immigration status – the legal or illegal character or condition under which an immigrant has entered the United States.

Lawfully present – a person who has entered or remains in the United States with legal immigration status.

Legal (or lawful) permanent resident (LPR) – an immigrant who has been granted lawful permanent residence status, i.e., who is a green card holder, and is entitled to remain in the United States indefinitely.

Limited English proficiency (LEP) – a term used to describe a person whose primary language is other than English and whose written and oral skill level with English is limited.

Mandatory state supplement – Cash payments that states are required to make to aged, blind, or disabled individuals in order to provide them with the same amount of cash assistance they were receiving before the SSI program was established.

Medicaid – a joint federal/state entitlement program that provides health insurance coverage for low-income people meeting minimum income and other eligibility standards.

Medically needy – **Individuals who fit into federal Medicaid program eligibility categories, but whose income and resources are above the categorically needy levels. States that opt to provide Medicaid for the medically needy allow applicants to "spend down" to eligibility by incurring medical expenses.**

Noncitizen - any person who is not a U.S. citizen or national.

Nonexempt federal means-tested public benefits - SSI, TANF, food stamps, nonemergency Medicaid and CHIP benefits.

Nonprofit, charitable organization – an organization that is: 1) created and operated for purposes other than making gains or profits for the organization, its member, or its shareholders, and that is precluded from distributing any gains or profits to its members or shareholders, and 2) organized and operated for charitable purposes such as relief to the poor, distressed, or

underprivileged, as well as religiously affiliated and educational institutions.

Not-qualified immigrants – immigrants who do not fall within the "qualified" immigrant categories, including persons residing under color of law, such as applicants for asylum and family unity and applicants for adjustment of status, undocumented immigrants, and non-immigrants such as students and foreign visitors.

Parolee for more than one year – a qualified immigrant who has been paroled into the United States for at least one year.

Persons residing under color of law (PRUCOL) – This includes the following immigrants: 1) granted indefinite voluntary departure, 2) residing in the United States under orders of supervision, 3) continuously living in the United States since January 1, 1972, 4) granted stays or suspension of deportation, or 5) whose departure the INS does not contemplate enforcing.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) – This is the welfare reform statute that replaced the Aid to Dependent Children (AFDC) entitlement with block grants to the states for temporary assistance for needy families (TANF); imposed new restrictions on immigrants' access to public benefits, and made it more difficult for children with disabilities to obtain Supplemental Security Income.

"Pickle people" – individuals who are ineligible for Supplemental Security Income or State Supplemental Payments because they have received Social Security cost-of-living increases that place their incomes above eligibility guidelines. Pickle people are categorically eligible for Medicaid. (The name Pickle refers to Congressman Jake Pickle who worked on changing the law to provide eligibility for these people under Medicaid.)

Presumptive Eligibility – at state option, a temporary Medicaid eligibility status that allows pregnant women and children to obtain Medicaid coverage without completing the formal Medicaid application process and waiting for an eligibility determination.

Public charge – determination by the INS or the State Department that an immigrant is likely to become primarily dependent on government public benefits for subsistence.

Qualified immigrant – a lawful permanent resident, a refugee; an asylee; an immigrant who had deportation withheld; an immigrant granted parole for at least one year; an immigrant granted conditional entry; a battered immigrant and her child/children; and immigrants born in Canada who possesses at least 50 percent blood of the American Indian race, or are members of certain Indian tribes.

Refugee - an immigrant who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and who obtains the status while abroad

Retroactive Medicaid – **the three-month period of time before the date of a Medicaid application during which the state must pay for Medicaid-reimbursable medical services received by the recipient. The recipient is eligible for retroactive Medicaid only if he/she would have been eligible had he/she applied for Medicaid at the time services were received.**

Section 1931 – **a section in the Personal Responsibility and Work Opportunity Reconciliation Act that is intended to ensure that low-income families remain eligible for Medicaid after repeal of the AFDC program. Under Section 1931, low-income families with dependent children are eligible for Medicaid if they meet the income and resource standards of the Aid to Families with Dependent Children Program in effect in the state as of July 14, 1996.**

Sponsor – a person who signs an affidavit of support for a person who is applying to immigrate to the United States as a resident. A sponsor must be a U.S. citizen, national, or legal permanent resident, 18 years or older, domiciled in the United States, and must meet income/assets requirements.

Sponsor deeming of income – for any federal means-tested public benefits program, such as TANF, SSI, food stamps, CHIP, and Medicaid, the income and resources of a sponsor are added to those of the immigrant when determining eligibility for, and amount of, benefits available under each of the programs

State Children's Health Insurance Program (SCHIP) – federally funded program to enable the states to provide health insurance to uninsured, "targeted low-income" children under the age of 19 and whose family income meet state-specified guidelines.

Totality of circumstances test – in making public charge determinations, the INS and State Department must look at the immigrant's total circumstances including his/her: 1) age, 2) health, 3) family status, 4) financial status, and 5) education and skills.

Transitional Medical Assistance (TMA) – time limited Medicaid coverage that is provided to families with children who are no longer eligible for Medicaid because of increased earnings. Families are entitled to receive the first six months of TMA, regardless of their income. They may be eligible for another six months of TMA depending on their income and compliance with certain reporting requirements.

"209(b) state" – a state that has opted to provide Medicaid using more restrictive definitions of blindness or disability, or using more restrictive financial eligibility standards then are used in the SSI program.

Undocumented immigrant – a person who is not a U.S. citizen or national, who has entered the United States (or has remained in the United States) without proper documentation and who does not have legal status for immigration purposes.

Withholding of removal (formerly withholding of deportation) – a person who has been granted withholding of removal and is eligible for the refugee exemption, even if he/she has subsequently adjusted to LPR status.

About the Author

Claudia Schlosberg currently serves as a Senior Civil Rights Analyst at the Office of Civil Rights for the U.S. Department of Health and Human Services. She was the staff attorney for the Washington, D.C. office of the National Health Law Program (NHeLP) when she prepared this manual. She was responsible for federal legislative and administrative advocacy on health issues affecting low-income people and for providing technical assistance and information to attorneys and advocates nationwide while at NHeLP.

Before joining the National Health Law Program in September 1996, Claudia was a senior staff attorney at the Judge David L. Bazelon Center for Mental Health Law. While there she was involved in advocacy and system change litigation to improve institutional and community-based services for adults and seniors with serious mental illness. Claudia also worked extensively with consumer groups and on Medicaid "restructuring" issues, i.e., managed care, for people with disabilities.

Since 1988, Claudia has served as legal advisor to the D.C. Long-Term Care Ombudsman Program. As legal advisor, she has represented the Ombudsman and residents in administrative and judicial proceedings and provided legal advice and assistance regarding nursing home and long-term care quality issues and residents' rights.

Claudia has also served as a training consultant for the National Training Project of the American Association of Retired Persons/ Legal Counsel for the Elderly and has trained Ombudsman staff and attorneys regarding nursing home law and advocacy throughout the United States.

Prior to 1988, Claudia directed Advocacy for the Elderly, a legal clinic of the Columbus School of Law at Catholic University, where she taught and supervised evening division law students who were providing legal services to homebound and institutionalized elderly residents of the District of Columbia. She was also in private practice for four years handling criminal, juvenile, domestic relations, and general civil litigation.

Claudia received her law degree from Antioch School of Law in 1981 and graduated from Union College with a B.A. in history in 1976.